Centers for Medicare & Medicaid Services
COVID-19 Office Hours
July 28, 2020
5:00 p.m. ET

Operator: This is Conference #: 1492795.

Alina Czekai: Good afternoon. Thank you for joining our July 28th CMS COVID-19 Office Hours. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai leading stakeholder engagement on COVID-19 in the office of CMS Administrator, Seema Verma.

Office Hours provides an opportunity for providers on the frontline to ask questions of agency officials regarding CMS's 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.

While members of the press are welcome to attend these calls, we do ask that they please refrain from asking questions. All press immediate questions can be submitted using our media inquiries form, which can be found online at cms.gov/newsroom. Any non-media COVID-19 related questions for CMS can be directed to covid-19@cms.hhs.gov.

Please keep in mind the questions discussed on this call are general representative questions. Their specific circumstances may be different; therefore, the information provided may not always be applicable to your unique situation. You're welcome to reach out to the COVID-19 mailbox for further assistance.

And we'd like to begin our call today with some updates on CMS's latest guidance and publication.

Last week, in our frequently asked questions document to assist Medicare providers, we updated the answer to a question raised several times on this call on the correct application of the CS modifier.

The question is – how should the CS modifier would remove application of beneficiary cost sharing, deductible and copayment, be applied to telehealth services and/or E&M visits?

The answer is, the CS modifier should be applied for certain E&M services related to COVID-19 testing whether they're furnished in person or via telehealth. These services are medical visits under the HCPCS evaluation and management categories described on outpatient providers, physicians, and other providers and suppliers who bill Medicare for Part B services or administers a COVID-19 lab test regardless of the HCPCS codes they use to report the tests.

Cost sharing does not apply for COVID-19 testing related services, which are medical visits that are furnished between March 18th, 2020 and the end of the public health emergency, results in order for or administration of a COVID-19 test are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test.

The answer then describes detailed updated guidance on the appropriate categories of HCPCS E&M category for the CS modifier, online digital evaluation and management services for which cost sharing does not apply and guidance for providers and suppliers that bill Medicare for Part B services.

Also, please see the updated FAQ under the section Billing and Coding Guidance on our current emergency page for the full text of the response.

Also, last week, we updated our guidance document 2019 Novel Coronavirus Medicare Provider Enrollment Relief Frequently Asked Questions. The updated FAQs can be found on our current emergency page under the section Provider Enrolment Guidance.

Additionally, the COVID toolkit for states to mitigate COVID-19 in nursing homes has been updated as of July 27th and can be found on the current emergency page under the section Clinical and Technical Guidance for Healthcare Facilities.

Finally, as you may already know, the public health emergency was extended last week for another 90 days.

Operator, let's please open up the lines for questions. As a friendly reminder, please keep your questions to one question or one question and a follow up today. Operator, over to you.

Operator: OK. And at this time, if you'd like to ask any questions, you may press star one on your telephone keypad. Again, that is star one on your telephone keypad. We will pause for just a moment to compile the Q&A roster.

And your first question comes from the line of (Inaudible). Your line is open.

Male: Hi. Thank you very much for taking my question. My question has to do with the expanded ability for hospitals to offer long-term care services, swing beds, in big hospitals. On your notes, you give good protocols on how to handle internal transfers, i.e., patient is moving from an acute care to swing bed within the same hospital.

But what we're trying to find out is – are the protocols for transfer from one hospital to a hospital that is now offering the swing bed services separate hospitals, are those protocols for their transfer the same as they normally are or is there some sort of different transfer for hospitals that are – have expanded their swing bed services?

Jason Bennett: I don't believe we have put out specific guidance on how we can address that circumstance, and we'll need to go back and confer with a couple colleagues.

Male: OK. Thank you – sorry, who is this?

Jason Bennett: Yes. This is Jason Bennett.

Male: Thanks, Jason. I appreciate it – I appreciate it. What we're just trying to find out is if you're moving from say a smaller hospital – we have a smaller hospital that is expanded into offering swing bed services, they want to accept swing bed patients from overrun hospitals an hour away.

