Centers for Medicare & Medicaid Services
COVID-19 Office Hours
Moderator: Alina Czekai
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5:00 p.m. ET

OPERATOR: This is Conference #: 1181167.

Alina Czekai: Good afternoon. Thank you for joining our May 7th CMS COVID-19 Office Hours. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai, leading Stakeholder Engagement on COVID-19 in the Office of CMS Administrator Seema Verma.

Office Hours provides an opportunity for providers on the frontline to ask questions of agency officials regarding CMS' temporary action that empowers local hospitals and health care systems to increase hospital capacity, rapidly expand the health care workforce, put patients over paperwork and further promote telehealth and Medicare, and as well members of the press are always welcome to attend this call.

We do ask that they please refrain from asking questions. All press and media questions can be submitted using our Media Inquiries form which can be found online at cms.gov/newsroom/mediainquiries, and any non-media COVID-19-related questions for CMS can be directed to our e-mail box which is covid-19@cms.hhs.gov.

And we'd like to begin today's call with some frequently raised questions and topics and address how the Interim Final Rule announced last week addresses these key topics. First topic being telehealth and remote services, CMS is further expanding telemedicine and remote services through the following flexibilities. Hospitals may bill for remote services furnished by hospital-based clinicians to patients in the hospital, including temporary expansion sites such as the patient's home.

Hospitals may also bill the originating site facility fee for services provided by in telehealth professional to be registered hospital outpatient even if the patient is located at a temporary expansion location of the hospital, such as the patient's home, any established pay parity for audio-only telephone consultation, and we are waiving the video requirement for certain E&M services.

And finally, we are initiating a speedier process for adding eligible telehealth services. In regards to COVID-19 testing, COVID-19 tests will be covered by Medicare when ordered by any health care professional and testing can be done at alternative sites and other point-of-care sites, such as pharmacies.

Additionally, hospitals and physicians and other eligible practitioners billing under the physician fee schedule can now bill for the specimen collection required to conduct COVID-19 tests for new and established patient. And finally, certain antibody tests for COVID-19 are also now covered by Medicare and Medicaid.

In regards to our Hospital Without Walls Initiative, CMS has added new flexibilities to those that were previously announced under the Hospital Without Walls Initiative to further increase hospital capacity, including increased number of beds in hospitals, teaching hospitals, rural health clinics and several types of inpatient facilities.

Inpatient rehab facilities can accept patients from acute care hospitals. Long-term acute care hospitals can now accept any acute care patients and hospital on and off campus outpatient departments have an avenue to relocate and continue to be paid at the rates under the OPPS.

And also in regards to Hospitals Without Walls, under the flexibilities that already existed under Hospital Without Walls, CMS affirmed that the patient's home can serve as a temporary expansion site to the hospital, so long as the hospital conditions of participation to the extent not waived are met in several scenarios, including therapy and counseling, patient education, glucose monitoring.

And finally, in regards to workforce flexibilities, CMS has added several workforce flexibilities across health care professionals, including nurse practitioners, CNAs and PAs can provide home health services. We waived the requirements for ambulatory surgery centers to reappraise medical staff privileges. (MTTs), SLPs and OTs can furnish services via telehealth.

And finally, we also received a question last week and the question was, is any guidance on coverage for pre-procedure testing being initiated or announced? And if a beneficiary had a COVID-19 test and then comes in for a procedure and the test was a week or two ago, can the patient be retested?

And the response to last week's question is CMS has not established national policy, either through rulemaking or a national coverage determination regarding coverage of this type of test. Therefore, (absent) any national policy coverage of these tests are determined by Medicare Administrative Contractors.

And with that, we will now open up the line for live question and answer. Operator, over to you.

Operator: At this time, if you would like to ask a question, simply press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Your first question is from the line of (Rebecca Moore).

(Rebecca Moore): Hello. I have a couple of questions. First, I want to validate with the new specimen code for COVID testing, the C9803, can this code be applied in the emergency room or only in the office or clinics?

(Tiffany): That code is only for hospital specimen collection, so …

(Rebecca Moore): Right.

(Tiffany): … the – if the emergency department is part of a hospital, that would be the appropriate code. Outside of the hospital …

(Rebecca Moore): Great.

(Tiffany): … the level 1 E&M code …

(Rebecca Moore): OK, great.

(Tiffany): … is appropriate.

(Rebecca Moore): OK. And does the specimen collection include both swabs for testing and serology test for antibody?

(Tiffany): I think the serology testing may be different. I'll defer to others on this call for that.

(Rebecca Moore): OK. And while someone is checking, I'll just ask can I assume that if we are using the C9803 for the blood specimen in the emergency room within the hospital, we would – that would replace that 36415, the venipuncture or a fingerstick code?

(Tiffany): You would look at the code description and make sure that the code that you're billing matches ...

(Rebecca Moore): OK.

