Centers for Medicare & Medicaid Services
COVID-19 Office Hours
June 16, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 4527348

Alina Czekai: Good afternoon. Thank you for joining our June 16th CMS COVID-19 Office Hours. We appreciate you taking the time out of your busy schedules to join us today.

This is Alina Czekai leading stakeholder engagement on COVID-19 in the office of CMS Administrator Seema Verma.

Office Hours provides an opportunity for providers on the frontlines 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 online media inquiries form which can be found at cms.gov/newsroom. Any non-media COVID-19 related questions can be directed to covid-19@cms.hhs.gov.

And we'd like to begin our call today with some updates on recent CMS publications and guidance.

As COVID-19 related healthcare demand decreases for some states and localities, CMS recently published updated guidance on reopening facilities to provide non-COVID-19 related healthcare. This guidance is specifically written for areas that are entering Phase 2, which is states and regions with no evidence of a rebound that satisfy the gating criteria, and that includes general considerations, facility considerations, testing guidelines, and recommendations on PPE, workforce availability and sanitation protocols. This guidance can be found on CMS' Current Emergency Page under the section – Clinical and Technical Guidance for All Healthcare Providers.

Further, last week, CMS published an updated set of FAQs that clarifies existing guidance and flexibilities and provides additional information for the following entities – ambulatory surgical centers, hospitals and critical access hospitals, hospice, intermediate care facilities for individuals with intellectual disabilities, rural health clinics and federally qualified health centers. And this guidance can be found on CMS' current emergencies page under the section – Clinical and Technical Guidance for Healthcare Facilities.

Lastly, we'd like to address a couple questions that we received last week. The first question is, some health plans are reinstating their prior authorization process as states reopen, what are the conditions and requirements under which prior authorization can be reinstated? And the answer to that question is, with the exception of COVID testing and testing related services during the public health emergency, Medicare Advantage plans may have policies that require prior authorization for covered items and services.

Consistent with flexibilities available outside of a public health emergency, MA plans may choose to waive or relax planned prior authorization requirements at any time in order to facilitate access to services with less burden on beneficiaries, plans and providers. MA plans that have waived or relaxed their PA requirements may reinstate them as long as they do so in a manner that treats similarly situated enrollees uniformly.

Our last question is, will the nursing home star ratings program be updated to take into account issues that COVID has underscored the importance of, particularly infection control? And the answer to that question is, CMS is currently evaluating how the nursing home five-star quality rating system and nursing home compare website have been impacted by the COVID-19 public health emergency, and how these programs might need to be changed in the future. We do not have an update at this time, but we'll communicate with stakeholders prior to implementing any changes.

As always, we appreciate your questions and are working to address them as soon as possible. Today, please try to keep your questions to one question or one question and a follow up. And please do keep in mind that the questions

discussed on this call and our responses are often general representative questions. Your specific circumstances may be different; therefore the information provided may not always be applicable to your unique situation.

As always, you are welcome to reach out to the COVID-19 mailbox for further assistance. And again, that mailbox is COVID-19@CMS.hhs.gov.

Operator? Let's open up the lines to take some questions. Thank you.

Operator: Sure, ma'am. Ladies and gentlemen, if you would like to ask a question at this time, please press "star" "1" on your telephone keypad and wait for your name to be announced. If you wish to cancel your request, press the "pound" key.

Again, that's "star" "1" to ask a question.

Your first question comes from the line of Barbara Cobuzzi with CRN Healthcare Solutions. Your line is now open.

Barbara Cobuzzi: Hi. I seem to – in discussing this with colleagues who've also been on the call, seemed to have some confusion as to the – what is billed for the facility when the HOPD has elected to relocate – temporary relocate to the patient's home.

The hospital can then bill a facility fee on the UB. Is that the Q-3014 code?

David: So if your question is for an off-campus provider-based department or on campus provider based department that has done a – submitted a temporary relocation request to the regional office to relocate that department to the – to the patient's home, they can they can bill for services that are provided at that patient's home on the UB-04 to receive OPPS payments with the PO modifier to indicate that it is an accepted off-campus provider-based department.

Barbara Cobuzzi: And is a Q-3014 billed on the UB?

David: Is that the originating site fee code?

Barbara Cobuzzi: Yes.

David: Yes. So this is where there's sort of a split in what your options are. If you bill the Q-3104 as the originating site fee, then it's a true telehealth service. So you would be – you would bill that originating site fee for the facility payment, but you wouldn't receive the other payments under the OPPS, it would be under the PFS for the professional service.

And I believe either Ryan or Emily could add more on the PFS side of the payment.

Barbara Cobuzzi: It's just confusing as whether it's a G-0463 or the Q-3014 in terms of what to build on the UB-04.

Ryan: So, I think ...

David: Go, ahead Ryan.

Ryan: No, I was just going to say that I think both of those codes could be billed on the UB claim. And whether or not there was a professional telehealth service reported and furnished and reported would help you determine whether or not the telehealth originating site facility fee would be the appropriate code. I don't know David, if that's right.

Barbara Cobuzzi: So, if a telehealth service is provided to the patient, the Q-3014 would be billed on the UB, and then on the professional claim on the CMS-1500, the telehealth service would be billed with a 95 modifier?

