Centers for Medicare & Medicaid Services
COVID-19 Call: Office Hours
Moderator: Alina Czekai
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OPERATOR: This is Conference # 1881716.

Alina Czekai: Good afternoon. Thank you for joining our call today CMS Office Hours on COVID-19. The next in our series of opportunities for hospitals, health systems, and providers to ask question as CMS 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 to promote telehealth in Medicare.

I am joined by a number of CMS subject matter experts and agency (officials) who are on the line to answer your questions. Operator, will you please open up the lines for Q&A?

Operator: At this time if you would like to ask a question, press "star" then the number "1" on your telephone key. Again, "star," "1" on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Again, to ask a question, press "star" then the number "1" on your telephone keypad.

Alina Czekai: And Operator, I think we have an echo, if you can help address that? Thank you.

Operator: Please mute your computer audio to prevent background noise. Your first question comes from the line of (Amber Williams).

(Amber Williams): Hello. How are you today?

Alina Czekai: Hi. (Thank you).

(Amber Williams): (Inaudible) I have a question today about the physical therapist, occupational therapist in SLPs, are there being credentialed right now through CMS and my

question is if they are credentialed through CMS, are they able to bill on a professional claim at CMS-1500 or their physical therapy services for telehealth the virtual e-visit, the e-visit, and the telephone calls, are they able to do that if they are credentialed with their own NPI number on the CMS-1500 claim?

Ryan Howe: So, I can try to answer that one – Ryan Howe at Center for Medicare. I want to make sure I understand the question. In general the therapist in prior practice can report this to their professional services and are paid under the physician fee schedule.

At the moment however, therapist aren't eligible to furnish telehealth services and so the services the first of telehealth services couldn't be reported. The virtual check-ins and the e-visits could be – I'm sorry, I should say that e-visits could be reported – actually I believe also the virtual check-ins could be as well.

But I'm not sure if that answers your question or are you asking about therapists that are employed in hospital and in the hospital setting?

(Amber Williams): Yes, so I have therapist that work in the outpatient hospitals citing that they'll – I mean UBO4 usually, so for them I understand they can't do this telehealth services but for the virtual check-ins and e-visits, are they able to go on the UBL4 for those services?

Ryan Howe: So as long as they're employed at the hospital then the hospital rules will continue to apply. So whatever the billing rules under the hospital would be those individual services wouldn't be able to the billable on a professional claim.

But I think we're certainly – we understand and have received a lot of questions along those lines and so we're actually taking a look at what flexibilities we would have in that area.

(Amber Williams): OK. And if my physical therapist do offer the telehealth to those Medicare patients letting them know that giving them an ABN waiver before the service explaining that it's not eligible due to them not being an eligible service

provider type and give them the total cost, is that something with right now since there are the quarantine issues that they can get that ABN by over the phone?

Ryan Howe: That's a great question. I can't answer it, I don't know if we have somebody else on the line who could? And if not we can certainly take that, and get it back to you.

(Amber Williams): OK. And I'm sorry, I just have one more question about patients that are disabled, have dementia, or in a skilled nursing facility or assisted living facility that need that PLA to be in charge of their health care right now.

In Michigan, there's a lot of restrictions and visitation with anybody coming into those facilities. So would the POA be able to have a telehealth visit with the provider to discuss that beneficiary and be able to (build) the telehealth service with the PA and the physician even though the patient may not be able to be in view of the provider?

Ryan Howe: That's another good question, and we should take that back and make sure to get the right answer to you. I don't know if anybody else on the call who can answer that directly?

Male: I don't think – I think that one crosses multiple areas probably, and we need to take that back.

Male: I can weigh in ...

(Amber Williams): OK. Thank you for your response.

Male: ... on the ABN question, we have out guidance that says that we cannot (re-allow) (inaudible), ABNs, several of the other documents that are required to be done to be delivered by telephone, (and otherwise). So I don't know if that's helpful, but it’s guidance that we put out called waiving signatures for beneficiary notices due to COVID-19.

(Amber Williams): OK, I will follow up with that policy then. Thank you so much.

Operator: Your next question comes from the line of (Jonathan Gold), your line is open please ask your question.

(Jonathan Gold): Hi. (Jonathan Gold) with AMRPA. Thanks again for taking the time to do this. My question pertains to the waiver you issued to allow excluded inpatient rehabilitation units to be cared for) in the acute care unit of a hospital.

Taking a close look at the language you provided, it says that it allows acute care hospitals with these units that need to relocate inpatients from the unit to the acute care bed can do so. And our question focuses on the word relocate and whether that means this is only permitted in the case when the patient was once in the unit and then has moved to the acute care side of the hospital?

