Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
Moderator: Alina Czekai
May 5, 2020
5:00 p.m. ET

OPERATOR: This is Conference #: 3996146

Alina Czekai: Good afternoon, thank you for joining our May 5th CMS COVID-19 Office Hours. We appreciate you taking time out of your schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19. In the office of administration, Seema Verma here at CMS.

Office Hours provides an opportunity for providers on the frontline to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote TeleHealth and Medicare. And while members of the press are always welcome to attend these calls, 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. Any non-media COVID-19 related questions for CMS can be directed to Covid-19@cms.hhs.gov.

And today we'd like to begin our call with some frequently raised questions and topics and address how the recently announced interim final rule last week addresses these key topics. First, starting with TeleHealth and remote services, CMS is further expanding TeleMedicine and remote services through the following flexibilities – first, 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 a TeleHealth professional to a registered hospital outpatient even if the patient

is located at a temporary expansion location of the hospital as the patient's home. We established pay parity for audio only telephone consultations and are waiving the video requirement for certain E&M services. We also initiated 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 healthcare 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 specimen collection required to conduct COVID-19 tests for new and established patients.

We've also established that certain antibodies for COVID-19, are also now covered by Medicare and Medicaid. In regards to hospitals without walls, CMS has added new flexibilities to those that were previously announced under the hospitals 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 OPPS. Additionally, under flexibilities that already existed under hospitals without walls, CMS affirms 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 and glucose monitoring.

And in regards to workforce flexibilities, CMS has added several workforce flexibilities across healthcare professionals including nurse practitioners, CNAs and PAs, can provide home health services. Waiving requirements for ambulatory surgery centers to reappraise medical staff privileges and finally PTs, SLPs and OTs can furnish services via TeleHealth.

And we also received one other question last week that we took as a takeaway that we wanted to address here at the top of the call and that question was, if any guidance on coverage for pre-procedure testing has been announced and if a beneficiary had a COVID-19 test, then comes in for a procedure and had a test a week or two ago, can they receive a re-test?

And the response to that question is CMS has not established a national policy either through rule making or a national coverage determination regarding coverage of this type of test. Therefore, as national policy, coverage of these types are determined by Medicare Administrative Contractors.

So before we open to live Q&A, I'd like to give the CMS subject matter experts an opportunity to add any additional comments to these updates. Great. Operator, let's open the lines for live Q&A.

Operator: If you would like to ask a question, please press "star", "1" on your telephone keypad now. Press "star", "1" to ask a question. One moment while we compile the Q&A roster. Any other questions?

Alina Czekai: Operator, I see a number of people in the queue.

Operator: And the first question comes from a caller. Caller, please go ahead. Please go ahead with your question.

Alina Czekai: It looks like the area code for our question is 313.

Rebecca Moore: Hi, this is Rebecca Moore. I'm not sure if you were – asking me. I wasn't – I wasn't quite sure who. So you've answered a lot of my …

Alina Cezkai: Hi. Hi. Yes, we can hear you. What is your question, please?

Rebecca Moore: Well, you answered quite a few in the pre-comments, so thank you so much for that. I just want to clarify that I'm understanding billing the originating site for the hospital-based clinicians with the Q3014, that would include services like psychotherapy, wound care, et cetera, is that correct?

Tiffany Swygert: Hi, this is Tiffany. It includes any TeleHealth service that's furnished by the professional for a hospital – a registered hospital outpatient, so …

Rebecca Moore: Great.

Tiffany Swygert: … for the service that's on the TeleHealth list that's being furnished by the eligible practitioner, that could be billed by the hospital. The originating site facility fee can be billed by the hospital as long as that patient is a registered hospital outpatient.

(Rebecca Moore): Great, thank you so much for clarifying that.

(Tiffany Swygert): Sure.

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

Operator: And the next question comes from a caller, 2692179836.

Female: Hi, thank you taking my call. My question – with the CMS press release dated, April 30th, I do see that they are allowing physical therapists, occupational therapists and speech language pathologists to perform physical – billed therapy services via TeleHealth but what's not stated as – are therapists billed out on a UB04 as they are part of the facility. So is that allowed for them to perform TeleHealth services and bill their services out on a UB04 facility claim?