Ryan: That is right.

Barbara Cobuzzi: OK.

Operator: Your next question comes from the line of Leslie Narramore with American Gastroenterological Association.

Leslie Narramore: Hi, thank you so much for taking my call. I just have one quick question. Will the COVID-19 public health emergency end date be extended? We're getting a lot of worry calls from our members who are concerned that with cases in some parts of the country on the rise, it won't be safe for patients with chronic conditions to return to face-to-face care before the end of summer.

And they're worried that coverage with telehealth will end prematurely. So any sort of information that you could give on that would be – it would be great.

Demetrios Kouzoukas: So I don't know that – I don't believe we have any update or advanced discussion at this point about the public health emergency in terms of its end date, but we are aware that people are relying on the public health emergency for some of the changes that they've made in their operations and the like.

So we're definitely cognizant of the impact of when it ends. And we'll certainly be taking that into account in terms of discussions with the rest of the executive branch, in terms of that decision being made as well.

Leslie Narramore: Thank you.

Operator: Your next question comes from the line of Rachel German. Your line is now open.

Rachel German: Hi, we are a critical access hospital and we were just wondering – for Tele Rehab services in particular, so PT, OT, and speech. We want to make sure that we're fulfilling Conditions of Participation and we're wondering how we document things like infection prevention and safety to make sure that we are compliant and we'll get paid.

Demetrios Kouzoukas: Is the – the question is about how you document quality in this circumstance or is this about payment?

Rachel German: It's about how do we – it's about payment – how do we bill it, and then how – because what we're getting – the questions that we're getting are, we're worried about fulfilling Conditions of Participation specifically for safety and infection prevention within the patient's home since they are not in our facility, we have less control over safety and infection prevention.

So what do we need to do– do we need to be documenting like emergency procedures in case something happens to the patient or what do we need to do to make sure we fulfill that?

Demetrios Kouzoukas: OK. I don't know if any of our CCSQ colleagues are on. Maybe you have some thoughts for our caller?

Sarah: This is Sarah and I would have (Maya Snee) take a look at that question. If you could send that question forward, and we will definitely follow up with you.

Rachel German: OK, thank you. Who should I send that on to?

Alina Czekai: Sure, you can send that to our COVID mailbox and it's COVID-19@CMS.hhs.gov. And we'll also take your question back, so we can try to address it at the top of our call next week. So we'll take our next question, please.

Rachel German: OK. Fabulous.

Alina Czekai: Great, thank you.

Operator: Your next question comes from the line of Kim Hug with UHS. Your line is now open.

Kim Hug: Hi, this is Kim Hug, we've asked the question and just didn't follow up anything to the lady who spoke on the first part of the call into my question asked two weeks ago. So, in the encompassing, so far a typical PBD practice split practice in Billings.

With extending the hospital walls to include the patient's home, we are interpreting that the G code, the GO-463, would be billed because it's encompassing off site and the extension of the clinic for the UB side of the house while billing the physician component on the Physician Fee Schedule on the 1500.

And I think a lot of people are having confusion onto this, and we need to get to a little bit more clear directive, particularly to the extension of the hospital site because it sounds like we're dancing around it a little bit and need to have that clarified further.

Emily: Hey, this is Emily. So, in instances where the beneficiary home is a PBD through the temporary expansion, and if for example, if it's a telehealth service, then if there's a professional claim for the telehealth service, then that would be billed on the professional claim and then the hospital would bill for the originating site facility fee.

If both the patient and the physician are in the hospital, either in the hospital proper or through the temporary site extension, then they would bill for the clinic visit using the G code you described.

Kim Hug: OK, so with that thing, we would enroll the patient's home location as an extension of the hospital clinic with the rule of the walls expanding including a patient's home, I'm hearing that we would bill the G code.

Emily: Yes, I believe that's right.

David: You would build the G code – this is sort of the issue of the two authorities that have been granted under the IFCs that are new and they're being some overlap. The one being that hospitals can now provide telehealth and if they're providing the telehealth as a true telehealth service, they would bill the originating site fee on the hospital side and then the standard telehealth fee on the PFS side.

Kim Hug: So from that standpoint there, would it be the extension so it's not being delivered from a full telemedicine model location, it being an interactive visit as a temporary extension of the hospital clinic due to the current pandemic, so it would not be registered or notified as a regular telehealth service in my mind because the roster has been submitted, including the attributes to extend the walls of the hospital clinic to the patient's address.

David: Right. So, the other option being that if the hospital has expanded the outpatient department to include the patient's home and are using technology, which might encompass telehealth similar technology, but this is not a true telehealth service hospital outpatient service being provided in the patient's home.

In that case, you would – you could fill the visit code and would append the PO modifier if you have submitted that temporary relocation request for the department.

Kim Hug: So then go to the next part. So, with that happening that would basically be then if it's an O2 for the place of service, we would bill the G code for the originating site fee because that would be from a telehealth delivery method.

But then for the 22, the outpatient, which would have occurred if the patient prior to the pandemic and utilizing an additional platform embedded within our EHR as an extension of the clinic that would be the G code for most likely the place of service 22?

David: Right.

Kim Hug: That's all.