But what we're trying to figure out is what's the right protocol. Do they use their normal protocol or do they use some sort of enhanced protocol to transfer those patients? So, that's it.

Jason Bennett: Do you mean protocol as in …

Male: For internal transfers, you have …

Jason Bennett: … health and safety type of protocols ...

Male: What I'm talking about – what I'm talking about under qualification protocol. Like right now, for an internal transfer, you have to call a MAC and attest before you transfer them internally. You have to call the MAC and attest that there are no SNF able to take care of this patient and will move them as quickly as possible – all these other – their enhanced protocols.

But if you're transferring them to another hospital that is set up using that, does that outgoing hospital have to make all those same – have to jump through all the hoops? Or can they just transfer that patient like a normal swing bed patient?

Jason Bennett: OK. Yes. That's what I thought you were asking. I think we have not been …

Male: Does that make sense in terms of the question?

Jason Bennett: Yes. I think …

Male: OK.

Jason Bennett: … I think we have not been specific on that because there's – just the history of sort of what swing beds were intended to relative to the emergency. So, I think we need to go back and be more specific.

Male: Thank you so much, Jason. Appreciate it.

Jason Bennett: Yes.

Male: All right. Bye.

Operator: And your next question comes from the line of Kristen Cope. Your line is open.

Kristen Cope: Hi. Thanks for taking my call. This is with regards to the C9803 for specimen collection at the hospital outpatient clinic. I just wanted to inquire if it's OK to provide only the swab, just the specimen collection, no assessment with that.

I know in May 26 call, you had answered with regards to the 99211. It was OK to just do the swab. And I just want to make sure that was also the case for the C9803. There's no expectation of any sort of nursing assessment to accompany that.

And I'm wondering, do these two codes have to be priced the same? Do we have to charge the same for both of these?

Female: I'll start with the first part of your question for hospitals unlike the level one E&M code in the office setting. The descriptor of the code is that it's a hospital outpatient clinic visit specimen collection for coronavirus or COVID-19, any specimen source. And so, in order to bill for that code, you would have to meet that description.

Can you clarify the second part of your question about which two codes are you referring to in terms of payment?

Kristen Cope: So the 99211 and the C9803 both intended for specimen collection. Would the hospital be expected to set up the charge for both of those to be the same charge depending on if they were done in the office setting or the clinic?

Female: I don't think we have specific hospital charging guidance or protocols on that. I'm going to pause and see if anyone else on the call would like to address that question. If not, we can certainly take it back. But I'm not aware of any Medicare guidelines with respect to having charges be equal for those two different CPT codes. They're different codes and they describe different

things. And so, I'm not aware of any charging requirements or charging parity requirements. But we can certainly take that back.

Kristen Cope: OK. Thank you.

Female: Sure.

Operator: And your next question comes from the line of Perry Harman. Your line is open.

Perry Harman: Yes. Hi. Thank you. I appreciate you guys taking my call. My call is relative to the SNF regarding the point of care test and the testing. Some of our centers – a few of our centers and some of our states have just received those.

So, my question is – I understand that we are getting these tests from CMS; the equipment itself and then the first, however, many testing strips or cassettes that it comes with. But there isn't anything that I have read regarding reimbursement of ongoing testing or ongoing screening.

And my second part of that is – are these available to be used for flu testing? And if so, is there any type of reimbursement available for the flu testing?

Demetrios Kouzoukas: Hi. This is Demetrios. So, I think I can try answer some of this.

Perry Harman: Thanks, Demetrios.

Demetrios Kouzoukas: Your question with regards to the ongoing screening evaluation, we do have an MLN article we put out that refers to some guidance we gave our contractors around screening and other kinds of tests – diagnostic tests – in context of SNFs.

And I don't – you shouldn't sort of rely completely on high-level summary, obviously, just look to the document itself. But it doesn't – it lays out some circumstances where we consider things to be diagnostic, but it doesn't change the fundamental rule that things that are screening aren't things that we at Medicare pay for, provides a little bit of clarification around some

circumstances where things – where certain tests could be diagnostic or would be diagnostic.