Or if for example an acute care inpatient who becomes ready from discharge for their acute care services but then needs the rehabilitation services could just stay in the acute care bed and we received their rehabilitation services like they normally would in the unit but in their acute care bed? Thanks so much.

Jason Bennett: Yes. This is Jason Bennett from the Center for Medicare. When exercising that blanket waiver it is acceptable to move the patient to the bed for the reason that the hospital may need for its surge capacity, or as part of an infection control program.

And so let's say in this case you're moving a patient in for rehab in the excluded part unit to a more typical IPPS bed, you would then continue to perform the rehab functions there in the IPPS bed for as long as you found that appropriate before discharge.

If you wanted to move a patient back to the – or excluded part unit at some point, you're also welcome to do that and we recommend that you just document in the medical record that this movement has occurred and indicate that it's related to the blanket waiver and the functions or needs of the hospital with regard to the bed capacity at that time.

(Jonathan Gold): Thank you for that. And just to clarify, did they ever actually have to be in the unit to begin with, or say for example that unit has been repurposed

because of surge capacity, could they just begin and finish their rehab service care in that acute care unit without ever having to been moved in and then move out?

Jason Bennett: So I think what you're talking about in that type of a circumstance is more with regard to what are the total numbers of units or total numbers of beds that are part of the – our unit? And I think in that case you need to look at the Medicare regulations and policies with regard to expanding the total number of units or total number of ...

(Jonathan Gold): OK, thank you.

Operator: Your next question comes from the line of (Christopher Acebedo), your line is open, please ask your question.

(Christopher Acebedo): Hi, good afternoon. Thank you for holding these calls, they've been very helpful. I have a follow-up question that I asked on Tuesday regarding hospice initial assessment visits being done through telehealth.

And I want to – wondering if you could clarify if both that the initial assessment for hospice and the required comprehensive assessments could both be rendered via telehealth and then if so, are the physical and intermediaries prepared to process claims that may have absolutely no visits on them because all discipline visits are being rendered either through telephone or telehealth?

Hillary Loeffler: So, this is Hillary Loeffler. I can probably answer the claims processing question you had. So if I understand your question on the claim side, if there's a claim that submitted to the fiscal intermediary or the Medicare administrative contractor and there's no visits reported, will the claim process? Is that your question?

(Christopher Acebedo): Yes. So if a hospice is unable to render physical visits to patients, individual patients, and they're able to meet the patient's need with telehealth initial assessments and comprehensive assessments that we've been instructed not to put on the claims so when that claim has been submitted, there are zero visits on the claim.

I'm just checking to ensure that A, again initial and comprehensive assessments can be done via telehealth. B, your instructions to not put them on the claim are still in place. And C, that than the claims will process without issue.

Hillary Loeffler: Sure, yes. So we received this question before and we did check and as long as you're putting the level of care on the claim, along with the unit for that like the number of days for that level of care plus the Q-codes, the location that claimable process without a G-code for a visit, so you should be OK ...

(Christopher Acebedo): Wonderful. And does the ability to do the assessments both comprehensive and/or initial via telehealth does that apply to home health as well?

Hillary Loeffler: So I'm going to turn it over to (Danielle). (Danielle), are you on the line that you can ask her the questions about the assessments for home health and hospice?

(Danielle): Yes, (Hillary) I'm here. So there is nothing in the COPs for either provider that dictates how an assessment is performed whether it's done in person by telehealth or anything to that level of specificity.

So there's nothing in the regulations that prohibit this from being done or the regulations do require is that the assessment comprehend – it provides a comprehensive view of the patient's status at that moment.

their psychosocial status, and their physical status, their functional status so to the extent that telehealth can be used to accomplish the assessment then the answer is that yes it can be done to the extent that there may need to be an in person contact in order to assess some of these key areas that would also need to be done.

So we can't give you a blanket yes or no, it's really going to come down to what the patient needs, what the caregivers needs, what their care preferences are, and how to balance all of that.

(Christopher Acebedo): Yes, no I understand the specificity for each unique patient needs to be met with their needs but if their needs can be met, then telehealth can be used for both home health and hospice and those comprehensive assessments since they're not otherwise stated as such (there).

Thank you. One other question, what code should a physician office use to report the specimen collection for a COVID-19 test? I don't believe CMS pays the 99000 code?

Male: Could you ask that one again? I'm not sure I fully understand.

(Christopher Acebedo): Sure if a physician office or an urgent care center were to be conducting the swap based test for COVID-19 testing, is there a code CMS is recognizing for that specimen collection just like they would recognize a blood draw for a normal laboratory test but something specific here for the COVID swab?

Male: Right. I don't know that there's a specific code for the swab. I think you would build the most appropriate code for the swab testing. In some cases, I would imagine that that service would be bundled or packaged into a visit service.

