Centers for Medicare & Medicaid Services
COVID-19 Call: Office Hours
Moderator: Alina Czekai
April 16, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 6168487.

Alina Czekai: Good afternoon. Thank you for joining our April 16th 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 engagements on COVID-19 in the office of administrator Seema Verma here at CMS.

Office Hours provides an opportunity for providers on the front lines to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and health care systems to increase hospital capacity, rapidly expand the healthcare work force, put patients over paperwork, and further promote telehealth and Medicare.

And while members of the press are always 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 on our website at cms.gov/newsroom/media-inquiries. Any non-media COVID-19 related questions for CMS can be directed to our COVID mail box, which is COVID-19@cms.hhs.gov.

And with that, Operator, we'll please open up and take our first question.

Operator: Yes Ma'am. To ask a question, you will need to press "star" and then the number "1" on your telephone key pad. To withdraw your question, please press the "pound" key. Please stand by while we compile the Q&A roster. And we have our first question, from a (Rebecca Moore).

(Rebecca Moore): Hi. Thanks for taking my call. I have questions about the CS modifier. So we understand that the CS modifier would be appended to the E&M service as you describe, that results in a COVID test. My first question is would that

modifier also be appended if the E&M is provided, but it doesn't result in a COVID test being needed?

Secondly, it references "related services". So we're wondering if there are related services, such as chest x-rays, lab work, that would also need to have that modifier appended. And then thirdly, last night in a special edition notice that came out from CMS, they reference "antibody testing," and that antibody testing would be at no cost. So we're wondering, do we append the modifier CS to antibody testing? And I'll stop for a second and let you answer those.

Tiffany Swygert: Hi, this is Tiffany Swygert. So the – the CS modifier – if you look at the statutory language – it applies for certain services – evaluation and management services. That can be found in the CPT code book. For hospitals, some of those CPT codes are not used under the hospital outpatient prospective payment system. And so it would be for the – the relevant (cross walked) code, such as the G code – like G0463.

The question that you're asking about whether a test itself needs to be furnished in order for the waiver of cost sharing to apply is one that we've started to get recently. And we're taking that back and discussing as a team, to look at whether the – the law allows us to waive cost sharing for those circumstances. So we don't have a specific answer for you on that part right now. But that is something that we're looking at.

(Rebecca Moore): OK.

Tiffany Swygert: I will – for your other questions, I think that's more about claim processing questions. So I'll defer to others on the call.

(Rebecca Moore): OK.

Diane Kovach: So – I'm sorry, this is Diane Kovach. And I heard the questions about – the questions about the codes, which I think was just answered. And I'm sorry that I missed the claims processing specific question. So if you could repeat that.

(Rebecca Moore): That's OK. Sure. We were wondering – well first, our most related services, which are going to get back with us. But last night's special edition from CMS noted that antibody testing was at no cost. So we're wondering if that is a service that would be – would require the CS modifier.

Diane Kovach: I do not know the answer to that. So we will have to get back to you as well. If there is a ...

(Rebecca Moore): OK. And I have one – I'm sorry.

Diane Kovach: I'm sorry. Just – in general though, lab tests – laboratory services are not subject to co pays.

(Rebecca Moore): Right.

Diane Kovach: So if it's not a service subject to co pays today, then no, you do not need the modifier for that.

(Rebecca Moore): OK, great. And then lastly – the E&M services that you listed. You're used (to) broad categories – except the online digital was a sub category – but critical care wasn't included. It's not infrequent that someone may have critical care – in the emergency room particularly – that results in a COVID testing done. They may be transferred. Sadly, they may expire. Or they could be discharged. Critical care was not one of those services. Would that need to be included as a – a service that would have the CS modifier appended?

Tiffany Swygert: This is Tiffany again. I think we'll have to take that back, and look again with – the statute lists the specific categories. And the language that we've communicated is directly from the law. So if you believe that the critical care codes are not within those categories, then that's one thing. If you think that they are, and we overlooked them, we can certainly take another look and make sure that we didn't leave anything out.

(Rebecca Moore): OK. That would be great. They're just – they're listed as their own category. And so were just wondering. We would assume that critical care would. I guess maybe if we could just – we have that clarified in the – in the FAQs.

