





Therapy Coding & Reimbursement Updates for 2020 and Beyond


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Disclaimer

The information shared in today’s presentation is shared in good faith and for general information purposes only. It is accurate as of the date and time of this presentation. Providers should seek further guidance and assistance from CMS and their Medicare Administrative Contractor (MAC), and state and national associations, and continue to watch for new developments and information regarding the topics discussed today.



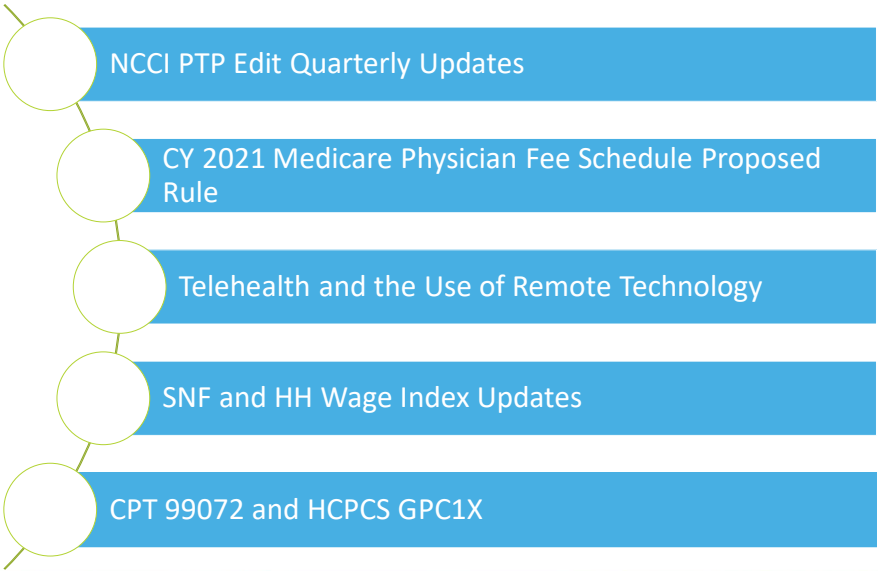
Objectives

- Discuss National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edit quarterly updates, including applicability of the edits to non-Medicare payers.
- Describe proposed coding and reimbursement changes outlined in the CY 2021 Medicare Physician Fee Schedule proposed rule.
- Clarify the use of two-way, audio-video technology under Medicare Part B (outpatient) and Medicare Part A (SNF and HH) during the COVID-19 Public Health Emergency (PHE) and beyond.
- Discuss changes to the wage index for SNF and HH providers, and CMS’s transition plan to mitigate the negative impact.

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Agenda



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NCCI PTP Edits

Updated by CMS quarterly (January, April, July, October)
<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits>
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes

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The 2020 NCCI PTP Edit Timeline

- January 2020 – New “hard” edits established between 97530/97150 and PT/OT eval codes such that if 97530 or 97150 was billed on the same day as a PT or OT eval, the eval code would not be paid.

97530	97161	→	20200101	*	0	←	CPT "separate procedure" definition
97530	97162		20200101	*	0		CPT "separate procedure" definition
97530	97163		20200101	*	0		CPT "separate procedure" definition
97530	97165		20200101	*	0		CPT "separate procedure" definition
97530	97166		20200101	*	0		CPT "separate procedure" definition
97530	97167		20200101	*	0		CPT "separate procedure" definition

- February 3, 2020 – CMS posted updated edit tables with these edits removed retroactive to 1/1/20 in response to aggressive industry-wide advocacy.

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The 2020 NCCI PTP Edit Timeline

- April 2020 – CMS removed many long-standing code pairings, such as the requirement for modifier 59 when 97530 and 97116 and 92507 and 97110 are billed together for the same patient on the same day, retroactively to 12/31/19.

92507	97110		20021001	20191231	1	Misuse of column two code with column one code
92507	97112		20021001	20191231	1	Misuse of column two code with column one code
92507	97127		20180101	20191231	1	Misuse of column two code with column one code
92507	97150		20021001	20191231	1	Misuse of column two code with column one code
92507	97530		20021001	20191231	1	Misuse of column two code with column one code



- July 2020 – No changes
- Removing these edits, while a “win” for the industry at first glance, posed significant challenges to providers when dealing with payers other than traditional Medicare Part B who may or may not have updated their systems with the most current edit table.