Male: So – sure – so under the clarifications here, the hospital – in cases where the hospital would report the therapy services, those services could be reported under the same circumstances where the hospital furnishes services to a patient when the patient is at home but remotely and the patient's home would be designated as a temporary expansion site of the hospital and so because it's the hospital billing, it would be the same mechanism that would be used for furnishing hospital services remotely to the patients in – in the home and not the mechanisms under Medicare TeleHealth which really only apply to therapists in – in private practice. But we think that the policy outcome is similar in that the provision of services could still be performed and reported when they're provided remotely

Female: OK, so then most would still require the modifier 95?

Male: No, they would not require the modifier 95. They – and – if others – let me pause there for a second and make sure that I have that right but – but the general – the rule is that they – the Medicare TeleHealth services, really, those rules including the 95 modifier generally only apply to the professional services that are billed on the – on the professional claim. For the hospital outpatient services furnished remotely, they would not require that modifier.

Female: OK, all right. And then I guess for – it says that "other hospital based practitioners, the hospital can be bill for those", does that include – are those practitioners, the dieticians, the social workers, the pharmacist, is that – all those ancillary staff that are part of the hospital that perform services able to bill out on the UB04 claim?

Tiffany Swygert: So for the hospital services itself, the regulation outlines the requirements for billing so the hospital would still – those services are still furnished in the hospital which can include a temporary expansion site of the hospital such as the patient's home and whoever would normally conduct those services and bill for them on the hospital claim, the regulation did not change that, so the hospital is still able to do those services and we gave many examples of the services that we believe can be done remotely as long as the patient is in the hospital, including the temporary expansion site of the hospital so no changes to who can furnish the service or how it would be coded on the hospital claim form.

The only change is that we have – acknowledged that under the hospital without walls flexibilities that those services can in fact be furnished as long as they're still in the – as long as the patient is still in the hospital which again can be any temporary expansion location.

Female: OK, well these are patients are not in a hospital. They're patients at home where we have a dietician that performs diabetic nutrition for our diabetics patients or we have a social worker that's performing behavioral health services or the psychotherapy code so you're still saying that they would not be able to bill their services out on a – on our facility UB04 claim.

Tiffany Swygert: Right, so we address that in the regulation and I understand that it's the patient's home. In order for the hospital to bill for the service, of the hospital service, the home location would have to be considered a provider based location of the hospital and the hospital would have to register the patient as a hospital outpatient and there are details on – on that in the regulation.

Female: So would that be the condition, code D – the DR condition code that would apply to that?

Tiffany Swygert: I'll let the provider's billing group talk about the condition codes that apply for any services that are billed under a waiver authority.

Diane Kovak: Hi, so this is Diane Kovak and the general rule on the use of a DR condition code and a CM modifier is that, yes, there is a formal waiver and you should place that on the claim. If you're unsure if you should place it on the claim, it does no harm if you put it on the claim so if you feel that it's not fair, then you can – you can go ahead and put it on there.

Female: All right, yes, I guess this – the bullet where it says, "hospitals may bill for services furnished remotely by hospital base practitioners to Medicare patients registered as hospital outpatients including when the patient is at home", that that's kind of misleading, saying that some of those ancillary staff are the providers that – are part of the hospital that do see those patients for TeleHealth services when they're at home but seen as an outpatient hospital patient that, you know, they're still not able to provide any of those services.

Diane Kovak: I don't agree …

Tiffany Swygert: Yes, I think – I think – so if you look at regulation itself, it goes into a lot more detail than the press release so I would encourage you to take a look at that – and maybe Ing Jye Cheng would like to add in a bit.

Ing Jye Cheng: Sure, I just wanted to add to what Tiffany and Diane were saying and it is a nuanced reading but the agency is trying to do as much as it can to support practitioners and hospitals in this very unique circumstance that we find ourselves in and we recognize that there are going to be plenty of times where

either you all as hospitals don't want to be – of any of your staff, having your staff come in, or you don't want a patient come in and we've tried to develop a range of flexibilities that allow other locations to essentially be part of the hospital. And I think what we were trying to explain is in this instance here, the patient's home could in fact be considered part of the hospital.