And then – I'm sorry, I do have one more. I think that I know this answer, but would there be any frequency with visits? So if a patient presented on Monday. The service had the COVID test. It was negative. They presented again the following week perhaps, and the visit resulted in a – a second COVID test. Are there any frequency limits on the cost sharing with the E&M service?

Male: I don't – I don't think there would be any – any frequency limit to that policy in general, assuming that the – in both cases, the services were – were medically – medically reasonable and necessary, of course. But in that scenario, then both – both times, the same policies would apply.

(Rebecca Moore): Great. Thank you so much for taking my call.

Operator: And our second question of the day comes from a Miss (Amber Williams).

(Amber Williams): Hello. I have a question about the RHC. If they provide a service whose Medicare reimbursement is conditional upon waiver exemptions or allowances, do they report that with the condition code DR on the UBO4, and modifier CR on the pro claim?

Female: Yes, they do.

(Amber Williams): OK. And I do have another question. Our – our facility does – has office hours for curb side collection for the COVID-19. They do have trained professionals doing those outside in the parking lot of a (PAG) clinic, and it is a physician based clinic. If those specimens are sent to our lab that is located inside the hospital, are we able to report E&M 99211 for the swab collection, if we put the place of service as 15?

Male: So the – could you remind me – the place of service code 15 – which – what is – what's the descriptor for that?

(Amber Williams): It is our curb side testing site that is a mobile unit that we have for our specimen collection for our COVID testing.

Male: I see. So in general, if the – if that place of service code describes the – the location, and you're meeting the requirements for the 99211, then – then you could bill that code.

(Amber Williams): OK. So we can code that for just the specimen collection, as long as we're – as that mobile unit on a professional claim for place of service 15.

Male: As long as you're meeting the requirements for the – for that level one (inaudible) code, then yes.

(Amber Williams): OK. OK. And right now there is the code out there for the specimen collection G2023 for independent laboratories to collect for home bound and non-hospital inpatients. Is CMS thinking about lifting that restriction to make that applicable for all hospitals or laboratories to collect a – specimen fee?

Male: We are ...

Male: We're keeping the (inaudible), right?

Male: Yes.

(Amber Williams): I'm sorry. There were two – I couldn't hear what the answer was.

Male: We're talking over each other. Sorry. Yes, we're definitely taking a look at that.

(Amber Williams): OK. All right. Thank you very much.

Operator: And our next question comes from the line of a Miss (Sherry).

(Sherry): Hi. Thank you for taking my call. I have a question about telephone visits. If two calls are needed to assess a patient on the same day by the same provider covering the same signs or symptoms, are we able to add those two separate phone call times together to report one code? Or how should we approach that scenario?

Male: Yes. So much – much like – much like the evaluation management codes that describe visit services, the same – the same general principles apply where –

where all of those services that have happened, even if on – on the same day, even if they're kind of broken up in time, would – would be aggregated for purposes of reporting.

(Sherry): OK. Thank you. I have one other question about reimbursement for the antibody test available under CPT86769. Is that reimbursable?

Male: That's the – the new CPT code?

(Sherry): Yes. It is a new CPT code. I'm wondering if you have established the fee schedule – the reimbursement rate.

Female: It may or may not be on a fee schedule.

Female: Can you say the code again?

Male: Yes.

(Sherry): Certainly. CPT86769.

Female: OK. At least for – and it sounded like you may have been asking for hospitals – it has not been added to the hospital list as of this time.

(Sherry): Is that being reviewed to be added to the hospital list?

Female: It is being reviewed …

(Sherry): (Inaudible). OK. Is there a length of time? I know it's probably hard to – but generally CPT ...

Female: As soon as we possibly can, we expect to have information on how it will be treated on the appropriate payments file.

(Sherry): OK. Thank you.

Female: Thank you.

Tiffany Swygert: And actually I have a ...

Operator: And our next question – yes, ma'am.