Perry Harman: OK.

Demetrios Kouzoukas: And so, I'd point you to that article. I don't know if you need help finding it.

Perry Harman: I do because I haven't seen that.

Demetrios Kouzoukas: OK. We can – it's MLN Number 20011.

Perry Harman: 20011. OK. I will look for that.

Demetrios Kouzoukas: OK. And then, your other question is about flu testing. And is it – are you sort of generally asking is there anything new or different about flu testing this year that you ought to be thinking about? Is that the gist of it?

Perry Harman: Well, what I – yes, pretty much. But what I was thinking is – could there be an opportunity to utilize this – the point of care, the machine – could we utilize that for the flu testing because I know that one of the machines has that availability. And so, is that an option for us?

One of the machines actually has five availabilities along with – well four other than the COVID or the SARS. And so, would that be something that the SNF could utilize for the flu testing? And if we do that, would that be reimbursable? Is there any reimbursement available for that diagnostic flu testing?

Demetrios Kouzoukas: OK. I think what I can say that might be helpful to you there is that there isn't sort of a separate wrinkle or unique issue around the use of these particular machines. I think we're generally treating them like other tests.

We do have some rules around circumstances where things are donated and those may apply. But my point is really that there isn't sort of something specific to this distribution of machines or these particular machines with a question of whether clinically or otherwise it might be appropriate to use

them. Obviously, I would defer to those far more expert than I in the public health or clinical questions about that.

And then, I think you asked the related question of is it reimbursable?

Perry Harman: Yes.

Demetrios Kouzoukas: And I would say that there isn't – again, that there isn't sort of a separate or unique rule that we put out in any way around this particular distribution of machines that we would point you to the general guidance we have around circumstances under which testing is reimbursable. And the circumstances under which donated products or products that have been received free of charge can be used.

And I don't think that there is an outright prohibition in those circumstances. There's some allowance for things like that. But you should look to the guidance for the particular contours.

Perry Harman: OK. I will do that. And I know it's very, very new. They're just now going out. But I thought since – and thank you very much for the assistance. And I will look up that article.

Demetrios Kouzoukas: OK. Thank you.

Operator: And your next question comes from the line of Amelia Adachi. Your line is open.

Amelia Adachi: Hi. Thank you for taking my call. My question is related to the guidance regarding S885 for nursing homes, which is informing residence, their representatives and families of COVID activity in the nursing homes.

Since we received the guidance on May 6, I just want to clarify whether that – I know that we did the initial notification to all the residence, representatives, and their families by 5 p.m. the next calendar day.

Now, my question has something to do with the subsequent cases. Am I understanding the guidance correctly that this (inaudible) given weekly updates is of the COVID cases is sufficient as per the guidance or are we

supposed to report every positive COVID case that comes up, any subsequent ones that comes up by 5 p.m. of the next calendar day because we're getting different responses from different surveyors in different states?

Sarah: This is Sarah. And I don't think that we have anyone on the line from the division of nursing homes. But if you could send that question in, I will certainly make sure you get an answer to that.

Amelia Adachi: OK. So, I should just – OK. I will do that although it felt like – I guess, it's in the – I thought it was clear in the frequently asked questions, but somehow some surveyors in some states are interpreting it differently. So, I'll just send the question. Thank you.

Sarah: Thank you.

Operator: And your next question comes from the line of Nancy Reed. Your line is open.

Nancy Reed: Hi. Thank you so much for taking my call. This is – I know that there was an update relative to the correct application of the CS modifier. However, we just want to clarify that just a little bit further.

Would it be appropriate to add that CS modifier to an E&M for an outpatient visit where a COVID lab is ordered – so, so far, we need the (inaudible) – when the documentation indicates that the sole purpose of that visit was to test for COVID in advance of a surgical procedure, so essentially, pre-procedure testing.

So, this would be for the safety of the organization and/or the patient as opposed to the patient presenting symptoms.