The hospital would have to actively make that decision, consider the patient's home a temporary expansion location of the hospital. The provider base rules have been waived – several of the COPs but not all of the conditions of participation have been waived under blanket waivers for Medicare.

And so I think, in that instance, I apologize if the press release seemed misleading, but I think what we were trying to convey is that there are certainly instances where we recognize that hospitals will be providing hospital outpatient services to a Medicare beneficiary in the Medicare beneficiary's home and we, through the most recent rule making, made those payable services but they're payable sort of within – within the confines that we have to operate under – in Medicare law.

Female: OK.

Ing Jye Cheng: Thank you.

Female: All right, thank you.

Operator: And the next question comes from …

Male: Hello?

Alina Czekai: Hi, there. What is your question, please?

Male: Can you hear me?

Alina Czekai: Hi, yes, we can hear you. What is your question, please?

Male: OK, I just thought – just so that we know, we can hear the operator. My question is, on April 30th, you extended TeleHealth to PT, OT, Speech, so a couple of questions, one – does this expansion also include physical therapist

assistants and occupational therapy assistants to do TeleHealth in a private practice setting? If yes, is direct supervision of the assistant still required?

Male: So the answer is yes as long as the – the requirements for billing are met – including the supervision requirements. And so for therapists in private practice, they could be – to the extent to that they could be supervising assistants directly providing the therapy and that is being done via TeleHealth, then those services would – would be – reportable by the therapists in – in private practice.

For therapists that are furnishing services to registered hospital outpatients, in the scenarios that we just discussed, then the same rules would apply that were applied in the hospital setting, even in cases where the patient's home has been designated a temporary expansion site for the purposes of that service.

Male: OK, so – I just want to clarify it, so in a private practice setting, the physical therapist assistant can do the TeleHealth visit but the physical therapist, do they have to be sitting next to the PT assistant? Because normally in private practice, the PT has to be on the premise when the PT assistant is doing it through in-person visit. So how …

Male: So under – the interim final rules that we released at the end of March, the requirements for direct supervision generally can be met through – through virtual means and the same thing would apply here.

Male: Right. Which means they can just be available. They don't have to be on the actual telehealth call at the same time as the assistant making them be available…

Male: Correct.

Male: …if – that's – and then one other question. In one of the documents, it's called physician and other practitioners, a PDF, a 13 page document. And at the top of page 3 is where you list the CPT codes used by PT and OT. The top bullet point says therapy services, physical and occupational therapy, all levels. And then it lists the CPT codes. We're confused what they mean by – what you mean by all levels.

Male: That's a good question. I don't know. We'll take a look at that and see if we need to clarify that. And get back to you – I'm not saying anybody else on the call knows that language specifically. I don't have it in front of me, so we can certainly take a look at that.

Male: OK.

Male: But the code should be listed, and so – and the list of Medicare telehealth services is available as well and the many of the – many of the communications documents refer back to that list of telehealth services and that would include all of the services that are eligible for telehealth.

Male: Correct. OK. And then in the – for the add in a patient's home provider based department, those instructions how to do that are in the interim plan a little. Like, how do we add someone's home to our provider based department in the hospital?

Female: So, in the regulations there – there's a whole section that gives some detail on making a temporary expansion location provider base to the hospital and how that works in terms of billing for the hospital outpatient service. You're probably familiar that for hospitals under the law, for provider based departments that were billing – that were not billing under the hospital outpatient prospective payment system prior to November 2nd, 2015, they are not generally payable under the hospital outpatient payment system. And so the…

Male: Correct.

Female: …regulation does go into some detail about that. However, I want to make it clear that the ability to make a patient's home or a temporary expansion site provider base to the hospital is not based on the regulation itself. It's based on the waiver of the provider base regulations at 42CFR413.65.

And so, there is information in there – but those rules were waived in their entirety through a blanket waiver, as long as the temporary expansion site is not inconsistent with the state emergency preparedness or pandemic plan.

And then if the hospital is, you know, was otherwise being paid the full hospital outpatient rate and wants to continue to receive that rate, the details of how to do that are outlined in the regulations that was just released.