Tiffany Swygert: I just wanted to – this is Tiffany Swygert. I wanted to go back. One of the questions earlier was about the CS modifier, and whether it did require a test – the COVID-19 test – to be furnished. And I did check the language of the statute, and it does, in fact, indicate that the – a test is required. It's one of the specific requirements in the law. So there – there is – you know, to the extent that we've implemented the law within our authority, it does clearly state that a test is necessary for that modifier to apply.

Operator: And our next question comes from a Mr. (Rick).

(Rick): Just kind of want to add on to the telephone service question. Because when you have the three CPT codes 98966, 67, 68. If you were on a call with a patient for 45 minutes, there's no code that says greater than 30 minutes. So if you're on a call for 45 minutes during a single call, would you then bill one unit of 98966, because that falls between the – I'm sorry, one unit of 98967, because that's between 11 to 20 minutes, and then a unit of 98968, because that's 21 to 30 minutes? 98969 only goes up to 30 minutes. So what do you do if you're on a phone call for, say, 45 minutes?

Male: I think that's a – a good question.

(Rick): Thank you.

Male: As a – as a general rule, you would aggregate the minutes together. But I think we understand the question and we'll take it back, unless anybody else on the call has a – has a definitive answer.

(Rick): So right – so right now – basically if a call goes 45 minutes, just bill for the 98968, that says 21 to 30 minutes? Is that the safest way to do it?

Male: I think – I think what's fair to say is that you can certainly bill for that 21 to 30 minute code if the – if the phone conversation or service lasts greater than 30 minutes. I think the subsequent question is – is there another code to bill on? And that's something that we will take back, and get back to you on.

(Rick): OK, thank you. Appreciate it.

Male: Sure.

Operator: And our next question comes from a Mr. (Lee).

(Lee): Hi. Thanks for taking my question. I have two quick questions. The first – under CMS' interim final rule, the rule waives clinical indications for coverage in certain local coverage decisions and national coverage determinations in recognition that patients may be receiving care in alternative settings during the emergency period. So for example, the LCD for external infusion pumps provides coverage of external infusion pumps, and related drug supplies.

And my question is, you know, assuming medical necessity is adequately documented, does CMS' waiver of clinical indications for coverage in this LCD mean that an external infusion pump and related drug supplies will be eligible for coverage, even if the drug itself is not listed in the current LCD?

Male: I don't know if we have the right people on the phone to answer that one. But we should definitely take account and get back.

(Lee): OK. That would be great. Yes. The language in the – in the interim final rule is, you know, "clinical indications for coverage". So I think the question is just getting some clarity on the scope of that – that waiver.

And I do have just a second question regarding hospitals without walls. So under this program, CMS has stated that hospitals are able to transfer patients to locations outside of their facility, including hotels and dormitories, while continuing to deliver inpatient services, and receive Medicare reimbursement under the inpatient prospective payment system. Assuming those same services are delivered in a patient's home, can CMS confirm that the program can be used to expand capacity for treating patients in their homes with the same recognition under the IPPS?

Female: Hi. So, you're right that under hospitals without walls, there were several waivers, and some changes to the regulations, to allow certain services to be

furnished outside of the walls of the hospital, including routine services. I want to note that that would include any location that is serving as a alternative expansion site of the hospital under hospitals without walls.

And so the COPs – the conditions that (protect) the patient that have not been waived – are still required to be met. And if the home is serving as a hospital site, the – that site would still have to meet any of the requirements that were not waived. And so – I'm giving you a caveated answer, because there are still some requirements in place that may be difficult for an inpatient service to be furnished in a personal home setting. But to the extent that they could be, and it's safe to do so, and the service is medically necessary, then those services could, in fact, be furnished in that alternative setting, and paid – billed under the IPPS.

(Lee): OK. And I know there was discussion in the past of, you know, releasing further guidance on – on that question. I was just wondering is that still under consideration, or will this be the type of forum that that information would come out?

Female: I think we've already issued FAQs on this. I think as we're continuing to get more questions, it helps us know where additional FAQs may be necessary. So we're evaluating those on an ongoing basis. But certainly happy to answer those types of questions on this forum as well.

(Lee): OK. Great. Thank you.

Operator: And we have our next question from a Miss (Susan).

(Susan): Yes. Thank you very much for having this forum. I have three questions. The first one – for office E&M codes, are we required to adopt the 2021 coding guidelines now, or can we continue to use the current guidelines that are already programmed in our EHO?