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The 2020 NCCI PTP Edit Timeline

- October 2020 – Changes (deletions) made in April have been reinstated, effective 10/1/20.

92507	97110		20021001	20191231	1	Misuse of column two code with column one code
92507	97110	→	20201001	*	1	Misuse of column two code with column one code
92507	97112		20201001	*	1	Misuse of column two code with column one code
→	92507	97112	20021001	20191231	1	Misuse of column two code with column one code
	92507	97127	20180101	20191231	1	Misuse of column two code with column one code
	92507	97150	20021001	20191231	1	Misuse of column two code with column one code
	92507	97150	20201001	*	1	Misuse of column two code with column one code
	92507	97530	20201001	*	1	Misuse of column two code with column one code
	92507	97530	20021001	20191231	1	Misuse of column two code with column one code
	92507	97532	20021001	20171231	1	Misuse of column two code with column one code
	92507	97533	20100701	20191231	1	Misuse of column two code with column one code
	92507	97533	20201001	*	1	Misuse of column two code with column one code
	92507	G0268	20030101	20191231	0	Misuse of column two code with column one code
→	92507	G0268	20201001	*	0	Misuse of column two code with column one code
	92507	G0515	20180101	20191231	1	Misuse of column two code with column one code

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Final Thoughts for 2020

- The hard edits between 97530/97150 and the PT/OT eval codes have *not* been reinstated.
- **There is no current edit between CPT 92507/92508 and 97129 (or 97130).** Meaning, modifier 59 is *not* required to bill treatment of speech and cognitive therapy for the same patient on the same day.
- **HOWEVER**, guidance provided by CMS in Chapter 11 of the Medicare NCCI Edit Manual states the following regarding this code pair:

A single practitioner shall not report CPT codes 92507 (Treatment of speech, language, voice...; individual) and/or 92508 (Treatment of speech, language, voice...; group) on the same date of service as HCPCS/CPT codes 97219 [97129], 97533 (Sensory integrative techniques to enhance...), or G0515 (Development of cognitive skills to improve...). However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech language pathologist performs the procedures described by CPT codes 92507 and/or 92508 on the same date of service that an occupational therapist performs the procedures described by HCPCS/CPT codes 97219, 97533, and/or G0515, a provider entity that employs both types of practitioners may report both services using an NCCI PTP-associated modifier. (CPT code 97532 was deleted on January 1, 2018. CPT code 97127 was deleted on January 1, 2020).

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CY 2021 Medicare Physician Fee Schedule Proposed Rule

Released 8/3/20; comment period closed 10/5/20

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CY 2021 MPFS Proposed Rule: Payment Updates

- CMS proposes a 10.61% decrease in the physician fee schedule (PFS) conversion factor – 32.2605 (vs. 36.0896 for CY 2020).
- PT and OT services paid via the PFS are expected to see an overall 9% reduction in reimbursement in 2021; SLP services, a 7% decrease in 2021.
 - Recall that in the CY 2020 final rule, CMS finalized changes to increase reimbursement for the office/outpatient physician E/M codes beginning 1/1/21. By law, PFS updates are to be budget neutral, resulting in cuts to payment for more than 30 specialties to offset the increase in payment for the physician E/M codes.

Specialty	Combined RVU Impact
Audiologist	-7%
Chiropractor	-10%
Endocrinology	17%
Family Practice	13%
Nurse Practitioner	8%
Orthopedic Surgery	-5%
Physical/Occupational Therapy	-9%
Radiology	-11%

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CY 2021 MPFS Proposed Rule: Payment Updates

- Proposes to revalue (i.e., increase) the work RVU of CPT codes 97161-97168 (PT/OT eval & re-eval) and 92521-92524 (speech-language eval) in the same way as they have revalued the office/outpatient E/M codes. CMS estimates this increase to the work RVU will be 28%.
 - While this increase is a positive adjustment, it does not counterbalance the significant decrease to every other PT, OT, and SLP CPT/HCPCS code proposed for CY 2021.
- CMS published an RVU addendum file which can be used, along with the proposed conversion factor of 32.2605, to calculate anticipated rates and payment changes for 2021*.