(Christopher Acebedo): OK. So, if they were sent to a testing plus to say an urgent care center is doing COVID-19 related testing and they were sent to that location to get the test done then that urgent care center would not have the ability to bill for the swab itself but they would be duplicating or evaluating management service because they're acting as a technician.

So if that's the case, that's OK. If you could put a minimum number consolation provides on ...

Male: Sure. No, we can certainly do both of those things and in general I think when there's not a specific code, I think a more generic code would be used and we'll certainly take it under advisement.

(Christopher Acebedo): Wonderful. Again, thank you all so much for holding this and doing your best to navigate these strange times.

Operator: Your next question comes from the line of (Mark Flynn), your line is open please ask your question.

(Mark Flynn): Yes. Hello, this is (Mark Flynn) from Healthcare Business Specialist in Chattanooga, Tennessee. First off, I like to thank everybody for doing such a marvelous job in keeping up with all these regulations that are changing daily.

I'm calling representing the rural health clinics. There's about 4,548 of those in the country which is not very many. That's about less than 2 percent of all physician practices yet RHCs will go embeddable safety roles, safety net provider in a rural underserved and are poor. We serve disproportionally number of Medicaid patients.

And while our small size, we understand how we can be treated like a redheaded stepchild occasionally. Two weeks ago the Cares Act was approved allowing RHCs' to bill as a distant side site for telehealth and it's been almost two weeks and we still have not seen any regulations on how to bill for that.

And I certainly understand two weeks is like a millisecond, in normal times but in COVID-19 time, it's equivalent to a millennium. We are really waiting for these reimbursement regulations to come out.

We made them – there's an Old Danish adage which says (advice after injuries is like medicine after death). And that's the point to where we're just about to get to for our rural health clinic. So with my soliloquy gone my question is when we do get these regulations out if you guys would consider the rurality and the types of patients that we're dealing with, we are not going to always be able to get audio visual and telephone at the same time with a lot of our clients, our patients in these rural areas I had several doctors call me up today and say, it's really been a problem, with getting audio and telephone at the same time.

And so, we would like to see, I know we have virtual visits but if there was a way to build in some type of telephone type of telehealth reimbursement for visual health clinics during this time of the PHE that would be great. Thank you for all you do.

Male: Thank you very much. To address a couple of your concerns. First, I just want to let you know that we appreciate all of what you're doing. While it may seem like if not high on our priorities, it certainly is and we understand that two weeks is short by way of usual time.

But in these challenging times, two weeks can be a really long time. That said, we're actively working on the new authorities and we are hopeful that we'll be able to release something shortly. As you probably know this statutory provision does allow for RHCs and FQACs, both to furnish telehealth services and instructs us to create a mechanism for payment and that's what you're anticipating and we're certainly trying to work on making that happen as soon as we can.

In terms of the audio-only, we certainly hear that and understand that. That's something that we're taking into advice as well and I did want to point out since you mentioned the virtual check-in codes, in the interim final rules that we released at the beginning of last week, the payment rate under both RHC and FQAC systems for that virtual code has been increased as well.

And I just wanted to make sure that you knew about that also. And those services can be done audio only. So again, we truly appreciate your position and we're working hard on getting the guidance set as soon as we can.

(Mark Flynn): OK, thank you very much.

Operator: Your next question comes from the line of (Melody Malone), your line is open please ask your question.

(Melody Malone): I didn't have a question, I was trying to get you to stop the echo and you did that. Thank you.

Operator: Your next question comes from the line of (Erin Cubit), your line is open, please ask your question.

(Erin Cubit): Good afternoon and thank you. I echo the graciousness of having you hold these calls. I had a question, a couple of questions. The first one is if there is

a physician that is in a neighboring state, how should that be billed for when we bring when a neighboring state brings on a physician with disaster privileges to assist in covering an emergency room?

Male: Any of our colleagues here, I'm assuming this side have a particular billing advice. I don't know that we've got – I'll just put out there, I don't think we have a particular billing requirement for when you're billing from another state. Is anything one else on the phone got a different answer please?

Yes, I don't think we – is there a particular requirement that you are speaking whether still in effect or that you would otherwise have?

(Erin Cubit): No, it's really just wanting to make sure to know how to bill. And so it sounds like it should just be billed as though it normally would be, is that accurate?

Male: Yes, we have a modifier for telehealth and the physicians' context and then for – is it the CR modifiers, someone else want to remind me here to put in other context? I think there are modifiers that are applicable relating to some of the waiver authorities that we've exercised or for telehealth but we don't have a particular requirement that relates to the other state issue.

(Erin Cubit): OK.

Male: Does that help?