Male: You can certainly continue to use the 2020 guidelines. The change that we made to allow use of the 2021 guidelines was to increase flexibility. But you are certainly not required to do so now.

(Susan): Great. Thank you. And regarding E&M services provided to patients in an assisted living, the first three new patient codes are missing from the interim final rules and the list of telehealth codes. Yet the CMS letter to clinicians states that, "All levels in this group of codes are covered."

Male: Thank you for letting us know. We can – we will take a look at that, and make any updates that are necessary. But we certainly appreciate you noting that.

(Susan): Thank you. And my last question. Can we build the telephone E&M codes for patients residing in SNF and assisted living facilities – the 99441, 442 and 443 – if the patients don't have access to a video?

Male: So in those cases, if the patients don't have access to a video, under the current rules the telephone E&M codes would be the appropriate codes to use for services furnished to those patients with audio only telephones.

(Susan): OK. Thank you very much. I appreciate the clarification. Thank you.

Operator: And our next question comes from a Mr. Mark.

Mark McDavid: Yes. Thank you so much. This is Mark McDavid with Seagrove Rehab Partners. My question is related to the 1135 waiver for skilled nursing facilities as it relates to extending or adding a second benefit period after the hundred days exhausts, without having a 60 day break.

The question is multi-faceted actually. First part of that is if we have someone who exhausts their hundred – hundredth day, do we have to have any sort of break – one day, two days, five days – in order to access the second benefit period? Or would the next day just be day 101? If it's not 101, would it possibly be day one, and we need to do a five day assessment again, or an initial Medicare assessment? So that's the first question.

Second question relates to that – the variable payment adjustment factor. In that second benefit period, does that variable payment adjustment factor – for the non-therapy ancillaries, and for the PT and OT (CNGs) – start over at a multiple of three for the NTA, and a hundred percent for PT and OT?

And then the last question is in that second benefit period, are the first 20 days fully covered, or is there a beneficiary copay required during those 20 days?

Jason Bennett: Yes. So this is Jason Bennett. Let me tackle basically the first question.

Mark McDavid: OK.

Jason Bennett: And I think you're referring to the 1812F waiver for the SNF stay – the (SNF) stay, which is generally recognized as a three day waiver. And so just contextually, what this waiver is intended to do is to help facilitate patients to be in a hospital for as short a period of time as necessary, or to directly enter a SNF from the community without corresponding three day hospital stay, as would normally be the case when the beneficiary is in need of skilled care.

And our purpose behind this waiver is to assist with making sure that we are creating surge capacity in hospitals around the country to be as responsive as possible to COVID-19 in getting beneficiaries to the skilled care that they need.

What I would direct you to is a series of questions that we have – FAQs on our website, in particular under the category of Skilled Nursing Facility Services. And not every scenario that – that one can come through – and you describe some very specific ones – are addressed in precisely here. But I think with the background that I gave you there, and one question – number two in particular in this set – that that will be helpful for you.

And I'll just give you the background on that. And the question is, "Can a Medicare Part A beneficiary, who has exhausted his or her SNF benefits, but continues to need and receive skilled care in the SNF – for example, for a qualifying feeding tube – renew their SNF benefits under the section 1812F waiver, regardless of whether or not the SNF or hospital was affected by the COVID-19 emergency?"

And the answer on our FAQ is that, "If the patient has a continued skilled care need, such as a feeding tube, that is unrelated to the COVID-19 emergency, and the beneficiary cannot renew his or her SNF benefits under the section

1812F waiver, as it is discontinued skilled care in the SNF rather than the emergency itself that's preventing the beneficiary from beginning the 60 day wellness period."

And so I think with almost of the scenarios that – that you're describing, or that you could envision, I would – I would point to that question there to – to really try to think through those types of scenarios, and whether or not the particular beneficiary may qualify under the section 1812F waiver, which is largely designed around bringing individuals from a hospital to the SNF in less than three days, or directly admitting from the community into the SNF, without first going through a three day hospital stay.