Demetrios Kouzoukas: OK. And is there question about whether it's covered or how to code it if it's covered or both?

Nancy Reed: Sure. We'll go with both.

Demetrios Kouzoukas: OK. I think that we've been pointing folks to the MAC for pre-procedure testing. It's a question that has enough sort of coverage context and

nuance to it that we want to have the MACs – I think the MACs are in the best position to answer it.

And as to how to bill, I'll – if it is covered, I'll defer to Tiffany if you got anything to add to that.

Tiffany Swygert: Yes. That's correct. If it's a hospital E&M code and it's all the other terms outlined in the statute in the guidance and as Demetrios has just mentioned, the coverage piece is separate. But in the guidance that we put out and that's a law talks about it, it doesn't say anything about the COVID test being for preop reasons or for any other reason. It just mentions that the visit results in an order for or the actual administration of the test. And so, that's sort of how the payment construct is set up.

And so, the preop testing coverage is a separate issue. And as Demetrios has mentioned, it would be best to check in with your MAC on that piece.

Nancy Reed: Alright. Well, thank you.

Operator: And your next question comes from the line of Angie Donovan. Your line is open.

Angie Donovan: Yes. My question is regarding the CR modifier. I just want – I'm trying to get clarification is if we're doing the 87635, which is the COVID test, along with the C9803, the collection, are we supposed to apply, attach the CR modifier to both of those line items for hospital billing? Can you all hear me?

Demetrios Kouzoukas: Yes. I think we lost our expert who can speak to that. But she's going to come back on shortly. Maybe we can take another question and circle back to this when she gets back in?

Angie Donovan: OK.

Operator: OK. And your next question comes from the line of (Gianne Ally). Your line is open.

Gianne Ally: Yes. My question is – when a provider is doing a telehealth visit, how specific does the documentation need to be for the patient's location? For

example, is it enough to say that the patient is at home or does the provider need to tell but state the patient is in or the patient's street address? Just how specific does that need to be?

Tiffany Swygert: Yes. So, payment purposes, we have not provided any specific guidance as to the documentation requirements necessary to demonstrate the location of the beneficiary. I don't know if MACs might have individual guidance about that. And so, I would sort of suggest that that be a place that you could pursue this question further.

But from a national policy perspective, we don't have any specific guidelines there.

Gianne Ally: OK. Thank you.

Operator: And your next question comes from the line of Aileen Lyons. Your line is open.

Aileen Lyons: Thank you very much for taking my call and thank you for having these calls. My question just revolves around codes 98966 to 98968. With the recent change regarding the registered dietician, I just want to make sure – is it still permissible for a psychiatrist, psychologist, social work, and all of the therapists; speech, PT, OT, to still use these codes?

Tiffany Swygert: Yes. They are still able to use these codes. That's correct.

Aileen Lyons: Fantastic. Thank you so much.

Demetrios Kouzoukas: Before we move on to the next question, just to circle back to the last question there. I think the answer we've got is that if the COVID article relates to the DR question is not – doesn't include the answer then we'd have you send it in. Diana, I don't know if you have more to add?

Diana Kovach: No. I don't have anything to add. I don't know the specific answer at this time. So, yes, if you could send that in, if our article doesn't handle it, that would be great.

Operator: And your next question comes from the line of Amanda Diane. Your line is open.

Amanda Diane: Thank you very much. So, if I understand you correctly, you had just said that we potentially need to contact the MAC about pre-procedural testing. But I guess my question is – if the patient is coming in for the normal preop testing that they would normally get. And while they're there, the provider suggests they get the COVID testing done or they end up doing it. Technically, the reason was not COVID related to come in. Would that E&M end up getting the CS modifier?

Demetrios Kouzoukas: I think you're really highlighting why we're sending these questions to the MAC, that there is a lot of context that can depend on the particular circumstances. I always feel a little shy about saying go to the MAC because it feels – some people might perceive as a dodge but it's really I think just the kind of nuance you're now laying out that illustrates that there's a lot of some facts and circumstances to this. And so we'll – I will defer you to the MAC for that as well.