(Erin Cubit): And then my next question is that getting some guidance on waiver coverage for performing wound care in a nursing home and how to bill for that? So for example, if somebody has a patient that cannot leave the nursing facility and the provider is willing to go there to perform the procedure the debridement but does not want the wound to deteriorate, how can that be billed for?

Male: Ryan, do you have anything? Or is it the physician office setting you're talking about or out-patient?

(Erin Cubit): Nursing facility.

Male: Nursing facility, sorry. Jason, (Hillary) or yes, go ahead.

Jason Bennett: Would this normally be packaged under consolidated billing for a sniff stay or would this normally be billed under part B?

(Erin Cubit): I'm not sure of that.

Jason Bennett: OK. Yes, we would need that type of detail to be able to provide you some advice.

(Erin Cubit): OK. Is it possible to have CMS look into these pieces for both of those questions and put out some guidance on that?

Jason Bennett: Yes, we can take a look at those questions.

(Erin Cubit): Thank you. That's much appreciated.

Hillary Loeffler: And I'd actually like to go back to the practitioner location question that you were asking about neighboring states. I would point you to one of the waivers that we had put out on our waiver flexibilities Web site which CMS is temporarily waiving requirements that out of state practitioners with license in the state where they're providing services when they are licensed in another state.

So we've got some specific items there that may answer your question, it doesn't get out the direct billing requirement but it does provide guidance on what will be waived and (will haven't).

(Erin Cubit): Great. Thank you.

Operator: Your next question comes from the line of (Kyla Collo), your line is open, please ask your question.

(Kyla Collo): This kind of goes off of the other rural health question, I just wanted to make sure that as of right now, there are no guidelines to bill for the telehealth services because we already bill on a UB form and I know the critical access hospitals were advised to bill on a UB with the GT modifier. But just looking for a little direction in billing.

Ryan Howe: Yes, again we are actively working on that. We understand that the need is there for that guidance. Because the provision was past two weeks ago, we're actively working on that. If not, it wouldn't be the exact same billing guidance for the critical access hospital because unfortunately the legal authorities are different. But we are again actively working on getting that guidance out and optimistic that it will happen soon.

(Kyla Collo): OK, thank you.

Operator: Your next question comes from the line of (Jessica Priscorn), your line is open, please ask your question. Again, (Ms. Jessica Priscorn), your line is open, please ask your question.

(Jessica Priscorn): I was just going to...

Alina Czekai: Operator, can we take our next question please? Thank you. Operator, we'll take our next question please. Thank you.

Operator: Your next question comes from the line of (Ruth Clark), your line is open, please ask your question.

(Ruth Clark): Hey, thank you. Appreciate the opportunity and appreciate all the work that you all are doing. I just kind of wanted to echo, I'm with the Kansas Medical Society. We represent about 3,000 actively processing physicians in the State of Kansas, many of whom are rural healthcare providers.

And we are anxious for some guidance on how to bill and how much, what reimbursement we'll look at or will look like? Do we have an idea of when we might see that? Can we expect it end of this week, early next week, do we have any gage on that?

Male: Is this question about outpatient billing in the hospital setting?

(Ruth Clark): I'm sorry, it's rural health clinic.

Male: Rural health clinics, yes. I don't know that we have anymore further answer than the one that Ryan so graciously gave.

(Ruth Clark): OK. My other question is just to verify billing if you're say a physician and you're doing telemedicine from your home with a patient who's also at their home, I want to make sure I understand that physicians can put in box 32 on the claim form their home address and they need not to update their file or their enrollment application with the contractor, is that correct?

Ryan Howe: So that is correct. The other point to remember on that is that in terms of the service location like the place of service code, the same policy would apply that if that visit would have ordinarily taken place in a practice location that the practice location could also be acceptable.

We used both as reflected on the place of service code but also in the service location information but even if the physician is home for example would be used, it wouldn't necessarily as I understand that the new provider enrollment rules that wouldn't necessarily need to be update in the file.

(Ruth Clark): Yes, correct.

Hillary Loeffler: No update (in either enrollment).

(Ruth Clark): Great. Thank you.

Operator: Your next question comes from the line of (Tom Norton), your line is open, please ask your question.

(Tom Norton): Hello. My question is about for telehealth the hospital billing. So I know that physicians are now to use the place of service where the service would have been provided. So if the service would have been provided in a hospital outpatient setting if it were in-person and of course the both of facility the hospital and the provider would be able to bill. So under this regulation, can the hospital bill their portion of the (E&M) for the telehealth visit?

Ryan Howe: So ...

Male: Go ahead Ryan.

Ryan Howe: So under the current rules, Medicare telehealth services are only billable by the professional who's furnishing the service from the distant site unless and

in such cases is where the patient is located within a hospital or other healthcare setting and then the originating site facility can be reported.

