Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
Moderator: Alina Czekai
Tuesday, April 14, 2020
5:00 p.m. ET

Alina Czekai: Good afternoon. Thank you for joining our April 14th CMS COVID-19 Office Hours Call. We really appreciate you taking the time out of your busy schedules to join us today.

I'm Alina Czekai, leading stakeholder engagement on COVID-19, here at CMS in the Office of the Administrator. Office Hours provides an opportunity for providers on the frontlines to ask questions of agency officials regarding CMS's temporary actions that empower local hospitals and providers to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote telehealth in Medicare.

And while members of the press are welcome to attend these calls, we ask that they refrain from asking questions. All press and media questions can be submitted using our standard media inquiries form, which can be found online at https://www.cms.gov/newsroom/media-inquiries.

And all non-media COVID-19 related questions for CMS can be directed to our COVID mailbox, which is COVID-19@cms.hhs.gov.

And today we'll begin our call with a few pre-submitted questions, and then we will open up the lines for attendees to ask questions live. As a friendly reminder, this call is being recorded and we will post the recording very shortly. And at the end of the call I will provide more information on that.

Now for our first question that was submitted. The question is, "If a patient is in observation at a hospital and needs to come to a SNF, will CMS waive the three-midnight rule, due to COVID-19?" Jeanette, I believe you were going to take that question?

Jeanette Kranacs: Yes, thanks, Alina. This is Jeanette Kranacs. This is one of the first things that we were able to do, as far as a waiver, under our 1812(f) authority. We're able to waive the three-day qualifying stay requirement for skilled-nursing facility level care.

We realize that patients may not be able to be in the hospital for those three days, or they may be in there for shorter than three days, in observation, or may not even be able to go to the hospital at all but require this level care. So, under the 1812(f) authority, we can waive that three-day stay for patients in observation.

Alina Czekai: Great, thank you, Jeanette. Our next question is, "Can CMS address questions about telehealth payments for physical/occupational/speech therapy?

We've heard concerns that hospital outpatient departments have been unintentionally excluded from being able to bill for physical/occupational/speech therapy provided via telehealth, due to their method of billing on a UB-04, which does not have an option for POS." Ryan, would you like to take that question?

Ryan Howe: Sure, certainly happy to. Ryan Howe in the Center for Medicare. So, we're aware of this question, and we understand the significance, particularly as healthcare providers across the country move to telehealth modalities in order to address the circumstances of the public health emergency.

And we're actively taking a look at all of the changes that we can make, based not only on our usual authorities, but especially given the new authorities from the CARES Act, which was just recently passed.

And so, we continue to look at those, and we're optimistic that changes can happen in the near future. But at present, that's an accurate assessment that, for the institutional billing, there's no mechanism for that. But, like I say, we're actively taking a look at it. We understand the urgency of the issue, and we're optimistic that changes can be made, and instructions will be forthcoming.

Alina Czekai: Perfect, thank you, Ryan. And we have another telehealth question that was submitted. "Will Medicare pay for telemedicine visits conducted by audio-only technology, for example, phone, or is it just that they will be paying for the previously unpaid telephone communication codes?" Ryan, would you like to take that one as well?

Ryan Howe: So that's another great question, and a similar answer for part of it. We continue to take a look at what our flexibilities might be, and we certainly have heard a lot about circumstances where audio-only is available for patients.

At present, based on changes in the interim-final rule that we released, the codes that describe telephone evaluation and management visits, those codes are now available for payment under the Physician Fee Schedule.

And that's both for physicians and other qualified practitioners to conduct those sorts of evaluation and management or assessments over the telephone. And again, those are specific CPT codes for the rest of the telehealth services, both audio and video, that must be used.

But again, we're taking a look at those policies, in the context of the requests that we've received, as well as the new statutory authorities. And we expect to have more information forthcoming.

Alina Czekai: Great, thanks, Ryan. Operator, we'd now like to open up the line for a live Q&A. Thank you.

Operator: I'd like to remind everyone, in order to ask a question, please press "star" then the number "1" on your telephone keypad. Your first question comes from the line of Rick Gawenda.

Rick Gawenda: Hi, thank you. You know, I know right now telehealth has still not been expanded to PT, OT and SLP. But back on March 30th, in that interim-final rule, CMS did add in CPT codes commonly used by PT, OT, SLP as covered telehealth services, because we know physicians, nurse practitioners can bill for those services.