Operator: Your next question comes from the line of Maria Burnett with Medstar Health. Your line is now open.

Maria Burnett: Good afternoon. My question relates to: we are receiving several requests from payers in our state that are indicating that they are going to end their cost share waivers. They're going to end paying for the COVID lab test as of July 25th. Has something been communicated?

One of these payers is the state – is our state Medicaid program. Has something already been communicated that they are to end their payments and waivers as of July 25th?

Demetrios Kouzoukas: So, are you referring – are you saying that one of them is the state Medicaid program? Is your question in part about Medicare Advance plans or just – do you know what the other payers that you're referencing are?

Maria Burnett: The other payer is a managed care payer, so it's a managed care payer and a Medicaid program.

Demetrios : OK, so, I think the call we have here is focused on Medicare issues, obviously we can work to see what we can find out about the Medicaid side. Nothing

comes to mind, but in terms of June 25th being a particular date, but we can definitely look into that and get you in touch with the right people at CMCS. It sounds like that's what you're asking about in terms of the Medicaid plan.

And then with – if any of the payers you're talking about our Medicare Advantage plans, the scenario they're playing out right now is that some plans that had previously put in place waivers or relaxation of certain requirements, including possibly cost sharing are making changes to some of those things. Those are flexibilities that we've given the plans to be – an ability to make. And so they're making decisions about how long those changes are in place.

I will say that there is a prohibition on prior authorization for COVID testing and testing related services. And there's also some limitations on cost sharing for some of those things as well. But outside of that, they will depend on the plan in terms of when and how they exercise the flexibility that we've been afforded so far.

Maria Burnett: OK. OK. So do you want me to submit the question through the website? Through the COVID-19 ...

Demetrios : Alina, what's best if we want to get her to CMCS on the Medicaid ...

Alina Czekai: Sure. If you want to do that, and Maria, I've also taken down your phone number so we can facilitate a reply to you directly, since your question's a bit more niche. But our e-mail address is COVID-19@cms.hhs.gov and I'll be sure to put you in touch with our Medicaid colleagues.

Maria Burnett: OK. All right, thank you very much.

Alina Czekai: Thank you.

Operator: Your next question comes from the line of Christine Maine with Tennessee Orthopedic. Your line is now open.

Christine Maine: Hi. I was wondering if any decisions have been made about some of the programs that will affect 2021 such as MIB, AWK and even the E&M Guidelines for 2021.

Emily: So I can speak a little bit to the changes for that were finalized in the CY 2020 Rule for CY 2021 for E&M. We are certainly sort of aware of – but we certainly heard from stakeholders some concerns about how those policies might intersect with the sort of the response to the COVID-19, and we're definitely considering how best to sort of address those concerns as we move forward.

Christine Maine: OK.

Operator: Your next question comes from the line the Yna Sander with Mount Sinai Medical. Your line is now open.

Yna Sander: Thank you for taking the call. I'm just trying to follow up on some of the questions I sent to CMS regarding the policy on billing for donor patients who are donating their blood for the either convalescent program offering or for any other related projects where we're trying to determine with the convalescent program blood administration is working on COVID patients.

Do you know if CMS had any further discussions about the policy for whether we can bill for those services or not?

Ryan: I think those are policies that we continue to work on. I think particularly to the extent that they're part of innovative services and obviously of great import, we are still act actively working on what the instructions would be regarding that, and we're hopeful that we'll have some information shortly, but there are a lot of different challenges and we continue to work on it. I don't know if – Demetrios , if you want to add anything else to that.

Demetrios Kouzoukas: No, I think that what Ing Jye had referred to at last week's call was that we were – they'd be drilling in on a couple of particular aspects of the service that you're describing to see if there might be some aspect of it that has a particular wrinkle or nuance to it in terms of what we pay for, in routine – in the sort of even outside the clinical trial context, and the general policies, the routine care in clinical trials policy that, I think you're probably familiar with.

And I know, I think that's what Ing Jye and the others are working on is that we're trying to drill down on whether there might be some piece of the general

layout of work that you described that might have a particular angle or a different kind of way to think about it.

Yna Sander: Yes, normally, I understand but the routine care policy and all of that except donors are just simply donating their blood. So, it's hard to say this is routine care of the patient.

So, we just need to get some clarification, but because more and more projects are coming on board, some of them are on the clinical trial umbrella. Some of them are sponsored by BARDA, and some of them are just innovative work that individual facilities are doing to try to find solutions to treatments for COVID patients.

So, I think some guidance would be really helpful, because there is a lot of cost involved in providing these services, the test kits, the time and all of that. So, we just need some direction what to do with these services we're providing when it comes to billing. So, I appreciate your response.

Demetrios : You're welcome and to the extent it's helpful, if you need to – in the absence of hearing sort of more detail from us, we definitely continue to work on it, I think you can rely on the general clinical trials policy setting out what we won't – what we do and don't pay for.

And I know that that puts you in the position of asking the sponsors to provide reimbursement for this particular work. We may be able to come up with some other aspect of our regulations or policies that allow for some Medicare coverage here, but I don't know that I would – at this point, assume that you can, I think, for now rely on the general coverage policies and we're working on seeing it if we have sort of a different answer for you, too, in the meantime.