HCPCS Code	Description	CY 2020 Rate	Proposed CY 2021 Rate	% Change
92507	Treatment of speech	\$81.20	\$71.97	-11.4%
G0283	Unattended estim	\$14.07	\$12.26	-12.9%
97110	Therapeutic exercise	\$31.40	\$28.07	-10.6%
97112	Neuro reeducation	\$36.09	\$32.58	-9.7%
97140	Manual therapy	\$28.87	\$25.81	-10.6%
97530	Therapeutic activities	\$40.42	\$36.45	-9.8%
97162	PT eval, moderate complexity	\$87.70	\$94.85	7.5%
97166	OT eval, moderate complexity	\$92.75	\$97.10	4.5%

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*Note: These rates reflect national payment rates, without consideration for geographic/wage index, MPPR, etc.



Advocacy Update

- The therapy professional organizations, including NARA, NASL, APTA, AOTA, and ASHA, joined with more than 30 other specialty organizations to advocate to stop these cuts.
- Advocacy efforts have been directed at both Congress and CMS, and these efforts continue.
- **Holding Providers Harmless From Medicare Cuts During COVID-19 Act of 2020 (H.R. 8702)**
 - Introduced in the House on 10/30/20.
 - Adds funding to Medicare and directs CMS to essentially reset payment to 2020 levels for the specialties impacted by the cuts – keeps payment stable for the next 2 years.

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CY 2021 MPFS Proposed Rule: Virtual Services

- Proposes to add services the Medicare telehealth list permanently, to create a new option for adding services to the list on a temporary basis (“Category 3”), and to not retain some services on the telehealth list after the COVID-19 PHE ends – therapy CPT codes are on the list to *not* be retained.
- Proposes to adopt the policy established during the PHE that allows PTs, OTs, and SLPs to furnish and bill e-visits (HCPCS G2061, G2062, G2063) on a permanent basis.
- Proposes to adopt 2 new G codes to represent virtual check-ins and remote assessment of recorded video/images for practitioners who cannot independently bill E/M services: G20X0 and G20X2.
 - This means these services would be available to therapists to render and bill *after the PHE ends*.

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CY 2021 MPFS Proposed Rule: Virtual Services

- CMS clarifies that if audio/video technology is used to furnish a service when the patient and practitioner are in the same institutional or office setting, the practitioner should bill as if the service was furnished in person (i.e., this is not considered telehealth).
- Proposes to extend the “virtual direct supervision” policy until the later of the end of the calendar year in which the PHE ends or 12/31/21.
 - Clarifies that the requirement of direct supervision could be met by the supervising physician or practitioner being “immediately able to engage via audio/video technology,” and does not require real-time presence or observation of the service via interactive A/V technology throughout the performance of the procedure.
- Clarifies that the CPT codes for remote physiologic monitoring (RPM) services (CPT 99453, 99454, 99091, 99457, 99458) are E/M codes and therefore may only be billed by physicians and other practitioners who are able to bill these codes – i.e., not PTs, OTs, and SLPs.

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Telehealth and the Use of Remote Technology

First, check state practice act.

Then, check payer policy.

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Terminology (CMS)

- **Telehealth:** Services provided by real-time, two-way audio/video technology that are described by HCPCS codes and *paid under the Physician Fee Schedule*. Telehealth visits replace in-person visits.
 - CMS does not use the term telehealth to describe services provided remotely using real-time, two-way audio/video technology to patients under Medicare Part A. Rather, CMS uses terms like “services provided remotely using technology” or “using telecommunications technology to furnish a service”.
- **Communication Technology Based Services (CTBS):** Assessment and management services provided using various forms of technology (e.g., online patient portal, telephone, synchronous two-way audio/video) that do not take the place of an in-person visit, but are intended to address a patient-identified need that has arisen since the last “interaction” with the provider and requires immediate attention.

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Telehealth vs. CTBS

TELEHEALTH

- Potential to deliver both evaluations and treatments; ability to establish and follow the plan of care virtually
- Therapists and assistants
- Real-time, two-way audio video technology
- Covered by Medicare Part B and many commercial payers

CTBS

- Assessment & management services provided between in-person “visits”
- Therapists only
- Platform dependent on service provided (e.g., telephone assessment, e-visit)
- Covered by Medicare Part B but not many commercial payers

Coverage of telehealth and CTBS under Medicare Part B for PT/OT/SLP is currently for the duration of the COVID-19 PHE only.