The question I have is, under normal therapy, physical and occupational therapists employed by a physician's office, can bill for those services, incident to a physician, under the physician's NPI.

So the question is, can a physical therapist, occupational therapist do a telehealth visit right now and have that billed incident to a physician's NPI, under a 1500 claims form and paid by Medicare, or is it still a "no", because a telehealth visit is still being done by a PT or an OT? Does that make sense?

Ryan Howe: That certainly makes sense. I think, historically, the Medicare policy surrounding telehealth has been that the practitioner furnishing the service directly or directly providing the service – that the billing for the telehealth service is specifically for that scenario, given that there's a list of particular practitioners who are allowed, by law, to provide those telehealth services.

I will say that we're actively taking a look at those questions and looking at our authorities, particularly under new statutory provisions that have passed. And I think it might be worth noting that – as you did, that we added a new number of therapy services to the telehealth list. And so, I would say that we continue to look at the policies, and we anticipate issuing guidance in the near future.

Rick Gawenda: So, is the answer, then, "no", in terms of incident to billing for telehealth? So, would the answer be "no"?

Ryan Howe: The answer is that under current policy, and the way that we've historically interpreted those services, the answer is "no" and that we're actively looking at …

Rick Gawenda: OK.

Ryan Howe: … the authorities that we have under the law.

Rick Gawenda: Thank you very much, I appreciate all you're doing, thank you.

Operator: And your next question comes from the line of Tom Norton.

Tom Norton: Hi, my question is, I understand that for the outpatient E&M codes 99201 to 215, that we can use the 2021 guidelines for determining the level for these telehealth visits that would be dependent upon either time or medical decision-making.

So, my question is, where do we find the guidelines for time? Is it the American Medical Association's CPT description? Do we use those times, or does CMS have their own list of times, or where do we go for that?

Ryan Howe: That is a great question. So, the times are available in the code descriptors themselves, suggesting the typical amount of time face to face with the patient. There are also times available with each of those CPT codes in the files on the Physician Fee Schedule website, on CMS.gov.

And those would be the relevant times for the purposes of reporting the codes. That said, I think that question may highlight for us a need to have a particular Frequently Asked Questions on that, and we'll take that back and try to be as clear as possible.

Tom Norton: OK, yes. Because I know that the kind of, the average times that are posted by CMS, especially for the established patients, do differ quite a bit from the CPT code descriptions. So that's why I was asking. But you're saying we can go with the CPT code descriptions?

Ryan Howe: Understood. So, I think you can go with the CPT code descriptor, and then we'll reiterate that in the future communications.

Tom Norton: Thank you.

Operator: And your next question comes from the line of Tim Walters.

Tim Walters: Yes, thank you very much. I just had several questions on rural hospital issues. The Rural Hospital Coalition that Eric Zimmerman, with McDermott Will & Emery has asked four separate questions related to, such as the rural health clinic 50-bed limitation, the Medicare hospital 100-bed limitation, and couple of community hospital questions. Could you give us any feedback on

your process there and when you might be able to answer these rural hospital questions?

Demetrios: So …

Ryan Howe: I – go ahead, Demetrios.

Demetrios: Yes. Those are all questions that we're actively working on. I don't know that I can give you a particular timeline, but know that we're definitely – we're well aware of the frequency with which we're being asked for those. And I understand the desire and need to hear from us on it.

Tim Walters: Yes, we're just starting to see cases in our area now and just trying to make contingency plans. So just we'd appreciate any insight you can give us, thank you.

Demetrios: You're welcome, thank you.

Operator: The next question comes from the line of Lee Schultz.

Lee Schultz: Yes, thank you. I just need a clarification of the CS modifier. I'm reading the MLN from April 7th, and I didn't see any kind of clarity on the Frequently Asked Questions. So, we're holding of all of our claims, you know, with COVID.

It looks like this CS modifier is particular to outpatients, because it mentions Medicare Part B, and it also seems to say that it's to be applied to the E&M codes. Is that true? So, like, an ER visit, obs hours, an E&M visit, that kind of thing, not, you know, anything else? Like, a one-line thing on the claim and that's it?

Tiffany Swygert: Hi, this is Tiffany Swygert from the Center for Medicare. The CS modifier which waives cost-sharing for certain services, evaluation and management services in accordance with the new statutes, is, as you described. It should be used when one of the evaluation and management services is billed.