Yna Sander: OK. Thank you.

Demetrios : You're welcome.

Operator: Your next question comes from the line that Johan Ediseleri. Your line is now open.

Johan Ediseleri: And I represent one of the ACLs in the Hudson, New York area. And my question is in regards with the communication that was put out on April 10. And you guys were talking about risk adjustment, and my question is that there is a portion of the communication that says that the diagnosis resulting from telehealth services can meet the risk adjustment face-to-face requirements when the service are provided using an interactive audio and video telecommunication system that permits real-time interactive communication.

So, I believe that Medicare at one point were waiving the audio and video requirements for telemedicine and so I'm wondering how this would affect the risk adjustment because as we know, the providers had the capabilities of providing telehealth services with an interactive system or using the phone, but some of our members didn't.

So, I believe that's how the flexibility for these two components came about. So, how this would affect if for example, the documentation of the providers doesn't really say that this was given by – that it was given via audio and video systems. That it was just maybe a video because the patient had only a video communication, maybe just a telephonic communication?

Demetrios Kouzoukas: Hi. This is Demetrios , I am happy to answer that. I think where possibly what might be helpful is to think about this as having really two different pieces to it. What the Medicare fee for service program has done is that there are several codes, I think, three or so but then we added some more where some of the fee for service program is paying for audio only services.

That flexibility is something that has long existed in MA either as a supplemental benefit or as part of what MA plans to do in the course of care management or in other ways that they might set up arrangements with their providers, and so beneficiaries MA plans have had access depending on the benefit design of the plan to audio only communications and reimbursement in connection with those.

And so those – that's how the payment for audio only services is treated in fee for service and in MA, respectively.

Now, I think the question you're raising is what about risk adjustment?

Johan Ediseleri: Yes, risk adjustment.

Demetrios Kouzoukas: And risk adjustment is really not affected by the change in what fee for service audio only reimbursement does and so, in that case, our policy is that for risk adjustment purposes, there's a requirement for that face-to-face communication and that can be fulfilled through an interactive audio-video interaction as along the lines we've described, but not a telephone only one for purposes of risk adjustment.

That doesn't mean that the service can't be provided and paid for and negotiated as part of an MA plan's arrangement that beneficiaries wouldn't have access to those services. The question around risk adjustment is purely about the extent to which those services necessarily make a change in a risk score for purposes of payment to the plan.

Johan Ediseleri: Because the concerns that we were having was basically on the very beginning of the PAT when some of these patients that came to see their – that were able to talk to their providers about COVID and things like that, they, at the very beginning did not have a video capability, right?

So, we still have patients that are trying to reach their providers that they're only coming once to their to their providers for, you know, COVID-related issues or comorbidities of the chronic conditions and we are concerned that some of these patients do not have a video access phone or a computer.

Demetrios Kouzoukas: Are you with a health plan or a provider?

Johan Ediseleri: With a health plan.

Demetrios Kouzoukas: OK. And does your health plan offer coverage for audio only services? Or ...

Johan Ediseleri: We cover over the phone, yes.

Demetrios Kouzoukas: You are covering them – these reimbursable services. So, the question is about access or payment to the plan?

Johan Ediseleri: The question is not meeting all the requirements because if our provider for example, it's not so much the provider as it is our patients so when we're talking about risk adjustment in this memo that came out on April 10, there is a very clear line that they said they'd have to be an interactive audio and video. So ...

Demetrios Kouzoukas: I'm sorry. OK. Please finish. I interrupted you.

Johan Ediseleri: Yes, so my concern is just to make sure that we are within compliance in the components of the interactive communication. Does it really have to be audio and video to qualify the patient for risk adjustment?

Demetrios Kouzoukas: The requirement for audio and video is only for purposes of risk score submission and for purposes of payment to the MA plan, but that it is not a limitation on the plan's ability to provide an audio only service consistent with its plans benefit package or consistent with, maybe your flexibility, we provide the plans to create new benefit enhancements in the middle of the year.

And so, it is a requirement, but it is only for purposes of the risk score submission and risk adjustment program, not a requirement for the MA plan to provide the service.

Johan Ediseleri: OK. Well, thank you very much.

Demetrios Kouzoukas: You're welcome. Thank you.

Operator: Your next question comes from the line of Gillian Belli with Memorial Sloan Kettering Cancer Center. Your line is now open.

Gillian Belli: Hi. I have a question about the hospital without walls and provider based waivers. On prior calls, I've understood you to respond to questions about these waivers by saying that you only need to go through the process of relocating a provider based department and registering patient addresses with the regional office. If you wants a bill for services for which you'd receive the full OPPS rate rather than a lower site neutral rate.

So, with that in mind, you make the home of a registered hospital outpatient provider based under these waivers, and you want to bill only for telehealth and the originating site fee using the PN modifier and without registering the patient's address with the regional office, can you do that even if the distance site practitioner providing the telehealth services normally practices at a provider based department that bills using the PO modifier?

So, in other words, can you apply a PN modifier for services in a provider based department that is a patient's home if the provider based department in which the distant site practitioner is normally practicing or practices reports a PO modifier?