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Telehealth and Therapy Services: Medicare Part B

- PTs, OTs, and SLPs were added as eligible providers of telehealth under Medicare Part B on 4/30/20 via a waiver that expanded the distant site provider list for the duration of the COVID-19 PHE. At that time, only therapists in private practice (i.e., those who bill on professional claims/1500 form) were designated as eligible.
- Per a revised FAQ posted by CMS on 5/27/20, institutional providers, including hospital OP departments, SNFs, rehab agencies, and HHAs, are able to provide and bill for outpatient therapy services delivered via telehealth on institutional claims/UB-04.
- CMS clarified on the 5/5/20 Office Hours call that PTAs and OTAs may provide telehealth – as long as allowed by state law and supervision requirements are met.
- Telehealth services should be reported with modifier 95 and the place of service (POS) equal to what it would have been had the service been issued in person (e.g., POS 11).
 - Note: POS codes are only reported on professional claims.

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Billing for Telehealth

- CPT/HCPCS codes – Medicare Telehealth services list; check with specific payer
- Modifiers
 - 95 – synchronous telehealth (Medicare Part B)
 - GT – synchronous telehealth
 - GQ – asynchronous telehealth
 - CR – catastrophe or disaster-related
 - And, other applicable modifiers (GP/GO/GN, CQ/CO, 59, KX)
- Place of Service (professional claims only)
 - 02 – Telehealth
 - 11 – Clinic (Medicare Part B)

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Telehealth and Therapy Services: Medicare Part B

▪ Approved HCPCS/CPT code list for telehealth during the COVID-19 PHE:

97161-97163	97535*
97164	97542
97165-97167	97750
97168	97755
97110	97760
97112	97761
97116	92521-92524*
97150	92507*
97530	92508*

▪ Note: 92610, 92526, 97129/97130 are not included here – check with other payers.

* These codes may be provided via audio-only technology for the duration of the PHE.

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Remote Visits and Therapy Services: Medicare Part A

▪ SNF:

- CMS stated in the COVID-19 FAQ document (updated 6/19/20) that therapy services may be furnished remotely to a Part A SNF patient during the COVID-19 PHE (consistent with state scope of practice laws), and that such services would remain subject to consolidated billing.
- And, during the COVID-19 Office Hours call on 6/2/20, CMS clarified that minutes provided remotely to a patient in a Part A SNF stay may be counted on the MDS.
- CMS clarified in the COVID-19 FAQ document (updated 4/9/20) and again in the CY 2021 Medicare Physician Fee Schedule proposed rule that if the patient and practitioner are “in the same institutional setting” and are using telecommunications technology to furnish a service, the practitioner should bill as if the service was furnished in person, and the service would not be subject to any of the telehealth requirements (such as the application of modifier 95).

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Remote Visits and Therapy Services: Medicare Part A

- Home Health:

- In the first Interim Final Rule released 3/30/20, CMS stated that during the COVID-19 PHE, providers could use “various types of telecommunications systems (that is, technology)” in addition to remote patient monitoring, in conjunction with in-person visits.
- Use of technology must be included on the HH plan of care.
- Visits provided remotely cannot replace an in-person visit, and therefore, are not counted toward the LUPA threshold or reported on the claim.
- In the CY 2021 HH PPS final rule, CMS made these current flexibilities with the use of technology permanent after the end of the PHE.
- **Home Health Emergency Access to Telehealth (HEAT) Act**
 - Introduced in the Senate 10/23/20.
 - Bipartisan bill to provide Medicare reimbursement for audio/video telehealth services during the PHE.

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Communication Technology-Based Services (CTBS)

- Assessment and management services that would not normally be provided in person; must be initiated by the patient.
 - Do not take the place of a visit (and do not “count” as a visit).
 - May be provided by a PT, OT, or SLP only – not a PTA or OTA.
1. E-visits (G2061, G2062, G2063)
 2. Virtual Check-in (G2012) – New HCPCS code proposed for nonphysician practitioners = G20X2
 3. Remote assessment of recorded video and/or images (G2010) – New HCPCS code proposed for nonphysician practitioners = G20X0
 4. Telephone assessment and management service (98966, 98967, 98968)