Those can be found in the CPT code book, as well as on the hospital side. Some of those CPT codes are not recognized, and so there's, for example, for the clinic visit, it's G046 …

Lee Schultz: Right.

Tiffany Swygert: … 3 …

Lee Schultz: Right.

Tiffany Swygert: … that would apply. And so, to the extent that you are submitting a claim for one of those services and that service is not packaged into another service, the cost sharing would be waived by the presence of the CS modifier.

Lee Schultz: OK, yes. Because later on in the article, it was saying, "Use the CS modifier on applicable claim lines." So then we were thinking, "Oh, does that mean we have more lines to put it on the same claim?" But you think the E&M, whether it's a HCPCS or CPT, any kind of visit, that's kind of what you're aiming for, one and done?

Tiffany Swygert: I'm going to turn it over to my colleague in the Provider Billing Group, with respect to whether it should be applied as a – the claim – the HCPCS level or the claim level. I'm not sure that we have a response for that right at this moment. If not, we can certainly take that back.

Lee Schultz: OK, yes. Because we're holding our claims, so I guess …

Tiffany Swygert: OK, let us …

Lee Schultz: … I just …

Tiffany Swygert: Let us take that back.

Lee Schultz: There's a particular …

Tiffany Swygert: Yes.

Lee Schultz: … condition code that identifies the claims with COVID. So, we're kind of sitting on them. And, you know, it says either submit them and resubmit them, so we don't want to do that. We just want to do it right the first time.

Diane Kovach: Yes, hi, this is Diane Kovach. So, if it's a practitioner claim, it would be on the line level, because the modifiers all go on the line level. So, it's basically at the level of the HCPCS code.

It looks like that's where you should be putting that modifier. If that doesn't answer your question, we can certainly also look to having an FAQ on that, if there is some clarity we can add. So, we'll look to that …

Lee Schultz: OK.

Diane Kovach: … as well.

Lee Schultz: All right, thank you very much.

Alina Czekai: Thank you. Next question, please.

Operator: And your next question …

Alina Czekai: Operator …

Operator: … comes from the line of Sandy Sage.

Sandy Sage: Hi, good timing. My question's on the CS modifier as well. In the FAQs that were just updated on 4/10, it says to use – that the use of modifier CR and condition code DR are mandatory.

So, I guess the question is, do we put the CS and the CR? Because the CR's mandatory. And I think, for the hospital outpatient, it would probably be line item adding the CS, because several line items on the claim can be cost-sharing items. So, I guess that is the clarification needed. But do we also use the CR?

Diane Kovach: So, this is Diane Kovach again. So, yes, and you're right, if there's – if it's line item detailed then, yes, you put the CS on the line level. For the CR and

DR modifier, that's – sorry, the modifier and the condition code, that's indicating that it's related to an emergency situation.

Through our telehealth, and Ryan you can jump in if I can say this incorrectly, but I believe, because it was on a – under a separate authority for telehealth specifically, I think we could – we do not need to have the CR or the DR. But in every other situation, we do. And that would be in addition, of course, to the CS, where that's applicable.

Ryan: So that is right Diane. The one thing that I'd add to that is that, in cases where the telehealth visit is associated with the COVID testing, you would need both the 95 and the CS modifier. So …

Sandy Sage: OK.

Ryan: … the presence of the telehealth modifier doesn't necessarily change the cost sharing.

Sandy Sage: OK. Well, on the UB-04 for outpatient hospitals is where we need the clarification on both the CR and the CS, and the DR. You guys could put out something about that for outpatient hospitals and not telehealth.

Demetrios: Thank you. We'll take a look at whether we could – whether we could add that or, you know, consider it.

Sandy Sage: OK, thank you so much, because we're holding claims as well. Thank you.

Operator: And your next question comes from the line of Ronald Hirsch.

Ronald Hirsch: So the previous questions brought up lots of stuff. First, thanks for everything you're doing. One is – Ryan, when you're talking about the PT and all the stuff you're doing, I can tell that you're winking at us, that this is going to happen.

The question is, will it be retroactive to the date that those codes were added to the list? So, can therapists start doing stuff by telehealth, and then, once it's approved, be able to go back and bill for that?

CMS Staff: So …

Ronald Hirsch: That...

