

UDS Novel Coronavirus Disease (COVID-19) Reporting

The guidance below provides responses to questions regarding UDS reporting impacted by COVID-19. For additional information on other COVID-19-related reporting considerations, such as temporary sites, health center staffing (e.g., volunteers), and funding and revenue, please refer to [HRSA’s COVID-19 Frequently Asked Questions \(FAQs\)](#).

Visits and Patients

If health centers increased virtual visit capabilities during the COVID-19 pandemic, how are these visits and patients reported on the UDS?

- Report virtual visits on Table 5 in Column b2 (Virtual Visits, shown below). These visits **must** meet the criteria for a UDS visit (documented contact between a provider and a patient in which the provider exercises independent, professional judgement in the provision of in-scope services to the patient at an approved location). Additionally, virtual visits must be coded as such in the health center’s health information technology or electronic health record system.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
*	Excerpt from Table 5				

- Count patients throughout the UDS (demographics, services, clinical, and financial sections) when their visits qualify as a virtual visit, even if the visit is the first or only visit for the patient during the reporting period. For further guidance, refer to [the UDS Virtual Visit resource guide](#).
- A UDS countable virtual visit must use live (synchronous, real-time) video connection between a provider and a patient (e.g., “FaceTime”) and/or two-way interactive audio technology (e.g., telephone). For the purpose of UDS reporting, store-and-forward (asynchronous, not real-time) or the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos is **not** a countable UDS virtual visit.
- Virtual check-ins, used to determine whether an established patient requires a visit, and e-visits, which are portal communications with established patients, would **not** count for UDS reporting purposes.

Should individuals who receive a COVID-19 test or screening during the reporting year be reported on the UDS?

- If an individual is screened or tested (i.e., a specimen is collected or a series of questions asked to assess condition) for COVID-19 and there is no treatment or examination that are typical with evaluation and management services (i.e., assessment of health status, examination, medical decision making) provided by the health center during the reporting year then this individual and encounter are not counted **anywhere** in the UDS (see also page 22 of the [2020 UDS Manual](#) for services and persons not reported).
 - The Centers for Medicare & Medicaid Services' (CMS) [Evaluation and Management Services Guide](#) is a useful resource for learning about the general principles of evaluation and management documentation, including the level and complexity of the service provided.
Note: Practitioner to practitioner consultation services are not countable as a UDS visit.
- If, during the reporting year, the health center provides an individual with additional services (either before or after a non-reportable UDS service) that meet the visit criteria mentioned above (see also page 19 of the [2020 UDS Manual](#)), that individual may be considered a patient for UDS reporting. Their visit and the associated care would be reported on the UDS Report.
- A test or screening alone does not count as a UDS visit.

Staffing

On Table 5, should possible staffing changes experienced by health centers be reported (e.g., staff furloughed, laid off, and/or out on Family and Medical Leave Act (FMLA))?

- Health centers should calculate and report any amount of staff full-time equivalent (FTE) on Table 5 that the health center is paying for or incurring costs for during the reporting year, even if the employee is not working (e.g., seeing patients) in that time.
- If a health center staff person was laid off or furloughed during the reporting year, any portion of the year where they were not employed by the health center or not being paid by the health center, should be not be included in the FTE reported on Table 5.
- If a health center staff person was out of work under FMLA during the reporting year, any portion of the year when a staff person was not working **and** not compensated should not be included in the FTE reported on Table 5.
- If a health center employed new staff during the reporting year and the staff provided in-scope activities, then their FTE should be calculated and reported on Table 5 based on the time worked and compensated during the year (see also page 46 of the [2020 UDS Manual](#) for Table 5 FTE reporting instructions).
- If volunteer staff provided in-scope services at a health center during the reporting year, then this volunteer time should be calculated and reported as FTE on Table 5 (see also page 158 of the [2020 UDS Manual](#) for reporting instructions on services provided by volunteer providers).

COVID-19 Tests and Diagnoses

Were new lines added to Table 6A to capture data on COVID-19 testing and diagnosis?

- Yes. Four new lines were added: Line 4c (Novel coronavirus (SARS-CoV-2) disease), Line 6a (Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease), Line 21c (Novel coronavirus (SARS-CoV-2) diagnostic test), and Line 21d (Novel coronavirus (SARS-CoV-2) antibody test).

Table 6A, Line 6a (Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease) includes a note that states, “count only when code U07.1 is present”. To be counted on Line 6a, does ICD code U07.1 (COVID-19) need to be included in the same visit as the acute respiratory illness diagnosis-coded visit?