Mark McDavid: OK. So let me just clarify, to make sure that I understand your answer. I understood your references to the 1812 waiver as well as the FAQ. Got it. So if we have a patient who is in the SNF – in the example you gave, peg tube – pick another, you know, any other example – that we continue to skill the patient after day 100. As I understood your answer, it sounds like we can't do that. That the patient had to come to the community, and waive the hospital stay potentially, or come short stay at the hospital – one or two days – into the SNF. But it couldn't be a patient who was already in the SNF, exhausted their hundred day benefit, and we needed to keep skilling them.

Jason Bennett: I think you've generally described the scenario and the response consistently. Yes.

Mark McDavid: So to be clear, that is not what's understood in the industry at present. There's lots of discussion regarding skilling patients who are in the skilled nursing facility now, who are long term residents, and maybe either is on a skilled stay now, and we exhaust the benefit, and we want to keep skilling them. So that's thing one.

And the second one is if they're long term care residents now, let's say that they have some precipitating event, we need to skill them for that post event care – falling, get a hip contusion, or a possible hip fracture – then it just doesn't seem that that's clear – yes. OK. I'll come back with more questions at Office Hours again, I'm sure. Thank you so much. I appreciate it.

Operator: And our next question comes from a Miss (Maria).

(Maria): Hello. Thank you for taking my question. Can you please clarify that we only need to apply modifier CR to the COVID lab test U0001 through 0004?

Diane Kovach: So this is Diane Kovach and you don't need to use the CR modifier for lab tests because co-pay does not apply for lab tests so you use the CR – I'm sorry you said CR not CS my apologies.

(Maria): Yeah.

Diane Kovach: I'm sorry, yes the CR modifier should be used any time that there is a formal waiver and this is true for the DR condition code as well. So our list of waivers is on our CMS (inaudible) website so anytime you see a form or waiver you should apprehend the CR or the DR as applicable.

I will clarify because we have gotten this question before, is it a problem if you use the CR or DR when you shouldn't that have any impact on claims processing? The answer to that is no, so if it is unclear if you should use it, if you believe it is related to one of our waivers I recommend you put it on the claim.

(Maria): OK.

Diane Kovach: So the one exception to the law – right so there you go.

(Maria): OK, all right and then for sure we do not use the CS for the call sharing because there is no co-payment that's applicable, correct?

Diane Kovach: That is correct.

(Maria): OK and then I have a second question and I am hoping that you all have finalized the billing requirements for the UBO4 for physical therapy telehealth visits that are performed in the hospital outpatient acute setting for telehealth.

Male: We don't at this time have instructions what would be billed in that scenario or the circumstances under which service furnished in that way would be

payable but as we said before we're actively working on it and optimistic that guidance will be forthcoming.

(Maria): All right that is my question, thank you very much.

Operator: And we have the next question from the line of a Miss (Jill).

(Jill): Yes my question has to do with the interm rule 1744 and they're very specific in talking supervision of incident two services for both NP's PA's and also our auxiliary staff and it says that the position certainly has the allowance to decide in which situations using the telecommunications technology portion would be appropriate or would not be appropriate.

I got that part but what I am not understanding is, does that mean that if they feel it's OK to use the telecommunication piece that the NP or PA has to have the phone right there and have their face up on the screen or is just the availability of the technology piece.

Because if we do supervision in an office the physician is readily available to help but we're talking technology so the question is, does the phone have to be on or is just the phone is available allowing for the technology piece supervision to be in place.

Male: Sure, the change in the policy is to allow the virtual presence to take the place of the immediate availability for in person presence and so I think one way to think of it is in the scenario where the direct supervision could be met with the billing practitioner.

Down the hall or in another part of the office suite and would be immediately available in a short period to travel from one room in the office suite to another to the extent that that could be accomplished, similarly, by using the phone that's readily available to ...

(Jill): Great OK.

Male: ... establish the virtual presence.

(Jill): And then on a call last week one of the people said in response to a question regarding the telephone calls, the 99441 series etc that the requirement that it not be related to an E & M service within the seven days before or a service blah, blah, blah, because it was regarding subsequent care dates where they were making phone calls to patients.