(Tiffany): … what you're billing. So, if you're doing for the C9803, if it's specific to COVID-19 specimen collection that would be an appropriate code. If you're doing something other than that, we would encourage you to look at the code descriptors and to bill the most appropriate code. We'll get back …

(Rebecca Moore): OK.

(Tiffany): … to you on the serology testing. We can take that one back with that kind of question …

(Rebecca Moore): OK. And then where home health – oh, OK.

(Tiffany): Go ahead. Go ahead.

(Rebecca Moore): I will – well, I was going to ask a home health nurse in the home doing specimen collection could bill the C9803?

(Tiffany): C9803 is for hospitals only.

(Rebecca Moore): Hospital only. OK. And you know when the MACs will be accepting that code?

(Tiffany): Hopefully, very soon. We don't have an update on when the MACs will be able to accept the code on today's call, but very soon.

(Rebecca Moore): OK. And I just have one more question, doesn't have anything to do with specimen collection. This is regarding teaching faculty and how to bill services provided by health officers when there is no face-to-face interaction, so the phone visits or e-visits.

The Medicare says the teaching physician must participate in the key portion to virtual technology, but it doesn't specify what it means for telephone calls to the 99441 to 99443, what the teaching physician has to do with three-way call, with either the fellow or health officer and the patients? And these are time-based.

(Ryan): So …

(Rebecca Moore): Oh, excuse me.

(Ryan): So, I think you would use the same – the same policy would apply – that would apply for an in-person visit that was time-based. So, it was primarily – so if you were coding a physician E&M code, for example, the time rules when it – when it was predominantly counseling service. The – what you would ordinarily do in terms of the requirement for the teaching physician to be in the room would instead – could take place via audio presence.

So, to the extent that that same service if billed in in-person would require the presence of a physician at a particular point or duration then the same thing would be true for the audio presence using technology.

(Rebecca Moore): OK. Great. Thank you so much for taking my questions.

Female: Sure, and before you get off the line, I just do want chime in real quickly on the specimen collection question that you had had. I think your question was about whether or not the various codes whether it's G223 or C9083, depending on who's performing the specimen collection and where it's done if those could be billed – were those limited just to the swab test or if that could also be billed for the serology test and the code descriptor is actually specify any specimen source?

(Rebecca Moore): OK.

Female: And so that means exactly what it is and the specimen source. So, it doesn't matter if it's a needle swab or if it's a blood draw.

(Rebecca Moore): Great. Thank you so much.

Female: Sure.

Operator: And your next question is from the line of Jim Collins.

(Jim Collins): Yes. Thank you. My question is about the supervision requirements. The Interim Final Rule says that virtual supervision via real-time audio and video connectivity would be sufficient. So, (obviously) doctor is doing a diagnostic test in their office and supervising it remotely, does that mean that we have to have real-time audio and video established throughout the entire duration of the procedure? Does it just mean we need to be available? I guess is the question.

(Ryan): No, so the – so similar to the last question. In terms of supervision requirements, the use of the audio/video technology for virtual presence would be similar to the in-person presence in their office suite.

(Jim Collins): OK.

(Ryan): So, that wouldn't necessarily mean that the person supervising would have to be in the same room. And as long as the – as long as the connection could be

established in the same way with the same facility as a person could sort of move from one part of the office suite to another then that would meet the requirements.

(Jim Collins): OK. That sounds great. And then the last thing is there any hint of what will happen to telehealth after the pandemic is over? What the patients like it, what the doctors like it, but it requires in a lot of places, there's a lot of investment and restructuring. Is this all going to turn into a pumpkin in a couple of weeks?

(Ryan): So, I don't think we would prognosticate about the timing of the public health emergency, though for many of the changes that have happened through the two Interim Final Rules, as well as the waivers, they are those changes in rules only apply for the duration of the public health emergency.

But as you probably know – and we have not addressed what happened to the end of that public health emergency, but under the rules that they are currently set up, all of those changes would expire at the end of the public health emergency. The exception would be some of the – some of the finer points in the – in the Interim Final Rules where we've clarified certain things as existing policy but may be needed to do some clarification.

Some of those would probably – would continue to apply, but for the most part, the bulk of the changes would expire at the end of the public health emergency, pending additional changes either in law or in regulation which are …

(Jim Collins): Got it.

Alina Czekai: OK.

(Ryan): … which are possible, yes.

(Jim Collins): OK, great. Thank you very much.

Operator: Your next question is from the line of Ronald Hirsch.

Ronald Hirsch: Hi. First, I have to go back to the C9803 and burst your bubble because the description of it says, "Hospital outpatient clinic visit for SARS-CoV-2. The swab test is for the virus. The blood test is for the antibody." So, it's not actually detecting the presence of the virus. So, I would be wary that that would apply to a venipuncture, but my real question is about observation.

And on Tuesday, it was said that if the hospitalist, they should place the CS on every one of their visit codes even though the visit that resulted in the COVID test was actually done by the emergency department based on the order for emergency doctor.

So, if the hospitalists are placing the CS modifier, what about all of the consultants that may see the patient while they're in their observation stay? They're going to bill with office visit code, which were included in the CARES Act phrasing.