Male: OK. And then I assume we had agencies who also submit on a UB04 they're kind of just out of luck. Correct? Because they're not on a 1500, like a private practice in that hospital system, so we had agencies basically can't do "telehealth" or any form of – with their patients telehealth wise. They're just kind of out of luck. Correct?

Female: Are you talking about clinics? I'm not sure which item (inaudible).

Male: Yes. So, a rehabilitation agency is not a private practice. It's an ORF, outpatient rehabilitation facility submit on a UB04. So they're not considered a private practice. They don't submit a1500, they're not considered a hospital setting.

But they provide – they're independent organizations that provide PT/OT/ speech, but they submit on a UB04 to Medicare program. So I'm assuming since it's really considered still institutional billing for them for telehealth, they're kind of left out because they're not on a 1500 professional and then of course the hospital waiver of course would not apply to them.

Male: I think that's one that we'll take back. It's an important question and we'll consider and get back to you with, with the right answers. Thank you.

Male: Thank you. I appreciate all your time. Thank you again.

Operator: And your next question comes from the line of last digits are 4376. Go ahead.

Male: (Inaudible).

Female: Hi, there, what was your question, please.

Male: Hello?

Alina Czekai: Hi there. Yes, we can hear you.

Male: You just had me on. I'm sorry, you just had me on. You just asked (inaudible).

Alina Czekai: Operator, we'll take the next question, please, then. Thank you.

Operator: So the next question comes from the line of 1991.

Female: No. No.

Alina Czekai: Hi there. We can hear you. What is your question?

Male: You hear me?

Alina Czekai: We can hear you. What is your question?

Male: 95 modifier is CS modifier and the March 30th publication, it said put the 95 on all the telehealth services and then in April 30th, you added those telephone only codes, the 99441 through 3. Should we be attaching the 95 modifier to those codes, the 95 to the audio and video, and those codes are defined as, you know, the audio only.

Male: Yes. Based on instructions in the newest – in the newest release, we added the telephone evaluation management codes to the Medicare telehealth list. And from a legal perspective, we used the waives made available to us under the CARERS Act authorities in order to include, for some services that are furnished audio only as telehealth services, and so that's why that's an apparent disconnect, but that's what we're asking folks to do.

Male: OK. And are you – is Medicare allowing us to use the 2021 medical decision making standard as an alternative? As far as for telehealth services, because there is no defined standard for MDM right now.

Male: Right. For the office outpatient visit codes when…

Male: (Inaudible).

Male: …when they're furnished – when they're furnished with via – via telehealth.

Male: Yes, so we use the 2021 medical decision making standard that's been published? Is it the doctors that are going to have to convert to that by January 1st and it's publicly available now, so it would be nice…

Male: Right. Right.

Male: …if it was alternate keep what you have now, but they – or you could use the 2021.

Male: I see. We can take that back. I think the intention was to use the – was to allow the flexibilities for using the inherent flexibilities in the 2021 policies are only for purposes of the PHE, but we could take back the specific question so that we can make sure that we answer you with all the right precision. So, thank you.

Male: Yes, I think there would be a lot of synergy, you know, let them start using it now, and then anything you can say about the Collins modifier, the CS modifier? Like, where you said you were going to give feedback about if we could you report that provision so much we evaluate the patient for a COVID test, but choose not to order a test, can we still attach the CS modifier?

Male: So I think we're still working on that. I don't know if anybody else has…

Female: (Inaudible).

Male: (Inaudible).

Female: In terms of needing an order, that is an explicit requirement in the statute. I think what we…

Male: (Inaudible) where…

Female: (Inaudible).

Male: Where's that? The reg says if in relation to the furnishing or administration of tests or the evaluation of the individual for purposes of determining the need for such – like that is not (inaudible) tests. I don't see that anywhere (inaudible).

Tiffany Swygert: Right. That's a part of section CC1(3), right before the part that you just mentioned, also says results in an order for or administration of the clinical diagnostic laboratory tests, and those are all requirements in the law. So but we can – we're happy to continue to evaluate this based on the rule.

Male: Is this just really (inaudible).

Tiffany Swygert: …thank you.