And the person from CMS on the phone call said, we're not really paying attention to that E & M seven days before on the telephone call rule. Could you clarify is that true? And is that something we'd get in writing or was it misspoken?

Male: I don't recall that specific exchange but I would say that none of those rules have been changed relative to the bundling rules for those virtual services. And so they would continue to apply, I think it's probably worth noting that again you can certainly – there are other cases where you can bill for non face to face services by adding minutes.

So things like – things like the chronic care management codes and other care management codes, those phone calls could be used for those services but there's nothing in the current billing rules that's changed relative to circumstances when those virtual check ins or things like that would be bundled into evaluation management, so they would continue to be bundled.

(Jill): OK so if I find that reference in a transcript, because that's what I'm looking for, the transcripts have just come out. Is that something to bring to your attention?

Male: Sure and I – sure and that way we can be sure to be clear in terms of what our intentions and policies are because they ...

(Jill): OK.

Male: ... obviously – yeah we certainly want to be that whenever – whenever possible so thank you.

(Jill): And again thanks you guys for hosting these it's tremendously helpful to get some of this clarified, thank you very much.

Operator: And our next question comes from a Sandy Sage.

Sandy Sage: Hey, yeah thank you for taking my call. I don't know if you realize or not how you just kind of dropped a bomb a little bit saying that the COVID test must be on the claim for the cost sharing, not to be attributed to the patient. So if the legislation says the COVID test has to be on there and a patient was at our hospital last week, came in five days later with worse symptoms, the first visit had the COVID test the second visit did not but it is related to the COVID. How do we – should we bill them for the cost sharing for the second one since the test isn't on the claim?

Female: Yeah I'm glad you asked actually. I used imprecise language, the statute requires that the test be ordered and so it doesn't go as far to say that the test must be on the claim and so I think the scenario that you just articulated we can take a look and see if we need to do some additional guidance on that.

But I do want to clarify that the tests – the law requires that the tests be ordered ...

(Sandy Sage): At some point.

Female: ... well it doesn't use the phrase at some point, but yeah, it does say ...

(Sandy Sage): OK.

Female: ... that the test be ordered and so we'll take a look and see if we need to issue further guidance on that kind of using the example that you just gave. Thank you for that.

(Sandy Sage): I guess, yeah I guess kind of the question also would be with the cost sharing if it's on the inpatient account with COVID of course there's nowhere to put a CS modifier because CPT codes aren't reported and so how is CMS going to tell?

Is it going to be by diagnosis code maybe that will trigger to CMS since there's no place to put a CS modifier on an inpatient claim? How would we be

able to get the 100 per cent Medicare payment with no cost sharing on a inpatient?

Female: It doesn't apply to inpatient the cost sharing waiver doesn't apply it's only for outpatients.

(Sandy Sage): So the deductibles and co-pays – or the deductible applies on an inpatient visit?

Female: Right that's my understanding although others should chime in, I do believe that there is a 20 percent add on for COVID related services that applies under the inpatient system.

(Sandy Sage): Right.

Female: But the statute that resulted in the CS modifier is specific to outpatient settings.

(Sandy Sage): OK.

Female: Part B providers.

(Sandy Sage): Yeah, one of the problems that we may find on the outpatient is that a lot of the labs like Quest and LabCorp are actually billing the lab tests and we're just collecting the specimens which of course at hospitals we can't bill for that collection and then they're billing for the actual lab, they're billing Medicare for that.

So it's ordered but it's never going to be on the hospital claims, hopefully if you guys can clarify that make sure that it's not going to matter, yeah.

Female: And obviously the statute itself, I have it pulled up now so I don't misquote anything.

(Sandy Sage): Thank you.

Female: One of the requirements is that is says, "Results in an order for or administration of a clinical diagnostic laboratory test." And it goes onto

articulate other requirements as well but I don't see that as an issue that the test itself is not on the same plain.

(Sandy Sage): OK.

Female: But again let us take that back and see how we can further clarify that in writing.

(Sandy Sage): Awesome, that would be great. Thank you guys so much for all the work you're doing, we appreciate it.

Female: Thank you.

Operator: And our next question comes from the line of a Miss (Ina Bender).