And then my other question also on observation is the hospital is going to submit an observation stay claim that includes the ED visit and the observation hours. And if all the normal conditions are met, that's to me is the comprehensive APC. So, if the CS modifier is on the line item for the ED visit, the facility fee, does that mean the observation APC will be paid at 100 percent?

(Ryan): So, in terms of the place under the CS modifier on the – on the various evaluation management visits, I think that the instruction, as well as the statutory provision addresses the services that are those kinds of visits that lead to the order of the administration of the test.

And so, it's certainly conceivable that you might have evaluation and management services furnished by more than one professional that leads to the test – that together both of those services lead to the test.

So, I think that there would not necessarily be a limiting provision of the CS modifier to a single E&M visit code, and I'll see if Tiffany wants to answer the other question on the sort of answer …

(Tiffany): Sure.

(Ryan): … of ABC.

(Tiffany): Sure. Dr. Hirsch for the hospital observation services, you're correct that they do map to a comprehensive APC payment, and those services are specifically called out in the statute. So, the cost-sharing labor would apply for the – for the comprehensive APC payment for observation services in that incident.

Ronald Hirsch: Very good. Thank you, Tiffany and Ryan.

(Tiffany): Sure.

Operator: Your next question is from the line of Mark McDavid.

(Mark McDavid): Hi, there. This is (Mark McDavid). Thank you so much for taking my call. I wanted to circle back to some conversation that was held on Tuesday related to – from physical, occupational and speech therapy services in telehealth. I think it's clear that those services can be provided via physical therapist or via OT and speech and private practice that bill on a 1500.

I just wanted to clarify that if you provided those services as incident to a physician visit also billed on the 1500, is that acceptable location to provide PT, OT and speech telehealth?

(Ryan): I think the short answer is yes that the – that the …

(Mark McDavid): Yes.

(Ryan): … that the PT, OT and SLP services could be furnished incident to from a physician's …

(Mark McDavid): OK.

(Ryan): … perspective and sort of – it's a different and under supervision via therapist in private practice, but in both cases …

(Mark McDavid): Yes.

(Ryan): … the – that could be done via telehealth.

(Mark McDavid): Got it. Thank you. Also, I believe Rick brought up on Tuesday's call services provided – outpatient services provided in a rehab agency which is I think Medicare files an outpatient physical therapy or an OPT, that service is billed on a UB-04 like an institutional setting.

Same thing for skilled nursing facility outpatient, many facilities in the country provide outpatient services to folks that they discharged, as well as home health. Home health provides some Part B therapy services from time to time.

And so my question is, is they're only in discussion about the ability for PT, OT and speech to provide telehealth when they bill on a UB-04 or is that issue basically closed at this point, and those settings are just not able to bill for telehealth or they're not going to be able to bill for telehealth?

(Ryan): So, I think we're still exploring what the – what the – what the possibilities are there, and we're working to …

(Mark McDavid): Sure.

(Ryan): … as soon as we can.

(Mark McDavid): OK. Thank you. Also related for Part A home health patients, when Rick brought up skilled nursing on the call on Tuesday, those in discussion about bundled payment and so on and so forth, understanding that skilled nursing facility Part A and Home Health Part A is a bundled payment.

I can foresee a scenario wherein the home health setting therapy and/or a Part A stay or a Part A visit may provide that service via telehealth or have the opportunity, too. Is there any limitation on therapy doing that under a Part A stay? I will – again, realizing it's under a bundled payment.

(Danielle Cara): This is Danielle Cara from CCSQ. I can answer this just from a COP's perspective.

(Mark McDavid): OK.

(Danielle Cara): That it is permissible if providing the service via telehealth actually meets – the patients need and preferences. Not now, I can't speak to it …

(Mark McDavid): Got it.

(Danielle Cara): … from the billing side.

(Mark McDavid): Sure. This is it. So, if patient had said, "I would rather not have providers coming to home, but I still need to do the exercise," but currently the supervision of the exercises then it could be possible for a PT or an OT to oversee via telehealth that visit.

(Danielle Cara): Yes, if that is – if the technology is capable of meeting the patients' needs is really what it comes down to.

(Mark McDavid): OK.

(Danielle Cara): So, yes, it is – it is possible …

(Mark McDavid): Yes.

(Danielle Cara): … that is permissible and it's possible and will be done on a case by case basis.

(Mark McDavid): Understood. OK, thank you. Probably more questions, I'm going to …

(Danielle Cara): OK.

(Mark McDavid): … shift gears and talk about skilled nursing facilities for a minute In the skilled nursing facility, the – for those parts that we had on isolation, there's a lot of donning and doffing of PPE as providers go in and out of those rooms and those (wings), they asked a few weeks ago on a call about (counting) for therapy to be able to count those minutes to set up as part of the therapy visit.

And does it – I believe you guys are going to check it out and I just haven't heard anything back , so I was just following up.