Male: It seems like by the time we get an answer, it's going to be late. The pandemic's going to be over and this is money that the government wanted to (inaudible) physicians, and nurse practitioners, CA for making these decisions, and it's like if they don't get it now, they're not going to get it.

Female: (Inaudible).

Male: (Inaudible).

Ing Jye Cheng: Thank you for your question. We understand that. I think in terms of the law, section 6002, which describes of the Families First Coronavirus Release Act, which describes waiving cost sharing under the Medicare program for certain visits.

Male: Right.

Ing Jye Cheng: It adds some very specific clauses to Medicare law and in terms of the government wanting to issue money, what congress told the executive branch to implement, certain requirements need to be met, and one of those requirements, as Tiffany stated – and I'll – CC number 1, roman xiii in the law states that it must result in an order for or administration of a clinical diagnostic laboratory test as described in section 1852(a)(1)(b) romanette iv big roman IV. And then there's a fourth condition. So, you know, again, if there is no order for a test (inaudible)…

Male: (Inaudible).

Ing Jye Cheng: (Inaudible) thinking broadly about many of the questions we've gotten on this, but I think the situation you're describing indicates that there was a service performed. What happened was in fact a test was not ordered and I don't think that could possibly meet the statutory requirement which talks about the furnishing or administration of such – results in an order for or administration of a clinical diagnostic lab test.

Male: Wait, but you're just looking at Roman numeral (iii). Roman numeral (iv) is the next item that's covered, and that says determining if the patient needs a test. Doesn't say (inaudible).

Ing Jye Cheng: Roman (iii) and roman (iv) are connected by a preposition of and. So both – all four of these conditions would need to be met.

Demetrios Kouzoukas: Just to weigh in here a little bit, this is Demetrious, and I appreciate the dialogue, because these are the very conversations I assure you we have had internally with even more passion, and around and around.

But this is where the law leaves us as we understand it and when Tiffany or others say that we're, you know, interested in (inaudible) or thinking about it, what we're doing there is we're signaling that if you have some legal interpretation that we've somehow missed that our collective team and CMS and beyond in figuring out how to proceed with these policies, that we've read the law wrong in some way, we're always interested and welcome and try to be open-minded about how to read the law in different ways.

But it seems, as you can tell from the detailed description that Ing Jye ran through and Tiffany has before, that this is a – this seems to us to be relatively clear. We don't (inaudible) that we're open to other interpretations, we're not saying that we're necessarily know of any other pathway at this point. But we're just letting you know that we are always open-minded as an agency. And I think that my suggestion is that if there are concerns about the scope of this, that they're best directed to congress.

Male: OK. So for now just only use it if you order a test. We just want to know one way or the other and right now half the people think (inaudible) it's like we want to do this the right way, you know.

Demetrios Kouzoukas: No, that's what we think is the right way. We kind of exhausted our – because of the same underlying concern, exhausted our sort of re-read and re-read of the statute. And when we say that we're continuing to look at it, what we're trying to do is let you know that we're not closed off to finding another way, we just haven't found one and obviously we're always open-minded to others (inaudible) suggestion.

Male: Well, that's great. Thank you for taking questions and for all you're doing. Appreciate it.

Demetrios Kouzoukas: Any time. Thank you.

Operator: And your next question comes from Kara Gaynor.

(Kara Gaynor): Yes. Thank you. I'm Kara Gaynor on behalf of the American Physical Therapy Association. I do want to say we greatly appreciate and thank you for adding physical therapists, occupational therapists and speech language pathologists as eligible healthcare professionals who can furnish and bill for telehealth services.

To clarify one question answered earlier, to confirm about physical therapists assistance and occupational therapists assistance furnishing telehealth in the private practice setting. If an assistant is furnishing telehealth to the Medicare patient from their home and the supervising therapist is readily available via telephone, assuming that satisfies state law supervision requirements, then those telehealth services furnished by the assistant would be eligible to be billed by the supervising physical or occupational therapist. Is that correct?

Male: That is correct, and that's an important caveat that all of the applicable state requirements would also have to be met, but yes.