CMS Staff: Obviously we'll put Ryan on the spot to speculate a bit, but really, I think where we have – I'd just point out at a higher level that, where we have made changes, we have been retroactive in many cases, or at least clarified. And so, I think that's an indication that we're willing and able to act in that way. I don't know, Ryan, if you have anything to add?

Ryan Howe: I don't, but that …

Ronald Hirsch: Thank you.

Ryan Howe: … that makes sense to me.

Ronald Hirsch: Yes. So, then the other question that just came up about the CR and DR is that the NUBC instructions seem to indicate that those go on every single COVID claim.

But CMS seems to make it clear that the DR goes on a claim only when there's a waiver used, such as a SNF stay without a three day, an LCAP without the 25-day expectation, et cetera. And it really isn't clear at all where the CR goes. So that's something that really needs to be clarified, on how those claims go out. So that's a statement.

And now, my other real question – and maybe Tiffany, since she's on the line, we're having trouble getting people into SNFs, as you know. And I know you're working very hard to work on that.

So, there are patients who are coming in for observations, let's say after a fall or a syncope, that need SNF care, they qualify for it, but we can't get a SNF to accept them until they get screened for COVID. That's taking two or three days. Can hospitals admit these people as inpatients, while they continue to provide the care for the patient waiting for a SNF to accept the patient?

Tiffany Swygert: I'll start, Dr. Hirsch, and then turn it over to my colleagues who handle SNF policy. So, I know you're well aware there are guidelines for hospital admission as inpatients.

Those have not changed during the public health emergency. So, you know, to the extent that hospital care is required, there's two different pathways to that. There's inpatient and outpatient. I would not advise you to admit a patient as an inpatient if they don't need to be admitted as an inpatient. And the two-midnight rule does still apply.

I think you heard other colleagues talking about the three-day stay inpatient requirement and the waiver associated with that. I don't know if they can address the aspect that you're talking about, which is finding a SNF to accept a …

Ronald Hirsch: Yes.

Tiffany Swygert: … patient timely. So, I will …

Ronald Hirsch: Right.

Tiffany Swygert: … turn it over to my colleagues.

Ronald Hirsch: Actually, you don't have to, because I don't expect any answer to that, because I know there's a million people working on it. It's really complex. But I – but I thank you …

Tiffany Swygert: OK.

Ronald Hirsch: … for your answer, and …

Tiffany Swygert: Thank you, Dr. Hirsch.

Ronald Hirsch: … I know, again, everyone's working hard. That's it for me, thanks.

Diane Kovach: And if I could just jump in, this is Diane Kovach again. On the CR and the DR, for Medicare purposes, they're used when there are waivers, not for every single claim submitted.

Ronald Hirsch: Great, that helps.

Operator: And your next question comes from the line of Cynthia Morton.

Cynthia Morton: Thank you. My question today is about the Public Health and Social Services Emergency Fund. There are some Medicare providers, especially specific to the skilled nursing facility space, who do not bill Medicare directly. They have to send their bills through the skilled nursing facility because of CMS' consolidated billing rules.

So, I'm speaking specifically of rehab therapy companies. And so, these therapy companies did not receive any of the public health funds, because of this, I assume, because the CMS rule on consolidated billing requires the billing to go on the skilled nursing facility's claim form.

But I wanted to enquire about that. Is CMS taking any steps to expand the public health fund, or how could I kind of address this type of issue? Thank you very much.

Todd: Hi, Cynthia, this is Todd. We're not familiar with that issue. I think we can certainly look into it and get back to you.

Cynthia Morton: OK, I …

CMS Staff: Yes, I wonder if the question – is it about the provider relief fund, the $100 billion, for which the $30 billion was provided

Cynthia Morton: Exactly, yes, that is the …

CMS Staff: OK.

Cynthia Morton: … fund I'm talking about.

CMS Staff: OK. Sorry, there is a – we got confused, there's another, separate fund that has the name you mentioned. But …

Cynthia Morton: I – OK.

CMS Staff: … the – that fund is one that is being administered not by the folks who are on this call and not at CMS, but we can get your question to the right place. I'll say – I'll venture just a little bit of an answer to it, which is that the basis for the claims that were made – the payments that were made under that fund, was Medicare billings. And so, obviously there's another $70 billion to distribute.

And I know that the office handling the funds at the Secretary's office and at HRSA are definitely looking at what to do with that other $70 billion. And among those things, are the kind of entities that might – that would not have received funds in the first launch.