Male: I think we're still …

(Mark McDavid): So, this is our private – OK, go ahead.

Male: Yes, could you go ahead and clarify that a little bit more. It's something that we've …

(Mark McDavid): Yes, so …

Male: … been – have been taking a look at but it would – it would be helpful to get a little more detail to make sure we're looking at the right question.

(Mark McDavid): OK. Absolutely. Understanding that therapy minutes no longer a driver of reimbursement, but we're still capturing that information on the MDS. So, in Section O of the MDS depending on which MDS we're completing, we're identifying how many therapy minutes were provided to patients in the previous seven days and are discharged in the previous entirety of the stay.

And so historically, we have counted setup time based on (RAI) definition and preparing for that therapy visit and now we're finding that there – again, a lot of PPE and such being donned and doffed and so the question is, can we count the time that the therapists are putting on or taking off the PPE as part of therapy minutes for purposes of counting minutes on the MDS?

Male: OK, yes. That's helpful to get – to hear that question, again, (phrase) in that way, I think that will help us make sure that we're looking in the right spot. I did want to go back to your question about home health and in terms of what is bundled under the home health benefit.

I just want to remind everyone that under the home health benefit, the plan of care is the controlling a document and that in-person visits are the ones that count towards payment purposes, but that remote work telehealth visits under the home health benefit can be used when appropriate or when recognized in the plan of care.

(Mark McDavid): Thank you for the clarification. Last question, again, in the nursing home setting, we have many folks, as I've said, they were putting on isolation for COVID or suspicion of COVID, CDC guidelines recommend that we cohort those patients, the RAI definition of isolation is one patient, one room. I know that these questions have been asked before. I just wanted to clarify and see if that was – this is where we're landing.

If there's any further explanation on the part of CMS, they're changing that definition for the extent of the emergency and the reason I asked the question, again, is we have not just therapist but a lot of staff, CNAs and nursing staff that are spending a lot more time donning and doffing that it's PPE and so the cost preparing for this individual was going up, and as you know, when you have a patient who qualified for isolation, there's an increase daily rates for those individuals.

And so it would be beneficial to the facility to be able to capture that increased rate so that they could offset the increased cost related to the care.

Male: This – what – the question that you've asked is one that we have been looking into, but are not …

(Mark McDavid): OK.

Male: … able to make a change of that nature via a sub-regulatory means, and so the current policy does continue to be that for payment purposes where it is one patient per room in terms of the higher payment, and we do recognize that cohortingof patients is actively going on and being recommended, but we're not able to provide a differential payment.

(Mark McDavid): OK. So, just to clarify, that's not something you saying that we can do in emergency type waiver or anything like that, sub-regulatory. We have changed regulation in order for that to happen.

Male: At this point, that is our interpretation, yes, of – are possible …

(Mark McDavid): OK. Understood. Perfect. Thank you so much, again. Thank you for the time and thank you for holding these calls. They're very helpful. Thank you.

Operator: Your next question is from the line of Rick Segawenda.

(Rick Segawenda): Hi. I just want to – a couple of questions about the Interim Final Rule and house was adding provider-based departments. For an Interim Final Rule published on April 30th, and pages 32 to 44 virtually discussing relocating the provider-based department and to be a patient's home, it continually uses the word hospitals and under OPPS.

Then on page 45, all of a sudden it mentions critical access hospital. So, I guess the – one – the first question is, does the expansion of a Medicare beneficiary's home as a provider-based department. Does it apply to critical access hospitals as well or just hospitals that are normally signed up with an acute care hospital paid under OPPS where these visits are not being – again, be paid under the physician fee schedule.

(Tiffany): So, the provider-based rules were waived in their entirety and that was under a blanket waiver not under the regulation that you just cited. So, for any hospital that is able to have provider-based department that would apply to those hospitals. The section that you're referring to in the regulation talks about how hospitals were paid under the OPPS would be paid if they relocate and accepted department which is paid under the OPPS.

If you relocate, that payment would be – could change it if that relocation is not given an exception. So, that only applies to – again, the hospitals that are paid under the OPPS and would not apply to critical access hospitals.

(Rick Segawenda): But a critical access hospital could add a Medicare beneficiary home as a provider-base department?

(Tiffany): If a critical access hospital can add provider-based department under normal regulation, there would be no change to that.

(Rick Segawenda): OK. And then continuing with that, CMS with same – if a hospital is going to add a patient's home as a provider-based department, and they need to send their information to CMS Regional Office that contains certain information.

Does that have to – does that – would the hospital have to send to CMS Regional Office a separate e-mail for each patient's home they want to add as provider-based department or could they kind of create an Excel spreadsheet and include each patient's name, add address of the location, reason why they're adding and just kind of send one document?

(Tiffany): Let me turn over to Dave, but before I do, there's nothing in the regulation that asked for the patient's name to be submitted to …

(Rick Segawenda): But one of the – one of the six requirements were that I think the address of the facility – I think the address of the patient's home, hospital CCN number, reason for, when to add, the six items.