Female: OK. Great. And then, to kind of build-up of what you've talked about earlier, can you please clarify whether or not skilled nursing facilities and home health agencies can bill telehealth services and/or communication based technology services furnished by therapists and therapists' assistants and

when they bill under the Medicare physician fee schedule using the UB04 claim form.

Male: So (inaudible).

Male: (Inaudible).

Male: Go ahead, Jason.

Jason: I was going to first say – and Ryan can follow on, that it's important to recognize that when the patient is under a part A SNF stay, a Medicare SNF stay that those services are bundled into the Medicare part A SNF stay, there's no change in terms of the – of what's part of the consolidated billing for part A.

And for home health, also that is a 30 day episode of care and so if it is part of the care that is on the home health plan of care for that particular patient, it is part of the bundle for that episode. Ryan, did you want to add anything further?

Ryan: No, I think you're asking an important question about the limitations of the current flexibilities, and there's been no change in the telehealth in terms of it's really applicable to those professionals who are billing on their professional claim and paid – so it would be therapists in private practice and then in the hospital, in the hospital outpatient setting, the construct that allows for remote services to be furnished to patients in their homes would also apply. But in the other settings, I think that's an area that we're still taking a look at and we appreciate the question, and I understand the concern, for sure.

Female: OK. Yes, I would just urge you to consider expanding the flexibilities to SNF and home health agencies that bill Medicare part B under physician fee schedule for outpatient therapy services, as that is quite significant amount of therapy those Medicare beneficiaries receive under Medicare part B in those settings.

And then just going back to something CMS has previously raised in previous town halls. You've talked about furnishing care remotely it's in the same

location but not the same room, and billing it as if furnished in person. And there is a FAQ on approximately page 23 or so in the 42 page FAQ document, question 9.

And it talks about how a physician or practitioner can furnish care and because the practitioner and the patient are in the same location but maybe not the same room, then furnishing that care would be not considered telehealth, kind of similar to what you've been talking about with the hospitals without walls flexibilities. And so I just was curious if you could clarify on this call does that policy of it doesn't count as telehealth if it's in the same location but not the same room. Does that apply across all institutional based settings?

Male: So, I can (inaudible) apologize in advance for this somewhat bureaucratic answer. I can say that for purposes of whether or not the statutory provisions that cover Medicare telehealth services are in effect. The answer would be that that would be consistent across settings. But it doesn't necessarily mean that furnish service furnish using communication technology within all of the institutions would be – would meet all of the applicable conditions of payment or coverage, et cetera. And so, I don't know if others want to weigh in on that but …

Female: OK thank you and I know …

Male: Yes.

Female: Just (inaudible).

Male: No, I was just going to say it doesn't sound like anybody wants to weigh in, so.

Female: OK I don't know if you can answer this today but on future guidance if you could answer whether those minutes furnished in the same location if not the same room

If it's furnished in the nursing home setting for example, whether those minutes can be counted on the MDS if delivered under Medicare part A, that's been a common question that we're seeking additional guidance on.

Male: OK, we can certainly take that back, thank you.

Female: Thanks.

Operator: Your next question is from Amy Maverick.

(Amy Maverick): Hi there, thank you for taking my question I'm a hospitalist and for physician billing and when we bring a patient in under observation – my question is we might order a COVID test on a patient as part of the work up. That patients going to stay more than one day, probably two, or maybe even a third hospital day.

Are we to attach the CS modifier to our billing for all of those days or just on the day that we order the COVID testing? I guess assuming that it was negative, and the patient ended up having a different illness requiring an observation stay?

Tiffany Swygert: So when you're billing for observation services for a hospital outpatient there's some specific requirements of which codes show up on the hospital claim and I just want to clarify that you are talking about the hospital claims, the institutional claims?

(Amy Maverick): So, no that is my question, as the physician claims do, we attach the CS modifier on our physician claims when a patient is brought in as an observation? So, outpatient hospital, correct.

Tiffany Swygert: OK so I'll – let me, let us try to tag team this because I think there's probably multiple pieces to it. So, I'll – I'll address the hospital part. The CS modifier does mention specifically hospital observation services or observation services and those services may have the CS modifier as long as all other requirements in the law are met.

