Updated Billing Guidelines for Outpatient Services For COVID-19 Cost Share Waiver

January 26, 2022

To ensure accurate claims payment, please follow the updated billing guidelines below for all HAP Commercial, ASO and Medicare products for outpatient services.

Important! For services provided through the end of the Public Health Emergency (PHE), you should use the CS modifier on applicable outpatient claim lines to show the service is subject to the cost-share waiver for COVID-19 testing-related services that result in an order for and are related to providing or administering a COVID-19 test.

Cost share will be waived when a provider:

- Submits a claim line with a CS modifier (professional, facility and telehealth) with a specific outpatient E&M or HCPCS code and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits a claim line with procedure code S9083 with a CS modifier for Urgent Care services and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits COVID-19 CPT/HCPCS testing codes on an outpatient claim if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits a claim line for COVID-19 specimen collection with a CS modifier on an outpatient claim and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate. HAP continues to reimburse only when billed alone. We consider this service inclusive when billed with an E&M code.

- Submits each claim line with CS modifier appended for each additional lab other than COVID-19 diagnostic test when ordered specifically to determine a diagnosis of COVID-19 and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits a claim line for COVID-19 CPT/HCPCS testing for pre-operative procedures. HAP supports correct coding guidelines and as such should be submitted with the following, as appropriate:
  - Z01.810 – Encounter for preprocedural cardiovascular examination
  - Z01.811 – Encounter for preprocedural respiratory examination
  - Z01.812 – Encounter for preprocedural laboratory examination
  - Z01.818 – Encounter for other preprocedural examination

COVID-19 testing for public health surveillance, employment purposes, and other testing not intended for individualized diagnosis or treatment of Covid-19:

- Submits a claim line for testing required for public health surveillance/screening, employment purposes or travel use Z11.52 as the primary diagnosis, as appropriate. This claim line will be denied as this is not a covered benefit.

Billing Guidelines for Telehealth Services During the Public Health Emergency

Our billing requirements for telehealth services are aligned with CMS.

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<tr><th>For</th><th>Billing
Guidelines</th></tr>
<tr><td>Dates of service on or after March 1, 2020, and for the duration of the PHE</td><td>

Bill with Place of Service (POS) equal to what it would have been had the service been furnished in-person and use modifier 95, indicating the service rendered was performed via telehealth
Traditional telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

Effective January 1, 2022
The POS 02 description was revised and a new code, POS 10, was developed. The place of service billed is dependent on where the patient is located during the telehealth service. When billing for telehealth services, use:

POS 02: Telehealth Provided Other than in Patient's Home
Patient is not located in their home when receiving health services or health related services through telecommunication technology
POS 10: Telehealth Provided in Patient's Home
Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

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The CR modifier is not required on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims.
Critical access hospital method II claims should continue to bill with modifier GT.

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