David: So, yes. You can use the PN modifier if you don't want to have to submit the temporary relocation request to relocate the department to the patient's home. You can just bill the PN.

Gillian Belli: OK, and it doesn't have to match the distance site provider's modifier. Those are disconnected.

David: Right. Right. Because in this case you're – the reason for the temporary extraordinary circumstances extent is relocation request is to maintain the department except the provider based apartment exception to receive the full PPS payment when it relocates to the patient's home.

In this case, you're sort of creating a new department in the patient's home that is not – that this new location doesn't need to maintain that PR modifier so you can just use the PN modifier.

Gillian Belli: OK, great. Thank you.

Operator: Your next question comes from the line of Becky Keither. Your line is now open.

Becky Keither: Good evening. I wanted to ask about partial hospitalization program billing and if there is any difference for PHP that's hospital base from any of the other hospital outpatient department billing guidelines that you have provided.

For instance, I know that if the practitioner is at a remote site, then they bill services telehealth and the hospital would typically bill an originating site fee. If we've expanded the walls and the practitioners on campus and the patient is at home, which is now on campus, then we would bill our normal codes with the PO and PN modifiers etcetera.

So the question that's been brought up by the PHP department is when that distant site provider is rendering the service via telehealth, typically the only elements that a hospital outpatient department would be allowed to report is the originating site fee with Q3014, but Q3014 isn't recognized on the PHP and can't count toward the number of required billable services for the program. So, is there an exception there for PHP in any way?

David: So, let me see if I'm following your question. As you recognize PHP is a bundled payment on a daily basis. And so it doesn't quite fit in the same regard necessarily to the way that other outpatient care is provided under hospitals and account walls.

Because it's a bundled payment, what we're doing is providing the flexibility for the patient's home to be part of that site of care for that payment episode.

Becky Keither: So, actually as long as you've expanded to the patient's home, well, I am assuming that requires the same modification as any other outpatient department that you're wanting to expand for, then you just bill it as if it occurred at the hospital pre – just like you would have pre-COVID.

David: Yes, I believe that.

Becky Keither: OK.

David: I believe that is correct. But if you want to send your question and more specifically, I'll be sure that we get the right experts to look at it because it involves a couple of different – a couple different components.

But I think what you've described sounds conceptually consistent with what we were trying to achieve.

Becky Keither: OK. Because I did read where it talks about in the way we specifically for PHP, that it doesn't really matter where your providers are, so I seemed to take that element out of the picture. So I just wanted to be certain of that fact.

OK, I'll go ahead and send it in in writing as well.

Male: OK. Yes, thank you.

Becky Keither: Thank you.

Operator: Your next question comes from the line of Nelia Odecci with the CHARGE Group. Your line is now open.

Nelia Odecci: Hi. Thank you for taking my call. I just have a question about that NHSN reporting of cases to CDC and the CMS penalties that are being issued right now. We have several facilities that have – that were told by NHSN that it was from a computer glitch, yet they have received the penalty letters.

Now, is there any way rather than going through the IIDR process that we can rectify this problem because the software glitch was on the end – it was on CDC's end and it's not really on the facility's end.

Demetrios Kouzoukas: Do we have any of our CCSQ or CMS colleagues on? I think we will have to take that one back.

Nelia Odecci: OK. Thank you very much. I would really appreciate it because every week that goes by, well, we have some resolved today, but it's been like – we already received – the facility has already received the penalty letters, which I believe is not fair if it's from a computer glitch on NHSN or (inaudible) so, thank you very much.

Demetrios Kouzoukas: Thank you.

Operator: Your next question comes from the line of Kate Walsh with Greenware. Your line is now open.

Kate Walsh: Hi, guys. Thanks for taking my call. I just had a quick question for the outpatient therapy services that hospitals are now about to fill with Modifier

95. I've been trying to get some clarity on what those specific services are on these past calls. I know we use the terms Physical Medicine, so PT/OT. Someone brought up diabetes management.

I am thinking you're talking about codes that are assigned to (Start) Indicator A because they're paid under the Physician Fee Schedule. But that's not really specified in your latest FAQ document.

Ryan: So, what we've answered on the call previously relates to the Outpatient Physical Occupational and Speech Language Pathology benefit. I think the question that you're asking is about some of the other services that are paid ordinarily at the Physician Fee Schedule rates when they're billed by the hospital and institutional claim, and I think that's something that we'll probably need to take back and make sure that we get you the right answer for that.

Kate Walsh: OK, just because to me, the biggest point of confusion is obviously Behavioral Health is often referred to as outpatient therapy, but those do have separate OPCS rates. So, just, if you can, I would appreciate some clarification on which specific codes can be billed with modifier 95.

Ryan: Sure. We will take that back and your point is well taken and often from a Medicare benefit statutory perspective, the outpatient therapy benefit is really for the Physical, Occupational and Speech Language Pathology, but understood that that can certainly be taken to mean more broad services. And so we'll be careful with that as well.

Kate Walsh: Thanks.

Operator: Your next question comes from the line of Sara Ayems. Your line is now open.

Sara Ayems: Hi, this is Sara. My question piggybacks right on the one just asked previously. It relates to the hospital outpatient therapy services when they're furnished via telehealth and billed with the 95 modifier.