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Billing for CTBS

CPT/HCPCS	Description	Modifier/POS Required	Unique Characteristics
G2061	E-visit – cumulative time during the 7 days; 5-10 min	GP/GO/GN	Communication via online patient portal; should not be billed if a face-to-face visit for the same/related problem occurs within 7 days before or after the e-visit
G2062	E-visit – cumulative time during the 7 days; 11-20 min	CR modifier for Med B	
G2063	E-visit – cumulative time during the 7 days; 21+ min	For institutional claims: DR condition code for Med B	
G2010 (G20X0?)	Remote evaluation of recorded video and/or images, not originating from a related service provided within the previous 7 days or next 24 hours	For professional claims: POS representing location of billing therapist	Broad range of communication methods may be used; “store and forward”; follow-up discussion must be within 24 hours
G2012 (G20X2?)	Virtual check-in; 5-10 min of medical discussion; not originating from a related service provided within the previous 7 days or next 24 hours	KX modifier for Med B	May use audio-only or two-way, real-time A/V technology; requires direct interaction between patient and provider
98966	Telephone assessment & management; 5-10 min; not originating from a related service provided within the previous 7 days or next 24 hours	GP/GO/GN	Telephone only; may communicate with patient, parent, or guardian
98967	Telephone assessment & management; 11-20 min; not originating from...	For professional claims: POS representing location of billing therapist	
98968	Telephone assessment & management; 21-30 min; not originating from...	KX modifier for Med B	

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Telehealth: Specific Payer Requirements

	Medicare Part B	UHC	AETNA*	CIGNA
Allowed Services	G2061-G2063, G2010, G2012, 98966-98968, 92507, 92508, 92521-92524, 97161-97168, 97110, 97112, 97116, 97150, 97530, 97535, 97542, 97550, 97755, 97760, 97761	92507, 92521-92524, 92526, 96105, 97129, 97130, 97161-97168, 97110, 97112, 97116, 97530, 97535, 97750, 97755, 97760, 97761	G2061-G2063 (or 98970-98972), 92507, 92521-92524, 97161-97168, 97110, 97112, 97116, 97535, 97755, 97760, 97761	“Any service” on the current fee schedule.
Modifiers	For CTBS: Modifier CR For Telehealth: Modifier 95	Modifier 95	Modifier GT or 95	Modifier GQ, GT, or 95
Professional or Institutional Claim	Professional claim w/ POS that would have been reported had service been furnished in person (e.g., POS 11). Also allowed on institutional claims.	Professional claim w/ POS that would have been reported had service been furnished in person (e.g., POS 11). Institutional claim w/ applicable revenue code.	For commercial members, professional claim telehealth billed w/ POS 02. For Medicare, POS 02 or POS that would have been reported w/ face-to-face. Also allowed on institutional claims.	Professional claim w/ face-to-face POS, such as POS 11. Also allowed on institutional claims w/ applicable revenue code.
Timeframe	DOS 3/1/20 through duration of PHE	DOS 3/18 through ?? (plan-dependent)	DOS 3/9/20 Through 12/31/20	Beginning 4/9/20 through 12/31/20

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*Applicable CPT codes for Aetna are accessible via the provider Availity portal. This list may not be comprehensive/current.



SNF & HH Wage Index Updates

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Changes to CBSAs

- In the FY 2021 SNF, Hospice, and IRF final rules and the CY 2021 HH final rule, CMS adopted the Office of Management and Budget's (OMB's) updates to delineations of statistical areas including some new core-based statistical areas (CBSAs), urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would be split apart beginning 10/1/20.
- With these changes, 34 counties currently classified as urban changed to rural, and 47 currently classified as rural changed to urban. Several counties will change from one urban CBSA to another, and still others will change from urban to another newly proposed or modified CBSA.
- To mitigate the potential negative impact of this change, CMS finalized a transition plan for FY / CY 2021.
 - CMS applied a 5% cap on any decrease in the wage index from the prior year in FY or CY 2021, phasing in the reduction over a two-year period.

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FY 2021 SNF PPS Final Rule: Wage Index Updates

- CMS posted updated wage index tables in conjunction with the final rule, including the impact on the wage index per facility.