(Tiffany): Yes.

(Dave): Yes. Thanks – sure. Thanks, Tiffany. So, hospitals have 120 days from the date on which they began furnishing the services at the PBD to submit the request. And as part of that request, they are not required to submit a separate e-mail for each relocation site. They can request all the addresses to which the PBD relocated over a period of weeks or months rather than a single request for each location.

So, regardless of what they decided doing the single e-mail or multiple e-mails, they should notify regional office of the address of any patient homes to which the PBD relocates and if the hospital intends to be paid under the OPPS for those services.

Alternatively, the hospital could choose not to submit this information for an extraordinary circumstance relocation request and could simply bill the services provided with the PN modifier and receive the PFS equivalent rate for those services.

We end – and as you mention about what should be included when this information is provided? We anticipate that hospitals will determine the disclosures of the patient address to CMS that's committed under HIPAA, but

hospitals should be careful not to include unnecessary personal information, such as beneficiaries' names or diagnosis on the relocation request.

In addition – additionally, hospital should encrypt the relocation request information prior to sending it to CMS regional office by e-mail. Would that…

(Rick Segawenda): Correct and then …

(Tiffany): Thank you.

(Rick Segawenda): … it does – and then those services – from a physical therapy standpoint would be billed as normal physical therapy in-person visit and paid under the physician fee schedule, correct?

(Dave): Right. That service would still be paid that …

Alina Czekai: Thank you, for your question.

(Dave): Correct.

Alina Czekai: We'll take another question, please.

Operator: Your next question is from the line of Robert Lattes.

(Robert Lattes): Thank you very much for taking my question, and I want to follow up a little bit on some of the questions (Mark) was asking earlier and this is related to the skilled nursing facility setting and recognizing that both CMS and providers want to limit the spread of COVID and understanding that COVID is present at times in nursing homes and also recognizing that the CDC recommends that we do not utilize PRN therapist in those homes.

And with all this together and it comes related to telehealth services, and a couple of scenarios might help, so therapist shows up at the door, I'm going to say a physical therapist in the situation but they do their temperature checks. The therapist is sent home that day because either temperature is high, whatever the case, or it could be they have – I've had another therapist go home early on maternity leave.

Saw their OB/GYN in the morning, couldn't come in the afternoon. In both cases, evaluations are scheduled for them. There are assistants on-site to provide the care. Everything is there. It's is a very safe setting for everyone involved, and I can only imagine that CMS wants to let us utilize telehealth in the scenario because it's an excellent way. It's one of the safest ways for a telehealth visit.

And so my real question comes down, how can I – with my doctorate in physical therapy, how can I bill my professional services in this scenario on the UB-04 where I provide a telehealth visit from the home into the skilled nursing facility with the physical therapist assistant there with the patient and with other health care providers nearby.

And I know that you've been talking about this for a while. We've been waiting for an answer for six weeks and that's happening these scenarios day after day in skilled nursing facilities across the country. And again, I can only believe that we want to be used in this. It's just how do we bill for these professional services.

And also, there is precedence, though some of the MACs have already paid for this, when the 95 code has been billed with no point of service. So, I think it's an easy process. We just need you to say, "Yes, we can do this." That's my question. Thank you.

Male: We certainly appreciate all of the scenarios as you present and all the work that you're doing and we're actively working on clarifying answers for your questions.

(Robert Lattes): I recognized we're actively working to do them. I'm just encouraging that we act a little bit sooner because we're getting more and more of these patients with COVID in these homes and these scenarios are happening, more and more regularly. And we really want to provide good care and that's one great way we can do so. Thank you.

Male: Thank you.

Operator: Your next question is from the line of (Kathy Austin).

(Kathy Austin): Hi. Thank you so much for taking my call. I'm going to try to make this short and sweet. I do have several questions, but I'll keep it to a minimum because I know others are anxious as I am to get in. My first question is regarding quote, "Our swab specimen collection that we are performing, hospital staff who's performing this service and we will be billing those with the C9803."

My question is, would it be acceptable for us to utilize the Roster Billing Format for this such as we do for our flu?

Diane Kovach: Hi. This is Diane Kovach. And no, we can't, Roster Billing – for that billing have the authority to allow Roster Billing for Flu and Pneumococcal and that resulted a legislative requirement.

(Kathy Austin): OK. Thank you, Diane. My second question is regarding quote, "Audiologist and our genetic counselors as a hospital-based providers." Given that the regulations that were enhanced last week for our PT, OT, et cetera, can these providers also provide the services that they normally were prior to pre-PHE just like the PT, OT, speech, even though their services may not be listed on the current list of services?

(Tiffany): I'll start and then I'll turn it over to Ryan. I think it's important and it is a hard nuance to appreciate and I totally understand that. The regulation that was released on April 30th, when it speaks about hospital services being remote. It does not make hospital services telehealth services.