When it's done under that – on the institutional claim bill with telehealth. My understanding is that a hospital is not required to designate or report the patient's home as an outpatient provider based apartment. They're not required to use any other provider based modifiers. And the patient's home is not, for purposes of furnishing the therapy service and when I say therapy service, I'm meaning PT/OT/Speech that the patient's home is not part of the hospital in that context.

And my question really is, to what extent do the hospital COPs – the Conditions of Participation extend to the patient's home there. In particular, some of the hospital without walls policy, there's a physical environment COP that states that the hospital has to obtain state approval of the patient's home and when it's done under this telehealth – under the telehealth option, it seems that shouldn't apply.

But I just wanted to confirm the extent to which the hospital COP is applied to a hospital billing, PT/OT as telehealth.

David: So to answer your first question on billing, that's right that if you're billing the service as a true telehealth service, and just billing the originating site fee on the facility, you don't need to designate the patient's home as an expansion of the hospital provider based apartment or provide the modifiers to indicate that is the PO and PN. So that part is correct.

On the second part, I don't know. Do we have anyone from CCSQ on who could answer the Conditions of Participation question?

Sarah: This is Sarah and if you could forward that question over to us, I will have one of our (semis) respond.

Sara Ayems: OK, I appreciate it. Is that just to the general COVID-19 mailbox?

Sarah: Yes.

Alina Czekai: That's right. Thank you.

Sara Ayems: OK. And just one other quick follow up, I would just reiterate what the previous caller asked about which was for other types of outpatient therapy or counseling services. In my case, the questions relate to the nutritionist and diabetic counselor services that can be furnished via telehealth and you know whether those services can also be billed on the UB with the 95 modifier. I think they're going to clarify that, but I just wanted to reiterate that that's a point of confusion.

Operator: Your next question comes from the line of Tim Harvid with (inaudible) University Healthcare. Your line is now open.

Tim Harvid: Hi. Thanks for taking my call. Recently, before some of the current waivers had been published, our organization was taking part of a strategic initiative with some of the nursing home populations in the New Jersey area, and just looking for some guidance or recommendations based on those circumstances – would they – as far as going out and providing specimen collections, would we better qualified for the C-9803 versus the 99211 for trying to collect reimbursement for going out and furnishing those services around the collection of that specimen?

Ryan: Could you provide a little bit more detail?

Tim Harvid: Sure. So, I guess, in relation to the hospital without walls and some of the expansion sites where our hospital is taking place in those expansion sites of having patients drive up and collect specimens to then send out to LabCorp or an independent laboratory, if we were to send clinical resources out to an actual nursing home to collect the specimens due to the patient population there and meeting them to actually stay in the nursing home itself.

So, we had gone out with our clinical staff, some of which were ambulatory clinical staff and some of which were hospital based clinical staff and went out to collect the specimens to then have them tested.

We were wondering if there was – if we would qualify to then bill the C-9803 that was recently created versus a 99211 for sending out that clinical staff to collect the specimen.

Ryan: So, I can start with the physician practice rules. I think the specimen collection using a 99211 really relies on the incident to physician service or other practitioner service part of the Medicare statute, and those sort – those incident to services aren't billable as a matter of general policy or paid in a nursing facility setting.

So, I think that that's pretty challenging. I think we can think about that to make sure that that's right, but that's sort of my initial thought is that the broader policy regarding when service incident to a physician service can be billed by the physician or another practitioner, and I think that that policy would continue to apply here.

And Tiffany, I'll hand it over to you for the hospital question.

Tiffany Swygert: Thanks, Ryan. I think – so for the C code that you mentioned, the hospital specimen collection and assessment. The key piece there is that it is the hospital furnishing the service and doing the collection, so, I think the twist to your question is that the collection is occurring in a nursing home and there may be some interaction between the nursing home and the hospital that we may need to further consider.

But in general, if it is hospital staff, regardless of whether it's off site of the hospital, but if it's hospital staff and the hospital is incurring the cost for those services, the C code would be appropriate to bill for the specimen collection.

Tim Harvid: OK. Great.

Male: I would also note that if the patient is in a Medicare Part A skilled nursing facility stay, that the specimen collection component would be part of the consolidated billing that the skilled nursing facility would be receiving from Medicare and it would not be separately billable for those particular patients.

But that is – that is not every Medicare patient in nursing homes and we recognize that nursing homes can include skilled nursing facility patients in a Part A stay and also otherwise. So, it is important to work with the nursing facility to understand the particular types of healthcare payment arrangement

with which they may be receiving, or in which the beneficiary may be enrolled.

Tim Harvid: Great, thank you very much.

Operator: Your next question comes from the line of Ric Galindo with Galindo Seminar and Consulting. Your line is now open.

Ric Galindo: Hey, thank you very much. Just – I guess one addendum to my question – the young lady that was asking about the list of telehealth services. I believe, if you just go to cms.gov/telehealth, there's a link on the left hand side where you can click on list of telehealth codes and that will tell you what codes are payable for telehealth versus a Physical/Occupational/Speech Therapy.

My comment/question is, I use PT/OT/SLP because I know hospitals are struggling with this remote services provider based status for a patient's home versus telehealth, and I guess, I just want to make sure I'm understanding it correctly.