Cynthia Morton: And that's the …

CMS Staff: Hopefully that …

Cynthia Morton: … exact issue …

CMS Staff: … answers your question.

Cynthia Morton: … I'm talking about, thank you.

CMS Staff: Yes.

Cynthia Morton: Could you direct me where I can inquire about that?

CMS Staff: We can take your question; we can funnel your questions into the right place. And then …

Cynthia Morton: OK.

CMS Staff: … we can – we can talk afterwards. I think we've got a couple of email addresses we can provide to people.

Cynthia Morton: OK, thank you very much.

Operator: And your next question comes from the line of Stacey Brian.

Stacey Brian: Hello.

Alina Czekai: Hi, we can hear you.

Stacey Brian: Yes, I have a couple of questions with regards to SNFs. The first one has to do with the CMS waived 42 CFR which is to provide relief to the SNFs for the MDS timeframe requirements, so the MDS assessments and transmissions.

But I've had a lot of SNFs ask me what exactly this means. Does it mean during this emergency they aren't required to do MDSs that are affected by it? Does it mean they still have to do the MDSs for this timeframe, but they don't have to be timely, or what kind of clarification can you provide on that?

Deb Lyons: Hi, Stacey, this is Deb Lyons in the Division of Nursing Homes. We're going to have to take that one back. We do have more information that we're working to get to clarify exactly how that waiver is operationalized. So, more information is going to be coming on that one.

Stacey Brian: OK. And then I have another question about isolation, if I can ask that as well. I was wondering, I've had multiple SNFs also ask me if they can code isolation on the MDS for residents that they cohort that both have positive confirmed cases of COVID-19, when the RAI manual states that the resident has to be in a room on their own. But they're wanting to know if an exception could be made for this emergency situation.

And in addition, they're wanting to know if – for residents that they bring into SNFs that they are (inaudible) in isolation for 14 days, and until they don't show some symptoms before they bring them into the other part of the SNFs, where the other residents are, they want to know if they can code isolation for that on the MDS, even though the resident may not have an active infection.

Deb Lyons: And so, unfortunately, I think we are going to have to take that one back as well, to get the specific information that you need.

Stacey Brian: OK. And where can I look to see when you all have answered? Where would those be for these?

Deb Lyons: I believe we're going to give follow-up information on subsequent Office-Hours calls. Is that correct? To those running …

CMS Staff: Yes.

Deb Lyons: … the Office-Hours calls.

Alina Czekai: Yes, sorry.

CMS Staff: Yes.

Alina Czekai: I'm sorry, yes, absolutely.

Stacey Brian: OK. I've also had …

CMS Staff: And we can also work to get – Alina, maybe, can connect you two as well, if you …

Stacey Brian: OK.

CMS Staff: … reply to the email afterwards.

Stacey Brian: And I've also had several SNFs ask me if they choose to use the 1135 waiver where they don't have to have a three-day qualifying hospital stay, what sort of documentation do they require?

Do they have to have something from the hospital that couldn't take them saying they have an influx of patients or what can they do to prove that this resident is affected by the COVID emergency and therefore they can waive the 1135?

Deb Lyons: Okay so my understanding is that that is a blanket waiver and you do not have to take any particular action to further waive that. So that requirement is already waived at this point.

Stacey Brian: Okay so they wouldn't be required to provide any documentation for that residents stay?

Todd Smith: This is Todd Smith. That's correct, this is a blanket waiver nationwide so it's for all beneficiaries.

Stacey Brian: Okay thank you very much.

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

Operator: And our next question comes from the line of Kira Gainer.

Kira Gainer: Not a question, my comment is we obviously greatly appreciate that CMS has added physical therapists as eligible to furnish e-visits and other communication technology-based services.

However, we are receiving reports of an increasing number of denials for e-visits due to the incorrect modifier being impended when both the GP and CR modifiers are on the claim.

And some MACs are telling providers not to use the GP modifiers. Some MACs are telling providers not to use the CR modifier. And CMS indicated in it's MLM Matters article on March 20th that the CR modifier is required for e-visits and in the Interim Final Rule indicated the GP modifier is required when e-visits are furnished by PT's in private practice.