- The COVID-19 diagnosis code, U07.1, needs to be associated **with** the acute respiratory illness visit for it to mean that the service visit for acute respiratory illness was due to the novel coronavirus.

Health centers are not always able to collect Current Procedural Terminology (CPT) codes for COVID-19 testing. Can lab codes, rather than the CPT codes listed in the manual, be used to report COVID-19 testing on Table 6A?

- If a lab code (e.g., Logical Observation Identifiers Names and Codes (LOINC) code) is specifically capturing the intended test and reflects that it is administered/completed (not just referred), then that code could be used. A test can be counted if it is: 1) performed by the health center, 2) paid for by the health center, but not performed by the health center, or 3) whose results are returned to the health center provider to evaluate and provide results to the patient, but not performed by the health center or paid for by the health center.

Will health centers need to report on patients who received COVID-19 vaccines, if developed in 2020?

- If a Food and Drug Administration-approved COVID-19 vaccine becomes available during the calendar year, health centers will report the count of patients who received the vaccine on the UDS Other Data Elements Form, Appendix E.
- The count will **not** include vaccines administered to health center patients while participating in clinical trials.

Clinical Quality Reporting

New health center protocols and workflows have changed the provision of care in response to COVID-19; and procedures, documentation, and follow up will be affected. How will UDS clinical quality measure performance be considered for 2020 UDS, especially if compliance rates suffer?

- BPHC recognizes the essential work (providing testing and care for those directly affected by the virus) being performed by health centers during the COVID-19 pandemic, while implementing steps to continue to provide routine, preventive, and chronic disease care to patients.
- There are steps that health centers can take to meet compliance with UDS clinical measure reporting. While some care must happen in person to meet the measurement standard, some care can be provided virtually. Please refer to the [Telehealth Impacts on Clinical Quality Measures handout](#) to see how virtual visits impact specific measure criteria.
- Document as much information in your systems as possible. Additionally, during the 2020 UDS data reporting and review period, health centers should document the impacts in UDS table validation comment fields prior to submission and work with their UDS Reviewer post-submission to help explain any changes resulting from the pandemic. For example, if a dental practice closed for three months and then reopened at limited capacity, provide that level of detail.

Can patient-reported vitals (e.g., blood pressure readings, height, and/or weight) obtained during a virtual visit count as meeting the measurement standard of certain UDS-reported clinical quality measures that require these? Can other services, tests, or procedures required to meet the measurement standard be done via telehealth?

- For some clinical measures that require these vitals, self-attestation is not accepted. Each electronic clinical quality measure (eCQM) is defined by the specified measure steward and the UDS Report aligns with their instruction.
- The measure stewards and CMS have provided [guidance](#) and decisions for inclusion (or removal) of telehealth (virtual) in the evaluation of each component (denominator, exclusion, numerator) of the eCQM. Please refer to the [Telehealth Impacts on Clinical Quality Measures handout](#) for specific guidance on each UDS-reported clinical measure.

On the Table 7, Controlling High Blood Pressure measure, what is the guidance on remote patient monitoring as it relates to virtual visits? How does remote patient monitoring differ from patient self-report?

- Only blood pressure readings performed by a clinician or care team member by a remote monitoring device are acceptable to meet the Controlling High Blood Pressure measurement standard, as specified by the measure steward ([CMS165v8](#)).
- The device must capture and store the reading taken by the patient from a device which is observed by the clinician or member of the care team, and recorded in the patient's chart at the health center. This is not the same as a patient providing this information to the provider (e.g.,

verbally or by entering the result into a patient portal), which would not meet the measurement standard.

Revenue

Where should health centers report COVID-19-related revenue on the UDS Report?

- For 2020 UDS reporting, several lines were added to the revenue tables (Tables 9D and 9E) for COVID-19 reporting. Additions include:
 - Table 9D, Line 8c ("Other Public, including COVID-19 Uninsured Program") to reflect charges, collections, and adjustments associated with testing and treatment of uninsured patients with suspected or diagnosed COVID-19.
 - Table 9E, Lines 1l through 1p: COVID-19 Supplemental Funding to reflect the grant amounts drawn down from BPHC activity codes H8C, H8D, ECT, or HEROES/HEALS, or other COVID-19-related funding from BPHC.
 - Note: HEROES and HEALS funding are still pending, and will be reported here only if legislation passes.
 - Table 9E, Line 3b: Provider Relief Fund to reflect funds received through the U.S. Department of Health and Human Services (HHS) to provide relief to eligible providers for health care-related expenses or lost revenue attributable to coronavirus.