Telehealth for PT/OT/Speech for hospital, you have certain CPT codes you have to use per that list, and a UB-04. There's no place of service code and we would use modifier 95 on those CPT codes.

If for some reason the hospital wants to do hospitals without walls and do PT/OT/Speech, they're not limited to those CPT codes via telehealth because it's technically not telehealth and they would just use the PN modifier on those CPT codes for services delivered remotely.

Is that a good kind of summary of the distinction between telehealth for hospital versus provider based status for hospital doing therapy?

Emily: Yes, so this is Emily, and I'll start and then hand it over to David. That is my understanding for the telehealth piece.

David: Yes, the same for the hospital outpatient piece.

Ric Galindo: OK. OK. I think that helps because people are just getting confused between the two and telehealth therapy, we are limited to those list of CPT codes on

the telehealth website, where if they wanted to do the hospital without walls, technically, they can use any CPT code that's available to them as if patient would have come into a clinic. OK. Thank you very much. Appreciate it.

Operator: Your next question comes from the line of Kelsey Hang with Agilon Health. Your line is now open.

Kelsey Hang: Hi. Yes. Thank you for taking my question. So, a few weeks ago, CMS put out an FAQ that speaks to situations where the video is disconnected during an audio-video Medicare telehealth visit due to some sort of technological issue. And CMS said that practitioners should report the code that best describes the service and the situation.

Will CMS be providing guidance to physicians on how to document their compliance with this instruction? And in the absence of any instruction or guidance, will acting in good faith be sufficient in subsequent auditing?

Emily: Hi, yes. Well, obviously I can't speak to whether or not – to forthcoming guidance. I will say that it is certainly not our intention to penalize practitioners who are acting in good faith. So, I will say – I will say, stay tuned for future guidance, but know that we are not sort of seeking to, as I said, to penalize practitioners.

Kelsey Hang: OK, thank you.

Operator: Your next question comes from the line of Pete Ferriquet. Your line is now open.

Pete Ferriquet: Yes, hi. I'm just calling about the swing bed waivers for urban hospitals and rural hospitals are continuing to see a sharp, sharp decline in swing bed patients coming from these hospitals and wanted to find out if there was any updates on the approval process and putting in that rural swing beds need to be considered when they make a good faith effort to exhaust all of their options, and that there are no snips within the hospital's catchment area, because we're still seeing patients from rural areas who are being swung in urban hospitals and they're desperate for those patients to get back.

David: Yes, thank you for that comment. We have heard this concern from a number of other rural hospital providers. And we do have that under advisement and under consideration, but I do not have a further update at this time.

Pete Ferriquet: Thank you very much.

Operator: We have one anonymous line on the queue. Please state your first and last name and your organization then your question. Your line is now open.

For participant who pressed star one, your line is now open.

Alina Czekai: Thank you, and it looks like the last four digits are 3571.

Operator, we'll take our next question, please.

Operator: Thank you, ma'am. Your next question comes from the line of Nelia Odecci with CHARGE Group.

Nelia Odecci: Hi. Thanks again for taking the question. My question had something to do with those certain beneficiaries in skilled nursing facilities who were about to exhaust their benefits and they were about to go home. However, prior to exhausting their benefits, they developed COVID and therefore they had to stay a little bit longer in the facility prior to getting discharged.

I was wondering if there was ever a resolution to the – on how this was going to be billed if there was a need to do gap billing or can we bill again with a new benefit period without having to have a gap?

Seyen Kovac: Hi, this is Seyen Kovac, and I know that this has been a question that's been outstanding for a while and we are still working on the billing rules for that. We are close to releasing something. I am hoping it is going to be out soon. So stay tuned and watch our website.

Nelia Odecci: OK, so meanwhile, we'll just hold off on billing for those. I mean, it's very rare. So for those certain beneficiaries, would that be your recommendation?

Seyen Kovac: Yes, absolutely. Hold on to those claims until we can get that billing guidance help.

Nelia Odecci: Thank you so much.

Seyen Kovac: You're welcome.

Operator: Your next question comes from the line of Linda Clark with Inova. Your line is now open.

Linda Clark: Hi, thanks for taking my call. So, I have a question about the COVID-19 swab collection. It appears that the 992211 code is the only code that would be available for urgent care centers to use when collecting and doing the swab collection. Is that true, first of all, and if so, is that going to be paid at a comparable rate to the codes that are available for laboratory?

Ryan: So, if an urgent care center is – it sort of depends on how the urgent care centers enrolls and bills Medicare. So I'll answer it, if there's a care center that's enrolled like a physician office setting, then they would bill the level one (inaudible) code. And assuming that there's no other service being furnished, that will be separately paid and it is paid at the same rate as the G code that the clinical laboratories use.

And, Dave, I don't know if you want to answer for the enrollment and the case of the hospital outpatient.

Linda Clark: So, was that a question back to me about the hospital outpatient?

Ryan: No, I'm sorry. I wasn't sure if you were asking also about the hospital outpatient setting. Again, it would depend on how the clinic was enrolled in Medicare.

Linda Clark: No, I was asking about the physician office enrollment. That was it.