Amanda Diane: OK, thanks. I do have a follow-up to that, if that's OK.

Demetrios Kouzoukas: Sure.

Amanda Diane: My MAC has not issued any guidance on this thus far and so are – is CMS going to try to relay to the MAC that they need to try to help the providers with this or is it really strictly just upon the MAC to initiate and do this by themselves?

Demetrios Kouzoukas: So, we've been in touch with the MACs. I don't know if you – you feel like – you feel like you're not getting answers or guidance that you need, then please let us know a little more about the question and the outreach you had and we'll see what we can do.

Amanda Diane: Perfect. Thank you very much.

Demetrios Kouzoukas: Thank you.

Operator: And your next question comes from the line of Rusty Stein. Your line is open.

Rusty Stein: Yes, hi. Thank you for taking my call. I was hoping I could get a little bit more clarification in terms of the application that's required for patient's home designated as provider-based. Is the requirement still that the patient's home address needs to be added to this application?

Male: So, this question is on the temporary – the temporary relocation request for a provider-based department, assuming you're asking about a department that you're looking to be accepted from section 603, then in that case, yes. If the provider-based department relocates to the patient's home, then their relocation request for that location needs to include the address at which the service is provided which in this case would be the patient's home.

Just would note that of course that the provider always has the option of not seeking the relocation request to be accepted in providing the service and billing with PN modifier as a non-accepted service. So, that would be the sort of the choice there.

Rusty Stein: OK. Thank you. I appreciate that.

Operator: And your next question comes from the line of Annie Hars. Your line is open.

Annie Hars: Hi. Thank you so much for hosting these calls. My question is in regards FQHC services. If we provide two telehealth services in the same date of service like a medical and behavioral health visit, is it safe to assume that we should be using two
G2025 codes? And if we do, do we add a 59 modifier and does it depend – does it matter if we add it to medical as opposed to behavioral health or the other way around?

Female: So hi there. I think that generally even pre-pandemic, two visits could be billed and there is a modifier. Unfortunately, I'm not sure if 59 is the absolute correct modifier. I don't have that guidance in front of me but sort of the telehealth rules did not change that. So if two visits that are separate and

distinct, according to the guidance we have pre-COVID-19 and telehealth that is still applicable.

Annie Hars: Great. Thank you so much. I really appreciate your help.

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

Jim Collins: Yes, thank you. So, my question is about the remote physiologic monitoring treatment management that was narrowed down to two codes, the 99457 which is the first 20 minutes of management services and then the 99454 which is the equipment rental basically. What I'm wondering is if these two services, the management service and the rental service, if it's OK to uncouple those?

So, one scenario would be we provide the patient with weight scale, blood pressure cuff, pulse oximeter and then they go home and they don't ever transmit data. Can we still bill the monthly rental fee, even though we're not getting the data? And then, the flipside of uncoupling is if the patient provides their own equipment like their watch, they purchased a weight scale, blood pressure cuff, pulse oximeter off of Amazon for 60 bucks for all three of them basically.

Can we still provide the monitoring the management service, even though we're using equipment that the patient brought to the equation? So, I'm just wondering if it's OK to uncouple those in both directions.

Female: Yes, so I think that you'll need to send that question in, so we can get an answer to sort of your specifics of what you're asking. However, just sort of a general rule with CPT code in general, in order to report the CPT codes, one needs to have furnished the service as described by the CPT code. And so instances where a portion of that service is not actually being – where the equipment for example that is described in the code and I have to confess the remote physiologic monitor is I'm not as familiar with those policies.

But if the code descriptors or the – and the CPT (inaudible) language indicate that the equipment would need to have been provided in a certain way, then that is the way that it needs – would need to be provided in order to bill for the

service. However, I would again suggest that you submit that specific question to us, so that we can get you a more fulsome answer.