And I think that's the really important nuance. So, what we were trying to say there and I'm really happy to hear all the questions and I think that shows us where we may need to do some additional guidance, but what we were trying to say is that if a hospital can furnish us an existing hospital service remotely to a patient in the hospital which can now include under the waivers the patient's home or another temporary expansion site …

(Kathy Austin): Right.

(Tiffany): … the hospital itself can bill for that service. That does not make that services – telehealth services, still is a service that's furnished in the hospital. So, the answer to your question I think is if the audiologist or any other clinician is a hospital employee who is billing for his or her services as hospital services not …

(Kathy Austin): Yes.

(Tiffany): … under the professional services.

(Kathy Austin): Correct.

(Tiffany): Those services can be done remotely …

(Kathy Austin): Yes.

(Tiffany): … then that's exactly what we were describing, but it is – but there is that nuance there. It's not telehealth.

(Kathy Austin): Correct. That is absolutely correct. You answered that perfectly Diane. Thank you so much. And if I may, may I ask just one more?

Alina Czekai: Go ahead.

(Kathy Austin): OK. Can you confirm that if a specific code such a speech therapy service CPT 92507 which is treatment of speech, language, voice, communication, et cetera per individual?

If it's not on that list of your example i.e. would it be OK to still bill that particular service to the patient that is home-bound even while the hospital staff is at the hospital because it can pretty much performed via communication whether it's a – the telehealth or audio, video, et cetera. So, you've kind of already answered that with number two that I'd already asked.

(Tiffany): Yes, yes. I think going – and that's the list of – it's exactly as you said. It's examples only.

(Kathy Austin): Yes.

(Tiffany): So, if there are other services that the hospital staff can furnish remotely and still be able to say that they have furnished that complete service to a patient who's again in a provider-based department of the hospital and it's a registered hospital outpatient. There's no prohibition on that, and it is an example list. We were trying to be helpful. We understand that sometimes people see the example and get nervous.

(Kathy Austin): Yes.

(Tiffany): But – does that answer …

(Kathy Austin): I appreciate all your time. Yes, it certainly does. Thank you so much, and I appreciate everything you all are doing. I'll let somebody else take the call now because I don't want to hog it all.

(Tiffany): All right. Thanks, (Kathy).

(Kathy Austin): Thank you.

Operator: Your next question is from the line of Sandy Sage.

(Sandy Sage): Hi. A quick question, we've been told by our MAC that inpatient COVID positive – inpatient COVID positive patients do not have the patient responsibility waived, only outpatient do. Is that correct? That there's still be – they're not paying 100 percent of the Medicare allowed – amount on inpatient because they're saying it can't be waived.

(Tiffany): It's correct that the CS modifier only applies to outpatient settings.

(Sandy Sage): Right. The modifier applies. That means that patients that are inpatient still have to pay their copays and does that rule et cetera?

(Tiffany): That's my understanding. I don't know if anyone else on the call wants to take one.

(Sandy Sage): Yikes. OK. One other thing is this – the C9803 for the collection, it's considered the clinic visit. So, if that was billed in the emergency department,

would that not hit an edit with the E&M level for the ER visit also being on it? It seems like it would be like two E&M levels kind of – since it's considered a clinic visit.

(Tiffany): I'm – it's a conditionally packaged code.

(Sandy Sage): Right.

(Tiffany): So, if you're billing it with a visit or another service that's primary, it would be packaged into that service. So, I don't anticipate that those editing issues you just mentioned would be an issue.

(Sandy Sage): OK. And a very final thing is the print – price transparency rule being delayed because of the COVID-19 public health emergency.

Male: No. There's a – there's a delay implementation on it already from when it was issued.

(Sandy Sage): Right. Well, we would like you all to delay that, again, if you don't mind because nobody said time to work on it with the COVID, but could you all maybe check and see if that's a possibility?

Male: We'll definitely consider albeit what we give but we do including that.

(Sandy Sage): Yes, OK. It's a huge job and so the hospitals I know would appreciate that. Thank you very much.

Alina Czekai: Thank you. We'll take our next question, please.

Operator: Your next question is from the line of Shay Von.

(Shay Von): Hi. I just wanted to ask this question, 605, the billing of the telephone-only codes were 99441 through 443 because we're hearing that MACs are applying the rules differently. So, I want to clarify CMS' stance on billing for those codes. Should they be billed with the 95 modifier? Should they be billed with place of service 02 or should provider use – like place of service 11, for example?

And will CMS be doing or the MACs be doing automatic adjustment of prior submitted claims that may have not been billed with the correct modifier or may have not been priced correctly prior to the Interim Final Rule? Will the price be adjust or will an all MAC adjustment be done?

(Ryan): Sure. So, thank you for your question. So, when those cohorts were first made payable with the Interim Final Rule that we released on – at the end of March. The 95 modifier wouldn't have been used, but with the second Interim Final Rule released at the end of April that also increased the payment rate for those services.