So would just greatly appreciate it if CMS could explicitly clarify, perhaps, in it's updated Q and A document and more importantly to all of the MACs the appropriate modifier as to be appended to the claim when billing e-visits and other communications technology-based services to prevent these denials from occurring moving forward.

And then my question is, can the e-visits, the G2061 or G2062 or G2063, can that code be billed more than once in a given episode of care, such as during two or more different seven-day periods within the same episode.

That's just been a common question and it hasn't been clear as to whether a provider could bill an e-visit more than once given that a therapy episode of care could be several months long? So that's my question.

Ryan Howe: I can start, on your second question I think the frequency limitations for the e-visits apply to as listed in the code and so there wouldn't necessarily be a restriction over a long episode of care but we can certainly address that in an FAQ as well.

On your first points, we certainly appreciate hearing when there's confusion and as you all know, there's been a lot of changes really rapidly, so yeah, that feedback is really important in terms of us making sure that the guidance is clear as well as the claims processing instructions are clear. So, we appreciate hearing all of that and we'll work on that.

Kira Gainer: Great, thank you so much.

Operator: And again if you'd like to ask a question please press star one and please leave your name, your first and last name, thank you. And your next question comes from the line of Heather Clarke.

Heather Clarke: Hi, thank you. I did want to clarify there's been a lot of questions about the CS modifier. There's a Q and A dated April 11th that basically says that any service that was done along with the E and M that lead up to the COVID-19 testing that was related would need to be covered with no cost sharing.

It goes on to say, "The CDC strongly encourages clinicians to test for other causes of respiratory illness. Therefore, for example, if the individuals attending provider determines that other tasks.

For example, influenza tests, blood tests, etc, should be performed during a visit, which term here includes in-person visits and telehealth visits, to determine the need for such individual for COVID-19 diagnostic testing and the visit results in an order for or administration of the COVID-19 diagnostic test and the plan or issuer must provide coverage for the related test also."

So I'm taking that to mean that the CS modifier would need to be put on other lab work, as well as maybe chest x-rays, things like that, that the doctors using to screen for other conditions before determining to do the COVID testing. Is that how you would take it?

Ryan Howe: So can you tell us a little bit more about the question, is it about the underlying policy or the coding?

Heather Clarke: It's page five and six and the question starts out as, "The FFCRA requires plans and issuers to cover items and services provided during a visit that relate to the furnishing or administration of COVID-19 diagnostic testing or that relate to the evaluation of such an individual for purposes of determining the need for diagnostic testing. What type of items and services must be covered pursuant to this requirement?

Ryan Howe: Okay I think that is a reference to interpreting the requirements that are applicable to plans and when they pay for what, and isn't meant to be a reference or answer…

Heather Clarke: I'm sorry you cut out. Are you still there?

Alina Czekai: I believe we're having some technical issues with that phone line but we can take this question Heather, I've recorded your contact information so we can be sure to follow up with you and really appreciate your question and joining our call today.

Heather Clarke: I have another question.

Alina Czekai: Sure.

Heather Clarke: Are there any virtual services that can be billed on a UB then? I've had some conflicting information. So I know telehealth can't currently. Can e-visits, the virtual check-ins, any of those other things be billed on a UB?

Ryan Howe: So they could be billed on the UB under the CAH Method II billing, that would be a particular case. As a general rule, and others should jump in if I have this wrong, I think most of the codes that describe those virtual services are really professional services.

And so for the most part I think that those would be not paid separately to the institutions themselves. But again we're actively taking a look at a lot of

those issues as the shift has obviously moved toward using that kind of technology and we're actively engaged in looking at what our authorities are.

Tiffany Swygert: Ms. Swygert again, I just want to echo what Ryan said. I agree, I think if there are any particular services that you think a facility and particular hospitals can do virtually, it would be helpful to hear what those particular services are.

I think some of the ones that we've heard already have to do with counseling type of services or certain therapy services that are done by someone who's not able to bill under this physician fee schedule.

But if there are other types of services, obviously most hospital outpatient therapeutic services do require an in-person visit and interaction with the patient. But if there are other services that you think would be helpful for us to keep in mind, please do feel free to submit those.

Heather Clarke: Okay, thank you I will. I do have one other thing, as you're researching the use of the DR modifier and putting out clarification or a CAH Method I . So I know one of the waivers was that we can exceed the 25-bed limit but I'm not sure it's at the point that we have more than 25 patients, inpatients. Does the DR go on every claim or would it just go on patient 26, 27, 28 and so on?