We are aware that there are a lot of additional questions surrounding that and we're actually taking a look at how the intersection of our existing payment rules works in the context of the changing environment that the public health emergency houses.

(Tom Norton): OK, thank you.

Operator: Your next question comes from the line of Kathi Austin, your line is open, please ask your question.

Kathi Austin: Hi, this is Kathi Austin with SSM Health. I just want to say thank you for giving me the opportunity. I actually have two questions if I may ask. The first one is regarding Q3014 for quote hospital billing.

We all know that's only applicable on a UV claim form regarding the situation with the pandemic and the professionals being at a distant site, they are providing their services on the 1500. Some of these professionals are actually on site at and within our hospitals maybe at a nurse's station, they're in one of the offices, et-cetera.

So they are utilizing our staff, our equipment, et-cetera, even though the provider is here and the patient is at home, we'd like to know if CMS is going to consider making adjustments so the hospitals can still build the telehealth Q3014 on a UV to cover those three forces being used?

Alina Czekai: Thoughts there?

Ryan Howe: Yes. So that is a great question and we're actually considering that sort of question. I think in the cases where the telehealth service is happening – when the service is happening within the same location we haven't historically considered that to be telehealth and therefore not subject to the telehealth restrictions.

I think in this case as you're pointing out, that really is part of our broader consideration of the cost of associated with the kinds of steps that the community is taking in response to the pandemic and we're actively taking a look at that.

Kathi Austin: Awesome. Thank you. My second question is referencing an earlier call. The gentleman was questioning i.e. specimen collection for our locations at our hospitals urgent care sites that are actually doing the swab testing. G2023 is a HCPCS code that is available and it is specimen collection for Severe Acute Respiratory Syndrome CoV-2 any specimen source, will CMS consider allowing hospitals and/or providers to utilize that HCPCS code for the swab test?

Ryan Howe: Could you – could you give me that HCPCS code again? I'm sorry to – I have to ask.

Kathi Austin: Sure, G2023. That's any specimen for the CoV-2 respiratory syndrome specimen collection.

Ryan Howe: I see. OK. Let me ...

(Danielle): And that's the code that we have finalized most recently in the interim final rule (say) for specimen collection by independent lab. So, I think this is a good question. It seems to be a concern that numerous providers have been asking about it.

When we finalized that code, really was to a parallel – to an existing policy we have in the clinical lab space where we paid for – pay a nominal fee that's required (by such fees) for specimen collection when the lab needs to send the qualified personnel to collect the specimen. Historically, that's done blood draws, venipuncture in the case here of the COVID-19 crisis.

There have been multiple reasons I think we've been asked to consider why a lab may need to send trained personnel out to collect the specimen from someone whether they are being isolated or for whatever other reason and to also consider the increase cost associated with that travel due to PPE and other requirements that the personnel might have to bring.

So, that – that – I just want to explain a little bit of our thinking (in the rule) around G2023, but certainly happy to take the question back. I think Ryan enumerated previously that typically to the extent hospitals and physicians are collecting these specimens regardless of how and where they are choosing to manage the infection control on their end.

Typically, we have considered that to be part of either the office visit, the physician, or the clinic visit and have not necessarily paid separately for it and don't see that certainly in the context of the ISP G2023 would not be used in the hospital setting, but happy to take the concern back and think about that a little bit more fully on our side.

Kathi Austin: Yes. That will be very much appreciated because it is the hospital staff and the physicians performing the swab test. Lab technicians are not going to patient's homes and doing those. It's happening hundreds of times daily at our hospitals.

Just like a venipuncture, a blood draw specimen collection, we're not able to charge anything for this right now. But that would be the code that we should be able to utilize. If CMS could give consideration to that, we would certainly appreciate it. And I'm sure I'm speaking on behalf of many others. Thank you for taking my questions today.

(Danielle): Sure, happy to ...

Ryan Howe: If I could ...

Kathi Austin: Yes.

Ryan Howe: Sorry, if I could just add one clarifying point on your earlier question?

Kathi Austin: Sure.

Ryan Howe: If the patient and the practitioner are both in the – in the institutional setting, say a hospital, if they are in the same location, then the telehealth wouldn't – you wouldn't build that professional services, the telehealth service.

And so, it wouldn't – it wouldn't be limited to merely the professional billing in that case if the – if the nursing staff for example is providing service with the patient in person – in the same room and the professionals in a different room. I just wanted to make sure that that was clear.

Kathi Austin: Yes. That – that was – that wasn't really part of the question. The question is because the patients are at homebound ...

Ryan Howe: Got it. Got it. OK.

Kathi Austin: ... the provider using our resources here at the hospital ...