We did also add them to the telehealth list and that was in connection with the increased payment rate, and so we are asking that the 95 modifier be applied and when would may be happening is as changes happened very quickly. They may be being implemented and addressed in different parts of the country at different rates or pays, I should say.

The pays have changed might be a little bit different but the current policy that remains in effect is to apply the 95 modifier and make payment for those codes at the higher of the two rates. With regards to the reprocessing, we do not believe the kind – that a provider should have a need to resubmit the claims and the (MACs) will be instructed to reprocess those claims to make payment at the higher rate.

(Shay Von): OK. And what about this place of service?

(Ryan): The place of service should follow the same as the current policy for the place of service for other telehealth services during the PAT. So, that would be not the – not the 02, but rather whatever the appropriate place of service code that would have been used have that service have been impression – furnished in person.

So, if it's in the – those are the clearest example as if it's – if it's – is replacing a visit that would have taken place in the office then the office place of service code would be reported, and if it would have been – if it would have otherwise

been taking place in a provider-based clinic then the appropriate place of code – service code for the provider-based clinic should be used.

(Shay Von): That's awesome. So, the MAC being instructed to auto adjust those at some point, that's not going to take place on July 1st, but will there be some new date announced regarding that?

(Ryan): I don't know if anybody else on the line. I don't think I can speak to when the – when that will happen or set up even what the expectation should be.

(Shay Von): OK. You're awesome. Thank you so much.

(Ryan): Thank you.

Operator: Your next question is from the line of Yvonne Seibert Bailey.

(Devon): Hi. Thank you for taking this – my call today. This is – my name is Devon. I'm with Strategic Healthcare but I'm calling on behalf of the Organ Procurement Organizations, and I'm sure probably none of you have – you may not know how the answers to some of these questions, but please bear with me.

First off, a number of hospitals have reached out to the OPOs saying that they are not going to notify them of an eminent death that has to do with COVID or that was a COVID-related death. This – nothing has been determined on whether or not those donors would be used or not, but in the Social Security Act under the Conditions of Participation, it states that every single death or eminent death must be reported to the OPO.

Has any guidance gone out to these hospitals to make sure that they understand that they must still report these deaths?

Karen Tritz: Hi. This is Karen Tritz. I'll speak to that. We have not issued specific guidance around the reporting of the deaths, issued guidance regarding access for OPO staff into those hospitals. We have also not waived to those requirements as part of any of our blanket waivers.

And so those requirements still remain in effect, but appreciate your feedback that there's still – there's some lack of clarity or lack of understanding about reporting those deaths to the OPO. So, thank you very much.

(Devon): Yes. There's quite a few hospitals that are letting OPOs know that they're not going to be reporting them. In fact, there was even one that stated – they were going to make an OPO sign a contract that they did not have to report those deaths and they were going to be asking for a waiver.

The OPO for – is currently trying to fight back with their attorneys that we're worried that they're missing out on deaths. So, it's some of clarification can be put out that would be helpful.

The other one is the question that several have sent there – some of you may be familiar with the recovery center model that OPOs are employing where they transfer the brain-dead donor from the hospital over to a separate center where they perform the recovery surgery. Transplant hospitals don't send donors over there due to a sub-regulatory guidance document that states that they can't.

But we were wondering if due to the current nature if we could – if that could be another additional waiver may be under Hospital Without Walls to allow them to perform these services outside the walls and that – it could – it could free up ICU beds and ventilators during the time.

Karen Tritz: So, this is Karen, again. I think that's something that we would want to take a look at. I think that guidance on Hospital Without Walls is quite broad, and so I think if you'd like to send that in we can just take a look at it.

(Devon): I have about five or six times.

Karen Tritz: OK. You can – you can send it to me directly. Let me give you my e-mail.

(Devon): You can give me your name, I can look it up. Karen …

Karen Tritz: OK. Karen Tritz, T-R-I-T-Z. Thank you.

(Devon): T-R-I-T-Z. Thank you very much, Karen. I appreciate that. That's all. Thank you.

Alina Czekai: (Inaudible), next question, please?

Operator: Your next question is from Sue Thomas.

(Sue Thomas): Hello. This is Sue Thomas. My questions are both related to the telehealth visits in a provider-based hospital clinic and one question is related to condition code DR. In the frequently asked questions, it says, except in the case of telehealth condition code DR should be used.

Can you clarify if the hospital should be applying that condition code to their UB claim for the telehealth service?

(Tiffany): I mentioned before that it's not a telehealth service when the hospital is furnishing a full remote service …

(Sue Thomas): OK.

(Tiffany): … to a patient in the hospital. However, when the hospital is serving as the originating site for a telehealth service furnished by a professional and they bill Q3104 that is telehealth related and maybe Diane if you can clarify whether the condition code would apply in that case.

(Sue Thomas): And actually that – that's right into my second question asking for clarity about how do you determine whether hospital is servicing as the originating site or functioning as a provider-based clinic and would bill the G0463 that would match with the physician 99213 or that kind of thing.