I'm not sure if and Diane or others on the line may have to jump in here, but I'm not sure if the modifier, like, if the claim spans multiple days I'm not sure of the requirement in terms of how often the CS modifier needs to show up but it would be appropriate to attend the CS modifier for observation services.

Assuming all other statutory requirements are met. In terms of the physician bill I will turn it over to my colleague Ryan Howe.

(Ryan Howe): Right so the same – basically the same answer. So for the physician services within the category of evaluation and management services that are associated with the services that are necessary to determine or manage care that leads to the testing or the ordering of the test then all of those would apply and it wouldn't just be limited to a single day if that's the appropriate level – level of care.

(Amy Maverick): OK, super. So, I think then for our services (inaudible) we were dependent to all if we're violating them to, I guess, basically rule out COVID. What about in the situation where the hospital policy is to check a COVID test because the patient is transferred in from another hospital?

That's come up numerous hospitals as well. So, we're really particularly suspecting there's no clinical physician that's (inaudible) that's COVID. But because they're been transferred from another facility our hospital is automatically as per the policy ordering in COVID tests on the patient. Do we submit the CS modifier with those as well?

Female: So, the law does talk about the service. So again, you're talking about hospital observation services …

(Amy Maverick): Correct, correct.

Tiffany Swygert: … I assume and there is an order for the COVID test in this case because it's the hospitals policy …

(Amy Maverick): Correct.

Tiffany Swygert: … and the care relates to the furnishing or the administration of the tests. Those are the requirements of the law, so again if those requirements are met it would be appropriate to append the CS modifier.

(Amy Maverick): OK, super, thank you.

Tiffany Swygert: Thank you.

Operator: And your question comes from Nancy Masoner.

Nancy Masoner: Hi, I just want to clarify, in reference to the updated in term final rule can ancillary staff such as the pharmacist bill G0463 on a UB04 with modifier 95 when performing audio video services in a provider based department?

Male: So, I can start with that so when the hospitals billing for services that are provided directly by a pharmacist and the pharmacist wouldn't be billing Medicare for their professional services under the physician fee schedule. In those cases, the telehealth rules wouldn't apply and consequently the 95 modifiers wouldn't be the appropriate mechanism.

I'll kind of hand it back to Tiffany in terms of what kinds of services under what circumstances service is provided by a pharmacist remotely under the same mechanisms that we've been talking about, could be billed by the hospital clinic.

(Tiffany Swygert): Yes so, the regulation doesn't change any rules about who can furnish a service or what the, like, what the clinic visit requirements are and Medicare doesn't generally give coding guidance.

So, I certainly won't attempt to do that today, but assuming that the service described by the HCPCS code is met, we detail in the regulation which ways a hospital can bill for them. Whether there remote services, as long as the patient is a registered hospital outpatient and the facility that the patient is residing in is considered a hospital location.

Which again, can include the patient's home under the waivers that are in place right now. So, if that is the case and the hospital is furnishing the service, either directly through physical presence or remotely if appropriate then the hospital may bill for those services.

And what we did is give an example of several CPT HCPCS codes that we believed could be done remotely, it's not an exhaustive list. The clinic visit is not listed on there, however if the hospital believes that it can furnish

appropriately that code or any other service remotely to a patient in the hospital then we would not stand in the way of that.

But it is – the onus is on the hospital to make sure that all billing requirements are met and if the service itself – we've had questions on some other calls about drug administration or wound care and other types of services that do seem to suggest and require in-person care.

And so, we wouldn't expect to see those being done remotely. But for services that can be done remotely it's best to take a close look at the regulation just to see what the rules are there.

(Nancy Masoner): Thank you.

(Tiffany Swygert): Sure.

Operator: Your next question comes from Tom Norton.

(Tom Norton): Hi, so I think I'm going to piggyback off of that one bit if I could just get more clarity because you just said, wound care could not. So, I see in the interim final rule as long as the home's considered part of the hospital then the hospital outpatient department could bill for the Q3014, the originating site fee for a telehealth visit.

And if they sent a nurse to the patient's home that was considered part of the hospital, they could bill an E & M. So I guess that is, the question is, is there a scenario that you could see where the hospital could bill the G0463 evaluation and management when it's on a wound care situation when we don't have a person in the patients home it's all done remotely?