Ryan Howe: Understood.

Kathi Austin: OK, awesome. Awesome. Thank you.

Ryan Howe: Understood. Thank you.

Kathi Austin: Yes.

Operator: Your next question comes from the line of (Barb Hansen). Your line is open. Please ask you question.

(Barb Hansen): Hi. I wanted to echo what everyone else is saying about how much we appreciate you having these opportunities to ask question. So, my question is about the face to face visit for hospice recertification. And we do understand that it must be an audiovisual telehealth visit.

And I know you're taking it under advisement for the patient who do live in rural areas and have no visual capacity because they don't have a smartphone or a tablet or internet access. They only have a landline. What do you suggest? Should hospices submit an individual waiver request that they can only do an audio-only telehealth visit for those patients who need to be recertified? Thank you?

Hillary Loeffler: Sure. So, this is Hillary Loeffler. The face-to-face encounter requirement for hospice is a statutory requirement. So, I think the agency is limited in its

ability to waive that requirement either on a case-by-case basis or as a blanket waiver.

But, as you mentioned, we are considering whether there is additional flexibility that should be in place for the examples that you mentioned like patients in rural areas that may not have access to the two-way audiovisual. So, that's something that we're taking another look at.

Male: Hillary, it wouldn't be a waiver though, right if I have – if I understand the question or ...

Hillary Loeffler: Yes.

Male: ... and how we will (do laboratories), so it would – it would be a policy change ...

Hillary Loeffler: Yes.

Male: ... is that correct – right?

Hillary Loeffler: Yes, correct.

(Barb Hansen): So, at this point, there is no reason that suggests to hospices that they submit individual waiver request for this because that wouldn't impact the outcome, it sounds like.

Hillary Loeffler: Correct.

(Barb Hansen): OK, thank you.

Hillary Loeffler: No problem.

Operator: Your next question comes from the line of (Brenda Schoep). Your line is open. Please ask your question.

(Brenda Schoep): Hi. Good afternoon. Thank you so very much for taking my call. I really appreciate it. I would like to say, for the G2023, I would love to have that question answered because there are nurses and physicians going in gowning

up putting on PPE in order to run the specimen. So, I applaud you for looking into that.

I have a bigger question that has to do with hospital-based guidance for non-physician services and not just PT, OT, SOP, but there's also several other non-physicians that provide services like audiologists, registered dietitian, social workers, wound care nurses, lactation nurses, psychometrist, and there is no guidance for them either.

And so, I think it would be very helpful if CMS could come out with some sort of guidance on the behalf of hospital-based non-physician practitioners? And the reason that I say that is if you step back and look at the PT, OT, SOP and they can do it in private practice, they can bill on a HCFA , and you're allowing that.

It doesn't make any sense why they can't do the exact same services in the hospital-based setting especially for like example outpatient settings. There's no difference. So, I just was wondering if there is a possibility that we can – that CMS could address the larger picture of non-physician services.

And I know that there's been a lot of questions about telemedicine, but there are a lot of people that are actually providing services that could provide services via telemedicine. So, I would love to hear your thoughts about the other individuals that I listed. And thank you for taking my question.

Male: Hi. We are definitely aware of the question that you're referring to in terms of the hospital-based services. We've gotten that question for many, many people. It's clearly a circumstance that we couldn't speak to as readily as some of the other things that we've already addressed, understanding very much why you're interested in it, and I assure you that we're working on it and we'll be providing clarity when we are – as soon as we can. So, appreciate you emphasizing that. It's ...

(Brenda Schoep): Well, I greatly appreciate you guys listening to our questions because it really is. We are getting a lot – I work on the facility side of things. And so, it's not just inpatients, and we're getting a lot of questions from revenue cycles, these

practitioners. We're holding hundreds of thousands of dollars to figure out what we're supposed to be able to do.

And so, that's why I think it's important, though let me be clear, I get physicians needed to get the telehealth and telemedicine up and running, totally get it, respect it, understand the 221-page interim final rule. But, I think there's another facet that also need some help. And so, I greatly appreciate you guys taking the time to take my question. Thank you.

Male: We'll take that as confirmation and we're putting our time and energy in the right place. Thank you.

Operator: Your next question comes from the line of (Ray Gowanda). Your line is open. Please ask your question.

(Ray Gowanda): Thank you. A couple of questions, number one, and you did talk about the G code – the e-visit code, the virtual check-in, and the telephone service codes. And in the interim final rule that was reached on March 30th specifically mentions physical therapist, occupational therapist.

So, the question is can a physical therapist assistant and an occupational therapy assistant provides an e-visit and a telephone service? And then, second, just to clarify the first question I was asked today, can a PT and OT in a UB04 claim from an institutional setting, can they bill those codes right now on a UB04 claim form?