Jim Collins: Yes. It's just CMS nationally is acting like MACs when it comes to this particular service. They're not answering any questions. One of the CMS representatives told me because of the Allina Health lawsuit, that Medicare has kind of a gag order against answering questions without first publishing them and then letting people comment.

But, these services had been up for two years, the codes had been, and there's been zero answers from Medicare and the MACs don't even – they're – as you're hearing in the last couple of calls, MACs are not doing their jobs. They're not answering questions, they're not clarifying gray areas. It's really frustrating, it's like these services, these physiologic monitoring, they have the potential to have a huge positive impact on both patients and the cost of their care.

But, a lot of people are afraid of doing because the numbers don't add up. I can buy a Bluetooth Scale for 10 bucks, give it to the patient and then Medicare will pay me $62.00 a month for providing that $10.00 scale to the patient. It doesn't add up. So it's just – well, I'll send in the answer or the questions, there's about 20 of them that I had been trying to get answers.

But it's one of those things where there's a void being created, a vacuum and there's – I think there's a lot of opportunity for people to take advantage of the system.

And then the last thing is not a – not a question but a comment is the question about the CS modifier being applicable to patient receiving the lab test because of hospital policy, that was actually addressed on the May 5th conference call, the May 5th Office Hours Call.

And it was a positive answer that yes, if – it was specifically said there – if there is an order for the COVID test in this case because it's the hospital's policy, that was given as an answer to – that it is appropriate to use the CS. So, I'll just throw that in there for the previous caller.

Demetrios Kouzoukas: Fair enough and the calls are posted online. So if we don't always have the same mix of people who can answer everything, then that's available at the resource too. I'll also say I understand sort of some of the frustration around guidance and the like obviously. That's something we're always working to improve there.

I will say on RPM that there's a host of sort of questions that had been – that kind of – are out there for a while over the last year or so or maybe longer, that we have answered in the FAQs and I'd refer you to those. I think that there's some overlap between some of the questions you're raising and the FAQs that we have answered, even if it's not absolutely narrowed within the four corners of your question but I think you'll ...

Jim Collins: OK.

Demetrios Kouzoukas: … you'll find that helpful. It's a question that relates to – we have something like the preparatory language for RPM, CPT codes required the device be used to capture a patient's physiologic data, must be a medical device as defined by FDA, can we assume that any device used to capture the data it meets this requirement and then an answer to that as well and some related questions too.

Jim Collins: OK. And where do I find that, is that on the COVID-19 web page or just on the general Medicare FAQ?

Demetrios Kouzoukas: I think it's on the COVID-19 FAQ, is that right, Tiffany?

Tiffany: Yes.

Demetrios Kouzoukas: Yes, OK.

Jim Collins: OK, I'll get to that. I appreciate it. Thanks a lot.

Demetrios Kouzoukas: Thank you and some of those questions by the way aren't specific to the public health emergency. They're more relevant in the context of the public health emergency but – and then where the RPM questions, we answered in a sort of in the abstract, even outside the PHE.

Jim Collins: Yes, great, that makes sense. Thank you.

Demetrios Kouzoukas: You're welcome.

Operator: And your next question comes from the line of Donna Riggs. Your line is open.

Donna Riggs: Hello, thank you for taking my question. This question is about hospital-based clinic as far as we're wondering about billing pulmonary rehab services via telehealth with the respiratory therapist overseeing the appointment. Will that work at hospital-based clinic billing pulmonary rehab with the respiratory therapist overseeing the appointment or is a pulmonologist required for them to oversee? And is respiratory – is pulmonary rehab allowed as a telehealth service?

Demetrios Kouzoukas: So, pulmonary rehab is a specific statutory – had a specific statutory provision associated with it. It's got some – for whatever reason, Congress legislated around it in a very specific way. So, we know that this is an outstanding question and we do think we have an answer but it's not out yet and we're working on it. I know that's not totally pleasing – satisfying.

But, I do know – we know the question and we're working on trying to provide some clarity around or change – may potentially make changes around when the service can be provided in a way that coincides with the current restrictions. I'll also just say more generally on some of these challenges, sometimes the reasons we take back the question is because we want to find a way to a better answer than the one that we – that we can – we can give that sometimes can be very limiting.