(Tiffany Swygert): Sure, so I think what you just described is right about the originating site fee. In terms of the remote services, again the hospital staff doesn't have to be in the same physical location as the patient, a long as the patient is in a hospital location.

And for services that require physical presence we would expect the hospital staff to be physically present to furnish the service. So that's a long-winded

way of saying that, again if the requirements of the code can be met, we left it up to the hospital to determine whether it should be done in person or can be done remotely.

Again the clinic visit is a pretty broad service, so we would refer, you know, to what the code itself requires and the hospital should make sure that they're meeting all billing requirements before submitting a claim for that. Including if the service does necessitate and the patient's condition does necessitate physical presence then we would expect that to be met.

(Tom Norton): OK. And I saw a interim final rule it seemed to say that even if you're normally – if you have an on campus hospital outpatient department but if these services are being provided to someone who's at home because it's temporarily part of the hospital.

Does the hospital need to use the PO modifier on any of those services or if they normally don't need the PO modifier because it's on campus, they don't need it? I was a little confused.

Male: Yes that's right, if the department is usually on campus and would not usually provide the PO modifier then if it's in the home then I think it would be the same set up, that you would not have to attach the PO modifier.

(Tom Norton): OK, thank you very much.

Operator: And your next question comes from Jane Russell.

(Jane Russell): I do have another question but there's a follow up from the question that was just asked if you're normally – if you're doing a service in a temporary provider based home and you normally report a PN modifier do you need to report the PN modifier on the service? Or is it always – would it be paid at the full amount with a PO?

Male: Right, it would maintain the modifier that you normally would have. So, if you are a department that attaches the PN modifier then you should maintain that PN modifier.

(Jane Russell): OK, thank helps. So, my question is about the Q3014 versus the G0463 and you may have answered it, but I don't quite understand it. So, if we have our institutional providers, we have a hospital outpatient we've done the work to make each patients home a temporary PPD and we're doing a medical visit. On the institutional claim do we bill a Q3014 or do we bill a G0463?

Tiffany Swygert: So, it depends, and it really depends on what service the patient is getting on the other end so in the scenario that you just mentioned is the patient receiving telehealth from a professional?

(Jane Russell): Yes, they're receiving an audio visual in their home. So my doctor is doing a medical visit with my patient in their home and I've made the home a temporary provider-based clinic.

Tiffany Swygert: And so, what we described in the regulation is, if the hospital is supporting that telehealth service the hospital could bill the originating site fee as long as the patient is a registered hospital outpatient.

(Jane Russell): So, my …

Tiffany Swygert: If the hospital is doing a clinic visit then the hospital can bill for a clinic visit and that's why we've tried to make sure that we're not giving coding guidance or addressing specific billing scenarios because the devils in the details, right?

So, if the hospital is furnishing your visit, they can bill for a visit assuming all requirements are met. If the hospital is supporting a telehealth service, they can bill for the originating site fee as long as that's a registered hospital outpatient.

(Jane Russell): And when you say originating site fee, you mean Q3014, correct?

Tiffany Swygert: That's correct.

(Jane Russell): OK. Just one more quick question, just to verify, each patient home has to be registered as a provider-based clinic, right? Every single patient.

Tiffany Swygert: If you're using the home as a temporary expansion location, we have outlined details about submitting those relocation requests to the regional office.

(Jane Russell): Yes.

Tiffany Swygert: If you're not making it part of the hospital certainly you wouldn't have to do that.

(Jane Russell): But if you are each patient home has to have the request, right? Every single home, right?

Tiffany Swygert: That's correct, and I think we are working on some additional guidance around that so happy if you have any specific questions or concerns about that happy to – if you can submit those to us.

(Jane Russell): OK, thank you.

Alina Czekai: Thank you and we are at 6 o'clock Eastern. We'd like to thank everyone for joining office hours today, we really do help these calls are helpful and appreciate all that you are doing as our nation continues to address COVID-19. Our next office hours will take place this Thursday May 7th at 5pm Eastern.

And in the meantime you can continue to submit questions by email at covid-19@cms.hhs.gov. This concludes today's call have a nice evening.

End