CMS Staff: Okay we'll consider that as we're looking at the FAQ's, thank you.

Heather Clarke: Thank you so much for this opportunity.

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

Operator: And your next question comes from the line of Heather Maganatti.

Heather Maganatti: Hi thank you, I am just calling again thank you so much for all of these opportunities and I realize this is just a Herculean effort for you to continue the work you're doing and the communication.

But the podcast and recordings website there were two meetings last week, the Hospitals Without Walls Open Door Forum and the Thursday Office Hours, that the recordings are not posted yet and I'm just hoping that they can be

posted quickly because to re-listen and get the information straight is very beneficial to us in the provider community.

Alina Czekai: Absolutely, thanks so much for your positive feedback and for joining our calls. Those recordings should be going up within the next two days or so. So we'll be sending email notifications when those major calls are posted so you'll know when it's up and when you can take a listen and really appreciate it, thank you.

Heather Maganatti: All right, thanks.

Operator: And your next question comes from the line of Brenda Sholkey.

Brenda Sholkey: Thank you so much again for taking the opportunity to take our calls. I have a follow up question in regard to the Q2023 which is to be billed for by independent laboratories. And the question came up about, what about hospital-based patients.

And having the nursing staff and/or the physicians having to go in and obtain the specimens for these inpatients and/or observation patients. And at the time there was going to be a discussion, CMS was going to be looking into actually covering to see whether or not the actual hospitals could be covering, could be billing for it really.

And my question is, A, if you've given anymore consideration to that because you paid for a CPT 36415 which isn't a blood draw, so I don't quite understand why this would be any different than a blood draw, that's the first thing.

And then the second question is I implore you to please provide some guidance about the hospital outpatient therapist, registered dieticians, you know, the lactation services.

All of these services can be performed via telemedicine. I'm not talking about inpatients, I'm talking about hospital outpatient, non-physician practitioners and I know that you're hinting at that you might be considering the therapy

services but I also implore you to look at the others like registered dieticians, social workers, you know the list goes on and on.

And I just implore you to please provide some guidance, specifically surrounding hospital outpatient departments, because we have thousands of claims holding, waiting to hear something from CMS. And we know that there is the interpretation of what was in the CARES Act and what is allowed under these waivers.

But I can tell you as an institution that is holding thousands upon thousands upon thousands of claims, it would be really helpful if we could get some guidance. But I would love to hear your thoughts in particular about the Q2023 and if it's available by hospital non-independent diagnostic testing facilities. Thank you for taking my call.

Tiffany Swygert: Sure, thank you so much. This is Tiffany Swygert and I'm going to start with your first question and a little bit into your second question and I'm going to turn it over to my colleague to address more fully the second question that you had. So with respect to the first question, specimen collection, the code is G2023 that I think you're asking about.

And that code is, you're correct, it's not currently payable for hospital outpatient departments. That is something that we are still looking into, we have heard, as you mentioned on the call last week, as well as from others, and are actively considering what we can do related to that code.

I would say while Medicare does not typically give coding guidance, to the extent that there are other codes in the meantime that you believe are appropriate. Including if you don't think there's another appropriate code that exists for specimen collection that hospitals do, there are also unlisted codes.

But I do think that we should have some guidance very soon on G2023. With respect to your second question, I know you said that you're not really talking about telehealth and I just want to clarify before I turn it over to Ryan.

When you talk about the registered dieticians and the like, are you talking about them personally furnishing a service in person or doing it remotely, where both the clinician and the patient are in a non-clinical setting?

Brenda Sholkey: So what I'm talking about is the therapist are in the hospital outpatient department and they are using audio visual technology to see the patient off-site. You allow that to be covered for the private practice, to be billed out on a HCFA. You're not allowing it for the UB, so there's no difference in that aspect.

So I'm talking about non-physician practitioners who are physically located in the hospital outpatient departments and the patients are not inpatients, nor are they on the campus anywhere, they're at their own house.

Tiffany Swygert: Okay that they're registered outpatients--

Brenda Sholkey: That's what I'm meaning.

Tiffany Swygert: --of a hospital?

Brenda Sholkey: Yes, yes.

Tiffany Swygert: Okay. thank you for that clarification.

Tiffany Swygert: Yep, I'm going to turn it over to Ryan who is our resident expert on all things remote services.