And so this is an example of that, this is something that we're working on and we might be able to find a path to something that a construct that is more amenable to patient utilization access but it will require some internal work and obviously thinking through the statutory provision that I mentioned.

Donna Riggs: OK.

Demetrios Kouzoukas: I don't know if there's anything, Tiffany, you want to add from A Hospital Without Walls perspective.

Tiffany Swygert: Sure. I would just add that the direct supervision requirement in the statute related to the pulmonary, cardiac and intensive cardiac rehabilitation services, they do require that the care be furnished in the hospital.

So to the extent that under the Hospitals Without Walls waivers that are in effect during the public health emergency are used in the hospital makes the patient's home provider-based to the hospital for the provision of services, then it seems that requirement can be met along with regulations that we adopted and as interim final that allowed for direct supervision to be met virtually.

So, I can't speak to your question about who exactly – the level of professionals who can do the service but in terms of the service needing to be performed in the hospital and needing to have direct supervision. I do think that those two aspects have been addressed by the Hospitals Without Walls provision.

Donna Riggs: OK, that helps.

Tiffany Swygert: OK, good.

Donna Riggs: All right, thank you.

Demetrios Kouzoukas: And just to bring a full circle, so the other answer I was giving at the beginning where they related to Sheppard from the Hospital Without Walls construct just as a matter of the ordinary benefit, if you will, what modifications or interpretations could be made by the circumstances under which it can be provided, so that’s the part that’s pending.

Donna Riggs: OK. Thank you.

Operator: And your next question comes from the line of Emma Vendor. Your line is open.

Emma Vendor: Yes, good afternoon. Thank you for taking my call. I just had a quick follow-up. You mentioned about the 99457 code, one of the (inaudible) that the provider is looking to get some clarification is definition of interactive communication and I was just wondering if there's any plan to issue that clarification. We're trying to build the appropriate documentation and process for that code but the interactive communication seems to be one of the open items for CMS to resolve.

Female: I see, OK, thank you for that. Thanks for that question, for flagging that for us. I think this is another thing that we will definitely need to take back and consider further. So if you can send an e-mail, that will be really (awesome). Thank you.

Emma Vendor: I did. I did send you the e-mail. All right, thank you.

Female: OK, great.

Operator: And your next question comes from the line of Gina Ruiz. Your line is open.

Gina Ruiz: Hi. Thank you for taking my call. I was just – I had a follow-up question with regard to the G0463 versus Q3014. I saw that the FAQ was updated today and so now there's clarification that if we register the patient's address as a temporary expansion location of the hospital outpatient department and we're providing an E&M service where our physician is actually in the clinic, the patient is actually in the home, we're allowed to bill the G0463, because, now it's a remote service and not a telehealth service.

But, the question is since we are providing the patient's address as a temporary relocation area of our hospital, are we billing that G0463 with a PO modifier? And because it's being billed under waiver, are we also billing the CR modifier and the DR condition code on our UB-04?

David: So yes, so taking the second part first, for any service provided at a location that has sought a temporary – extraordinary circumstances relocation request, you would bill with the PO modifier to signify that – as an accepted service and – as well as the applicable CR/DR modifier to show that it is the service being provided under the waiver authority.

And of course as I mentioned before, there is the question of whether or not – going back to the first question, there's the question of whether or not it is something that's on the service that's on the telehealth service list and it's being provided by distant site provider. If that's the case, then it should be billed with the 95 modifier, the physician site and the originating site fee. If it's not, one of those services isn't – doesn't meet those circumstances, then it should be billed as the G0463, signifying that it's a remote hospital service.

Gina Ruiz: OK, so I'm sorry, can you – so I was – I had sent a question in to the help desk and – stating the patient is at home with the registered address, the physician is in our clinic. Should this be billed as telehealth with the 95 modifier? Because, previous Office Hours Calls stated that we should bill it a Q3014 for originating site and the answer came back no. You should bill that as a G0463 because it's a remote service and the hospital should bill it as they normally would.