(Tiffany): We expect the most cases that when the telehealth professional is furnishing its service remotely and it's not hospital clinical staff providing the service directly that the originating site be – would be appropriate. However, if the hospital is furnishing a visit itself, then the clinic visit, the code may be appropriate.

But, again, in most instances where there is a telehealth service by a professional and the place of service ordinarily would have been the hospital and the patient is a registered hospital outpatient, we anticipate that the hospital would bill the originating site C in those scenarios.

(Sue Thomas): In lieu of G043?

(Tiffany): Correct.

(Sue Thomas): And it's – (inaudible).

(Tiffany): That's correct.

(Sues Thomas): The concern I have with that is in the Interim Final Rule you know it says, "The intention of CMS is to pay for the visit as if it had been performed in person," but the reimbursement for Q3014 is significantly less than GAO463. So, that doesn't seem to fit together.

(Tiffany): Are you referring to the first regulation that talked about the Telehealth for the professional?

(Sue Thomas): I don't remember it saying that it was only applied to professionals, but yes, the first interim final rule where I said intended to pay …

(Tiffany): Right.

(Sue Thomas): … as if it had been performed in person.

(Tiffany): Right, that referred to the professional billing. We certainly understand the concern and the way that we have addressed that concern. And the second regulation is to allow the hospital to bill the originating site fee.

(Sue Thomas): OK. That's significantly less than the reimbursement as if it's been in person. And as it's said in the first interim final rule, CMS was acknowledging that the clinics were still having to employ the same support staff and have the same expenses. So, I would ask that you reconsider that.

(Tiffany): Thank you for your question.

Alina Czekai: Thank you. We will take our final question, please.

Operator: And your next question is from Christian Gabriel.

(Christian Gabriel): Hi. Thank you for taking my question. This is in relation to making the patient's home a provider-based department hospital. So, on page 210, the second issuance is the interim final rule. It says that hospitals will submit a maximum of one, a relocation request e-mail even though the request may include more than one location.

So, the question that I had is how do hospitals continue to provide and notify CMS Regional Office on any new patient that might be receiving care that may not have been originally submitted in the original request?

(Dave): So, they can provide an additional request for additional locations that are being added. So, as we mentioned earlier, they could – within 120 days to provide or to submit a request they could batch several locations together in a submission. But, if they – if there are nuance past that, they can submit for the additional locations that are – that were not included previously.

(Christian Gabriel): OK, great. Additional question would be recognizing that the state variant scope in the level of restrictions enforced to keep social distancing, should the type of state restrictions prevent hospitals from requesting relocation?

(Tiffany): Can you give more context? I'm not understanding …

(Christian Gabriel): Sure.

(Tiffany): … that question.

(Christian Gabriel): Sure. So, there – yes, there were examples of where you would expect hospitals to make a request for relocation of the provider-based department to the patient's home. States are lifting stay-at-home orders, but if there is a decision of the hospital to indicate that it's still not safe and they want to submit a request for the patient's home to be a provider-based department, are

they limited from doing that, given that public health emergency is a federal requirement versus the state?

(Tiffany): Yes. I think one of the …

(Christian Gabriel): Are they allowed to …

(Tiffany): … requirement – yes.

(Christian Gabriel): I'm sorry.

(Tiffany): … so – just as a reminder, so for a temporary extraordinary circumstance relocation, we outlined the factors that come into play there. One of them is that it's not inconsistent with the state pandemic plan.

And we would leave that up to the hospital to determine whether or not that particular relocation was in a manner not inconsistent with the state's preparedness in pandemic plan. Again, that is all submitted to the regional office and subject to the discretion of the regional office.

But, part that request is the justification for why the relocation was warranted, so we expect that to be included.

(Christian Gabriel): Great. Last but not the least, PO modifier to call on Tuesday was indicated that it was not needed for when the patient's home was designated as a provider-based department, is that – is that correct? I was under the assumption that the …

(Dave): Yes.

(Christian Gabriel): … PO modifier was required.

(Dave): Yes. The PO modifier should be included whenever a relocated on-campus or accepted off-campus department moves to a new off-campus location, including when that location would be the patient's home.

(Christian Gabriel): And the …

(Tiffany): … and consider another way – let me just say. So, it's either – if the PO, if it's accepted, the PN if it's not accepted following the matrix that we outlined in the regulation, so PO for anything that's off-campus that is accepted and PN for anything that is not accepted.

(Christian Gabriel): Great. Thank you very much.

(Tiffany): Thank you.

Alina Czekai: Thank you for your question. And thank you, everyone, for joining our office hours today. We do hope this call continue to be helpful. And we appreciate all that you're doing as our nation addresses COVID-19. Our next office hours will take place next Tuesday, May 12th at 5:00 p.m. Eastern.

And in the meantime, you may continue to submit questions by e-mail at covid-19@cms.hhs.gov. And the recording and transcript of this call will be posted very shortly on the CMS podcast page. This concludes today's call. Have a nice evening.

Operator: Thank you all for joining. You may now disconnect.

End