Ryan Howe: So, the – the e-visit Code, those are – those are reported for the services that are directly provided generally by the practitioners who are reporting them. And so, generally, those are going to be reported on a professional claim.

In terms of – I think in terms of the professionals and others who are employed by the hospital whose services will typically be reported on the hospital claim and will be paid under the hospital payment systems like the Outpatient Prospective Payment System, those codes whatever the – however those codes would ordinarily pay I think that they wouldn't pay separately under the OPPS and that will continue to apply.

Again, I think, this is part of that answer – just to put it in the context of what we've been saying about understanding a lot of these concerns and we're actively taking a look at all of those issues. And we certainly appreciate about hearing the importance of them.

(Ray Gowanda): Can you clarify though can a physical therapist assistant and occupational therapy assistant and a professional claim, can they do the e-visit – can they do the telephone service though and have the ...

Ryan Howe: So ...

(Ray Gowanda): ... under the NPI of the therapist or if they have to be done by a therapist?

Ryan Howe: So, I think under our current policies, the – those codes are for the services that are directly provided by the individual who's billing for those professional services. And so, at the moment, I think the answer would be no. But, again, it's part of the question, that we're actively considering.

(Ray Gowanda): OK. And just as you go back and consider to keep in mind in the hospital setting, therapy is paid and billed under the Medicare physician fee schedule not under OPPS, if that makes a difference how you answer that question for the UB04 were still paid under the Medicare Physician Fee Schedule not OPPS.

Ryan Howe: We certainly understand that and that makes a lot of sense then. It's helpful to understand as well. Thank you.

(Ray Gowanda): Well, thank you, I appreciate it.

Operator: Your next question comes from the line of (Cathy Borne), your line is open, please ask your question.

(Cathy Borne): I retract my question. It was about the echo earlier. Thank you.

Operator: Your next question comes from the line of (Sharon Burns), your line is open, please ask you question.

(Sharon Burns): All right. Thank you. My question is regarding the COVID-19 stimulus payments for skilled nursing facilities, if a skilled nursing facility submits a request for the Medicare accelerated in advance payment, will the sniff still be able to apply for the COVID-19 stimulus $1.5 billion fund grant for skilled nursing facilities whose primary income comes from Medicare? In other words, can a sniff request both of these or only one?

Jason Bennett: We have our (all-time) colleagues on the line? So ...

(Sharon Burns): Well ...

Jason Bennett: Yes, I mean, I can tell you that generally, the accelerated payment provisions don't go – don't believe – I don't believe they have kind of a rehabilitation like that in them. And so, I can venture a bit of an answer for you.

What – I think you need to look at all the grant conditions when they come out and I don't know that – is it a HRSA Grant or – that you're referring to? I apologize, I'm not totally familiar with the grant program you're referring to.

(Sharon Burns): Let's see, it's says the federal government this week announced that hospitals and other Medicare reimburse healthcare providers will receive the first disbursement for $100 billion emergency COVID-19 stimulus fund. And it talks about skilled nursing facilities, primary – derive their income from Medicare the windfall could be significant. They estimate an allocation of about $1.5 billion to skilled nursing based on this allocation system.

Jason Bennett: OK.

(Sharon Burns): So it's under the blanket of the $2 trillion coronavirus stimulus bill passed last month.

Jason Bennett: OK. So the details on the grant program haven't been released in – beyond some of the statements have been made at a high-level. You'll have that – when they're out, I think you'll be able to see how that's envisioned in terms of exactly how the money will be distributed. The accelerated payment program is really a different creature.

And so, I think I can tell you that from the CMS side with regards to the accelerated payment program there wouldn't be a conclusion in that regard. The other part I'm hesitant to speak to because the details aren't out finally yet, but they should be soon. And I would draw your attention to those when they come out to see if there's any – a particular preclusion but they are – I'll just say at a high level, we are really two separate programs.

(Sharon Burns): Oh good. OK. So, this would be – you say pretty soon? Do you have any idea of the time frame?

Jason Bennett: I – every time I speculate it, I end up being wrong. So I won't mislead you ...

(Sharon Burns): I understand. Better not do that then. Well, thank you for your help. I appreciate it.

Jason Bennett: You're welcome.

Operator: Your next question comes from the line of (Vanessa Williams). Your line is open, please ask your question.

(Vanessa Williams): Hi. I didn't have a question. I just wanted to let you know that when we first started the call, it wasn't coming through clear. But it sounds real good now. Thank you.

Alina Czekai: Thank you.

Operator: Your next question comes from the line of (Leslie Naramore). Your line is open, please ask your question.

Your next question comes from the line of (Tim Walters), your line is open, please ask your question.