Ryan Howe: I just first want to say I appreciate your concerns and I certainly really appreciate hearing such a well-articulated perspective on the need for us to address this. I want to reiterate that when I say we're exploring authority I don't mean to suggest that we're sort of contemplatively taking a look at it.

But rather we're addressing the issues as quickly as we can, understanding the importance of the issue. And I just want to make that really clear, because you, as well as others, have certainly brought that to our attention. And we continue to appreciate hearing it and we're actively working on it.

I think part of the challenge is figuring out all of the different, sort of, iterations and the circumstances under which the services are furnished for the sake of the beneficiaries and to make sure that we're getting all of the scenarios so that we're not leaving holes in the payment policies that create a problem and so we're trying to…

Brenda Sholkey: I appreciate that.

Ryan Howe: --as quickly as we can under the circumstances. So thank you very much and we're optimistic that we'll have some guidance soon.

Brenda Sholkey: Awesome, thank you so very much sir.

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

Operator: And our next question comes from the line of Artis Campbell.

Artis Campbell: Hello I believe my question was answered but I did want to get clarification on the modifier CR because there was in the special edition 20011 article it says that the telehealth does not need to have the modifier CR but in the Medicare fee for service providers FAQ document it's under the general billing guidelines.

It says that the CR needs to go on all claims, so I just wanted to make sure as you mentioned earlier because it's under different authority that's why there appears to be the different guidance.

CMS Staff: Yes, that's correct, but we will look at both of those, the FAQ's versus the article and make sure that we're consistent between the two.

Artis Campbell: Okay I just wanted to clarify because it would be nice for me to see that, you know, except for telehealth services on the general guidance. But thank you very much and I've appreciated all your hard work.

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

Operator: And the next question comes from Ima Bender.

Ima Bender: Yes, thank you. A lot of my questions actually were answered but I wanted to raise one question regarding the residents. Some of the services sometimes are provided just by residents in emergency room departments in the hospital setting.

Currently, we can not bill those services unless they are co-signed and validated by attending physicians. But as you know, with the surge of patients, we don't know if we necessarily have the chance to have an attending physician review or be a participant in the care of the patient by the residents.

Are there any plans to allow under these waivers for the facility side to bill for the resident services if attending was not present at the key portions of the visit? And I know there's some exceptions made that those portions can be down to telehealth but if that's not possible, is CMS thinking of allowing some exceptions for the hospitals to bill for those services?

Ryan Howe: We certainly appreciate the question and understand the needs of the providers given all of the pressures on the physicians and other practitioners. I think that's something that we can take a look at and see.

As you note, we did issue some changes that allow for more supervision through virtual means. But I understand that your questions are sort of broader than that and we can take that into consideration as well.

Ima Bender: Okay, thank you very much.

Female: Thank you, operator well take one final question, thank you.

Operator: And your final question comes from the line of Debra Manning.

Debra Manning: Hi thank you for taking my question. My questions actually related to a previous question that came up and it's related to the modifier CS being appended to evaluation and management services. But the reference was to outpatient only.

So if the patient is an inpatient and a provider does an E and M service and subsequently orders that COVID test. Are we saying then that that inpatient

visit is not – we can not append that CS to the inpatient visit or would it just be not applicable in this sense?

CMS Staff: So the CS modifier doesn't apply to inpatient, and others can jump in here and help me if I have that incorrect. But we will certainly try to make the very clear as well in the FAQ's.

Tiffany Swygert: Yeah and this is Tiffany Swygert. The cost sharing waiver specifies the payment systems to which it applies, it did not mention inpatient, but there are other provisions specifically related to inpatient services including a DRG add-on payment that does apply.

So, you know, this is sort tied to the specific way that the statute was written. But the CS modifier only applies, for the hospital setting, it only applies to outpatients.

Debra Manning: Okay, thank you.

Alina Czekai: Thank you. I'd like to thank you all for joining our office hours today. We really hope these calls are helpful and we appreciate all that you're doing as our nation addresses COVID-19.

Our next office hours will take place this Thursday April 16th at 5pm Eastern. And any additional questions may be submitted by email at COVID-19@cms.hhs.gov. And a recording and transcript of this call will be posted very shortly on the CMS podcast page, which you can locate by going to CMS.gov clicking on the Coronavirus icon and scrolling to the bottom of the page. This concludes today's call, have a nice evening.

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