And then the FAQ was just updated today with the graphic that includes the decision tree and it's a section LL, hospital billing for remote services, question 3 and the answer is we should be billing these as a G0463. So, that is what you're saying as well, right?

David: I'm saying you should – yes, you should follow the decision tree and if the service is – kind of initial part of that decision tree is the service being provided by a distant site provider and is the service being provided on the telehealth services list. If those are the case, then it should be billed with the originating site fee. If that's not the case, then it would be billed as a G0463 under the – as a remote hospital service.

Gina Ruiz: OK. OK and then we would be billing that with the PO modifier and the CR and DR?

David: Correct.

Gina Ruiz: OK, all right. Thank you very much.

Operator: And your next question comes from the line of Mary Gracie White. Your line is open.

Mary Gracie White: Thank you very much. I appreciate these calls and all the great information. Actually, I'm just trying to see if there is information available on the CMS, CDC training that will be tied to funding, additional funding for nursing homes. Would that be the infection preventionist's training? We have many members in New York who are asking that question, if someone can advise.

Demetrios Kouzoukas: So, I think the funding that you're talking about is coming from the Provider Relief Fund and …

Mary Gracie White: Yes.

Demetrios Kouzoukas: … that's not administered at CMS but we can get your question to the right place, if you want to.

Mary Gracie White: Thank you. I appreciate that. Would that same place be where we can get information on point of care testing that's being made available and sent to nursing homes?

Demetrios Kouzoukas: No, that's a different a place but we can try to get to the …

Mary Gracie White: OK.

Demetrios Kouzoukas: … the exact question to that place too. So, the Provider Relief Fund is being run out of HRSA. The Health Resources and Services Administration along with the – sort of interdisciplinary team that they got supporting them as well, so that's a sister agency.

The point of care test I believe are being distributed either by ASPR, the preparedness response folks but under the – working closely with the Assistant Secretary for Health and I just walked you through the HHS org chart probably but – so a lot of different players but we can definitely route your questions to the right place.

Mary Gracie White: Thank you. And how will I do the follow-up? How can I – is there an e-mail or …

Demetrios Kouzoukas: Yes, Alina, you want to share that?

Alina Czekai: Sure thing. Yes, that e-mail address is covid-19@cms.hhs.gov and if we have any updates for you that would be helpful for a larger audience, we'll be sure to incorporate them in our top of the call remarks next week as well.

Mary Gracie White: Thank you. I appreciate it.

Alina Czekai: You're welcome and we'll take our final question today. Thank you.

Operator: And your last question comes from the line of Jonathan Gold. Your line is open.

Jonathan Gold: Yes, thank you so much for taking our calls. My call – question has to do with the notice that was put out that contractor audits will continue and – on August 3rd. And I just wanted to know if any further information will be put out about that such as how a provider would claim a hardship exception for that, if they're receiving auditor's request or if there's any additional information you can provide. And thank you again for your time.

Demetrios Kouzoukas: OK, I don't know that there's a hardship exemption per se but obviously there's always circumstances that ought to be considered and it certainly is conceivable that there will be some situations where there is some kind of imminent crisis or access issue that is occupying the energy of the organization and as it desire or need for the MAC to work on a schedule that is – that accommodates that and reflects it.

So, I think that the MAC or other reviewer that is, so I think really the guidance I'll give you there is to – if you were to get an audit notice and you feel like there's a circumstance that requires an individual accommodation like that, that you let the entity that's conducting the audit know and you can always also engage with our Center for Program Integrity. I don't know if any of our CPI folks have anything to add to that who might be on the call.

OK. I think not.

Alina Czekai: Great. Thank you for your questions and thank you everyone for joining our call today. Our next Office Hours will take place next Tuesday at 5:00 p.m. Eastern. In the meantime, you can continue to submit questions through our COVID-19 mailbox. Again, that is covid-19@cms.hhs.gov.

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

End