Ryan: OK. Great.

Linda Clark: Thank you.

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

Operator: Thank you, ma'am. Your next question comes from the line of Matt Valliere Patients Rights Action Fund. Your line is now open.

Matt Valliere: Hello. Thanks very much for taking my question. Matt Valliere of Patients Rights Action Fund.

My specific question is about the funds that are flowing in order to expand telehealth access both with regard to accessing infrastructure, but as well as through expanded reimbursements and how that expansion ties together with the Assisted Suicide Funding Restriction Act and in what ways those funds and that additional infrastructure could be used with regard to the Act and the reimbursements for telehealth services related to the practice of assisted suicide in the states in which it's legal.

Demetrios Kouzoukas: So, yes, your question is about statutory prohibition on funding for assisted suicide and whether or not we've made any changes to it, or whether the changes that we've otherwise made have any effect on it.

Matt Valliere: That's right.

Demetrios Kouzoukas: So the funding restriction that you're talking about is very broad and longstanding in Medicare policy, and we did not – we did not have – we haven't made any changes to it and the changes that we've made with regards to the public health emergency don't affect the funding restriction, which limits any kind of Federal dollars going for assisted suicide directly or indirectly.

And we wouldn't be making payment for such services, and if such payment were made, those are overpayments that we would pursue. I don't know if that answers your question.

Matt Valliere: It does in the part – on the side of the reimbursements and this may not be within your scope, but with regard to say like HR essays – grants that they awarded through the CARES Act and other funding sources where they provide funds for increased access and infrastructure, and I assume access there would mean training for the medical professionals and providers, et cetera. Would those resources say that included specific hard infrastructure

that got installed in either the hospitals or in the medical professionals – issued to medical professionals?

Would any of those resources be able to be used in any way related to assisted suicide because of the Assisted Suicide Funding Restriction Act?

Demetrios Kouzoukas: So the prohibition is broad, and if you're asking about Medicare funding, I think what I would refer you to is back to the statute, which I think refers to any kind of indirect funding as well as direct funding and obviously, the particulars of non-CMS programs, I wouldn't be in a position to speak to, but for our programs we would be following that, as I imagine any agency would follow the statutory prohibition closely.

Matt Valliere: OK, thanks very much.

Operator: Your next question comes from the line of Yna Sander with Mount Sinai Medical. Your line is now open.

Yna Sander: Yes. Hi, I'm sorry. Thank you for taking my call again. I had a question, a billing question. Is there a policy are some instructions for the codes to be used for antibody testing prior to the new code that was issued on 4/10.

It seems like both Medicare, HRSA and most of the, if not all of the payers are only acknowledging the new antibiotic code 86769. But that code only came into existence on 4/10. So, all the antibody work that may have been done prior to that official code is not included in any documents for cost sharing purposes.

Are there any instructions or maybe CMS can come up with instructions how to bill for antibody prior to that date and what other codes should be included in any cost sharing requirements from CMS.

Demetrios Kouzoukas: I think this is – unless we have some of our either clinical lab colleagues on because you're really asking about the codes, right, not necessarily the coverage.

Yna Sander: No, not coverage. It is more about the codes and whether the cost sharing provisions that both CMS, HRSA and payers are following, and they are all following these new codes, but the antibody testing work was done prior to 4/10. And it's raising the question about the cost components for patients. We just need some guidance.

Ryan: So, I think I can speak in general principles at the moment and we can certainly take it back and see if we can issue a clear guidance on it. As a general matter, a lot of times when codes are created, they're made effective retroactively, and so that that would be one approach.

Another, in terms of the COVID testing, one thing that we've tried to do is to ensure that there is code set – within the code set, there are codes that describe sort of a broader range of tests that we haven't identified specifically and in cases where there wasn't a specific code for say an antibody test, one of the broader codes might accurately describe that test given its broad definition for dates of service, prior to when the more specific code was available. But like I say, we'll take that back as well.

Yna Sander: Yes, I think it would be helpful because cutting off or setting the new code on 4/10 is causing problems with the cost share provisions both for Medicare and any other payers who are kind of following Medicare's policies including managed care where they will not recognize anything else.

So then in some of those cases, the cost share kicks in, but the patient was treated or was tested through – for antibodies, but the code that we may have used, which was an old existing broad code is not included in any documents or policies. So, it will be helpful if you can ...

Alina Czekai: Can you send us – hi, would you be able to send us the code or codes that you were using prior to that, so we can take that into our analysis. Thank you.

Yna Sander: Yes. All right. Thank you very much.

Operator: And we have no ...

Alina Czekai: Thank you. Go ahead, operator.

Operator: Yes, ma'am. We have no further question at this point. Please continue.

Alina Czekai: Great. Thank you. And thank you everyone for joining our call today. Our next Office Hours will take place next Tuesday, June 23rd. And we also have our Lessons from the Frontlines Call this Friday, June 19th, at 12:00 p.m. Eastern where we'll be joined by experts in the field to share some of their best practices. This week's topic is Oncology Care during COVID-19.

And in the meantime, you can continue to direct your questions to COVID-19@CMS.hhs.gov.

This concludes today's call. Have a great rest of your day.

End