Wage Index Change			
FY 2020 Wage Index	FY 2021 Wage Index (Old OMB Delineati on)	FY 2021 Wage Index (New OMB Delineati on)	FY 2021 Wage Index (New OMB Delineation + 5% Cap)
1.2745	1.2998	1.0623	1.2108
1.2745	1.2998	1.0623	1.2108
1.2745	1.2998	1.0623	1.2108
1.2745	1.2998	1.0623	1.2108
1.2745	1.2998	1.0623	1.2108
0.9950	0.8962	0.8962	0.9453
0.9950	0.8962	0.8962	0.9453
0.9950	0.8962	0.8962	0.9453



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CY 2021 HH PPS Final Rule: Wage Index Updates

- Updated wage index files are posted on the CMS Home Health Agency website.
- Unlike other CMS payment systems (like SNF PPS), the geographic area adjustment – the wage index update – is determined by the beneficiary’s county of residence rather than the provider’s location.

Proposed Wage Index New CBSA Designation & 5% Cap	CBSA Number or Alternate Number that would go in the CBSA field on the claim
0.9987	26900
0.9854	26980
0.9854	26980
0.9581	27060
0.8661	27100
0.8306	27140

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CPT 99072 & HCPCS GPC1X

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CPT 99072: Effective 9/8/20

- **CPT 99072:** Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease.
 - Patient symptom checks over the phone and upon arrival
 - Donning and removing PPE
 - Increased sanitation measures
- Should only be reported when the service is rendered in a *non-facility place of service* (POS) setting and in an area where it is required to mitigate the transmission of the respiratory disease for which the PHE was declared.
- Reported only once per in-person patient encounter.
- CMS has not assigned payment to this code. Check with commercial payers.

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HCPCS GPC1X: Effective 1/1/2021

- **HCPCS GPC1X:** Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).
- In the CY 2020 PFS final rule, CMS finalized separate payment for this code and assigned a work RVU of 0.33.
- In this year’s proposed rule, CMS is soliciting comments on which aspects of the definition of the code are unclear, how CMS might address those concerns, and how CMS might refine utilization assumptions for the code.
 - NARA submitted comments asking for clarification on when and how often this code could be billed and notes that practitioners who are not eligible to bill E/M codes see the same types of patients to whom this code would apply.
- Bottom Line: As it stands today, this is not an add-on code that would be applicable to PTs, OTs, or SLPs.

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Questions?
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Resources

- APTA. Commercial Payer Telehealth or E-visits Coverage. https://www.apta.org/uploadedFiles/APTAorg/Practice_and_Patient_Care/Patient_Care/Technology/Telehealth/Coding_and_Billing/TelehealthEvisitsCOVID19CommercialPayer.pdf
- AOTA. Commercial Payer Telehealth Coverage. <https://www.aota.org/~media/Corporate/Files/Advocacy/Telehealth-Insurance-Companies-COVID.pdf>
- ASHA. Coding and Reimbursement of Cognitive Evaluation and Treatment Services. <https://www.asha.org/practice/reimbursement/coding-and-reimbursement-of-cognitive-evaluation-and-treatment-services/>
- Center for Connected Health Policy. <https://www.cchpca.org/>
- Cigna's Response to COVID-19. <https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwcCOVID-19.html>
- CMS Coronavirus Waivers & Flexibilities. <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>
- CMS Coronavirus COVID-19 Stakeholder Calls. <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts>
- CMS Covered Telehealth Services for the PHE for the COVID-19 pandemic (effective 3/1/20). <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- CMS COVID-19 FAQs (updated 10/20/20). <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

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Resources

- CMS CY 2021 Home Health PPS Final Rule (10/29/20). <https://public-inspection.federalregister.gov/2020-24146.pdf>
- CMS HH PPS Wage Index Tables. <https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center>
- CMS CY 2021 Medicare Physician Fee Schedule Proposed Rule (8/3/20). <https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-17127.pdf>
- CMS (8/26/20). MLN Matters SE20011. "Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)." <https://www.cms.gov/files/document/se20011.pdf>
- CMS NCCI Policy Manual for Medicare Services (rev 1/1/20). <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd>
- CMS NCCI PTP Edit Tables. <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits>
- CMS Quarterly PTP and MUE Version Update Changes. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes
- CMS SNF PPS Wage Index Tables. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/WageIndex.html>
- CMS SNF PPS Final Rule (7/31/20). <https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-16900.pdf>
- CPT Assistant. "COVID-19 Coding Update." <https://www.ama-assn.org/system/files/2020-09/cpt-assistant-guide-coronavirus-september-2020.pdf>
- UHC COVID-19 Telehealth Services. <https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services.html>

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