(Tim Walters): Yes. Thank you very much. We are a rural hospital operating a number of rural health clinics and to be exempted from rural health clinic cost (limit), we have – we are limited to 50 beds in the hospital without walls. (Inaudible) we're trying to determine how we might put more beds into service if needed.

But we need know we're going to be – that 50 bed rule will be waived during the period of the emergency. Has that – I asked that question a few weeks ago, just trying to get an update on that – has that been resolved yet?

Jason Bennett: It is not resolved yet, but we are – it's definitely on our list of things that we're working on. And so – including some of the other things you've heard before, but it is definitely something that we're working on.

(Tim Walters): OK. All right. Thank you.

Operator: Your next question comes from the line of (Thaddeus Alito), your line is open, please ask you question.

(Thaddeus Alito): Hi. Thank you very much for this opportunity to ask my question. My question also revolved around hospitals without walls. Are you going to consider places of residence, like a patient's home or apartment as an inpatient or a temporary extension within the guidance of the hospitals without walls?

Jason Bennett: OK. So, we're definitely looking – this is sort of really ties very much to the – some of your other questions about what would constitute a hospital and how to bill for hospital-type services when the patient is outpatient service is provided and the patient is not at the hospital? And we're working to address that too. I know that it's an issue that many have asked about.

(Thaddeus Alito): Thank you.

Operator: Your next question comes from the line of (Christy Mae), your line is open. Please ask your question.

(Christy Mae): Hi. I have seen some information that we should be dealing with the 95 modifier in the place of service telehealth would have originated from. And we were fine with that except in the beginning we started out with place of service (too).

Today, however, I found an article admittedly not from CMS, but indicated they were quoting CMS as to state that we should be using now a CS modifier in order to ensure that we receive non-facility over facility reimbursement.

Jason Bennett: So thank you for your questions. So for all telehealth services during the public health emergency, we are asking to use the 95 modifier and then the place of service code where the service would've been furnished were telehealth not needed.

And that place of service code will be the driver of whether or not the non-facility as a facility amount under the physician fee schedule is paid. And so relative to telehealth services alone, there's no additional modifier needed other than the 95.

The other modifiers relate to COVID testing which could be furnished via telehealth visits associated with COVID testing, but not – those modifiers aren't required in order for the appropriate payment to be made for telehealth itself. I know it's confusing and then there are a lot of a lot of changes happening rapidly, so we certainly appreciate hearing the question and we'll keep working on making that guidance as clear as possible.

(Christy Mae): OK. Thank you. I do have just one other quick question on the claims we filed as O2, are we going to receive the facility rate on those and will we have an opportunity to upheld those?

Jason Bennett: Those will be paid – those should be paid with the facility PFS rate and your second question in terms of can that be changed or rectified? That's a good question, and we'll have to take that back. And we will issue subsequent guidance on that.

(Christy Mae): OK. Thank you, so much.

Jason Bennett: Sure.

(Diane Kobak): And (this is Diane Kobak), just for clarification there is a CS modifier. I know there's some confusion around it, because a long time ago it was used for claims related to oil spill. But we have repurposed that modifier, and that is the one you would use in those situations where there would be no cost-sharing that's applicable. And I believe messaging was released through our (MLN) connects pretty recently on that.

Jason Bennett: So the article that you're referencing might have gotten the two mixed together or thought about them as overlapping in some circumstances.

(Christy Mae): Yes. I have that clear, so we will make sure that we're clear on that modifier.

Jason Bennett: In the article yes, the call I was referencing.

(Diane Kobak): Perhaps. Sure, yes, perhaps.

Jason Bennett: And (Diane), do you have some news to share with our group about some more guidance to put up?

(Diane Kobak): I sure do. So, everybody is probably aware that we put out a large amount of guidance on cms.gov on our emergency preparedness and response operations page and while we were on this call today, we've updated our frequently asked questions document and it has a large number of FAQs on there related to the interim final rule.

So I urge everybody to do and look at that. I think a lot of your additional questions will be answered with that information. And also to let you know, we're working on updating the rest of that document. So we're hoping in the next day or so, we'll have additional information that's updated on the FAQs.

Alina Czekai: Thank you (Diane). And thank you everyone for joining our call this afternoon. As always, you can e-mail us with any questions at our COVID-19 inbox. And that is covid-19@cms.hhs.gov.

I'd also like to note that all of our stakeholder calls are recorded and you can access those online including this call and others this week at cms.gov/outreachandeducation. Under open door forums we have a tab with all of our podcasts, recordings and transcripts and hope you find those resources helpful. Have a great rest of your night. We will talk to you all soon.

Operator: This concludes today's conference call. Thank you for participating. You may now disconnect.

End