(Ina Bender): Yes, hi thank you for taking the call. I have a couple of questions actually. I think it would really helpful with this whole CS modifier because I'm looking at the medical – the Med learn article and it says something totally different, or partially different that all the explanations I've heard yesterday and today regarding the CS modifier.

It's also not really clear whether, for example, if you go to the emergency and you're getting your COVID testing that you could have also had an x-ray and the CAT scan and all kinds of other things. Some of these services, since they're getting paid on CPG levels will have a cost-sharing implication.

So I think it would be really helpful to publish a clear document with specific examples to cover, maybe emergency room or clinic visits with specific services to say, which items requires CS modifier and which ones do not. And the Med learn from April 7 implies that you either have to have a test, order the test or you're being evaluated to determine if you need a test.

So if the regulations required that you actually have to order a test that's quite different than what was being published at least, you know, last week. The second question I just had, we also need some clarification about 121 bill type and this CS modifier

The inpatient doesn't have this cost-sharing requirement but does the CS modifier apply to 121 bill type where some of the lab tests or other things will be billed as if it's outpatient claim. Do they require then the CS modifier? so I'm not sure if you have an answer for that.

Diane Kovach: This is Diane Kovach and I will speak to your first question about the clarity of our guidance on the CS modifier particularly this week we have gotten a number of questions about the CS modifier and we agree that we need to come out with some additional guidance that we are collecting all these questions and taking them back and determining how we can put out some additional guidance, so that will be forthcoming.

(Ina Bender): And the 121 can you also, I guess, look into that scenario as well to let us know if we need to use CS modifier and 121 bill type?

Diane Kovach: So if that is an inpatient, forgive me for not knowing if that's an inpatient bill type then no.

(Ina Bender): It's an inpatient part B claim.

Female: It's a part B.

(Ina Bender): Yeah, so they absorb their, you know ...

Female: I can take that one.

Diane Kovach: OK.

(Ina Bender): Go ahead.

Diane Kovach: Sounds good to me.

Female: Sure, so that is a patient – it's obviously rarely used but to the extent that you're furnishing outpatient services or CPT codes that would be on that 121 – or the 12X bill. But they're still considered the services that are listed that are eligible for the – I'm sorry for the CS modifiers then I think that's fine.

I don't recall us getting this particular question before so we'll definitely need to take it back and, you know, issue some clarifying guidance on it. But to the extent that you're still billing for covered services that are listed in the law that would otherwise have a cost-sharing amount for those services.

It seems to me that it would be appropriate to use the CS modifier in that instance but we'll take it back and discuss internally and take that into consideration for the updated guidance that Diane mentioned.

Ina Bender: Thank you and I have just one more question, regarding the new policy that was published with CMS about paying $100 for this high-speed test. There's no mention about what specific test the $100 fee is going to apply to. Is there a list of actual CPT codes that qualify for these high-speed tests?

Since this whole antibody testing is brand new and I understand that the FDA may have just approved at least one, maybe more, actual antibody tests. Is there a CPT code that the $100 fee applies to? Because there's no mention of that in any of the documents.

Male: So we created two U codes for those particular types of tests that would fall into the category and then the descriptor for the U codes refers back to the CMS ruling which provides an explanation of the types of tests which would fit in.

There are, I think, a couple of examples in there but it is not a definitive listing, rather it provides very specific criteria for the types of machines that would fall within and that should allow for sufficient precision to bill.

Ina Bender: So I guess the question is, so each lab has to determine whether they follow or use that particular equipment for those U codes, so I know about the U codes but is there a difference that if using the U code one is high speed and maybe one is not. How would anybody know what to bill or what to – or how would CMS know what to pay? Because the original rates on those U codes were lower than $100. So I'm assuming it doesn't apply automatically to every lab test billed under one of those U codes?

Male: No, the U codes for the new tests I believe are different. If (inaudible) maybe can correct me if I've got that wrong but I think they're new U codes, is it three and four Ing Jye?

Ina Bender: I didn't see those ...

Female: That's correct.

Ina Bender: ... I only saw about the U01 and 002. So there is two more codes that came out?

Female: So there are two codes that came out.

Male: Correct, three and four.

Ing Jye Cheng: The U003 and U004 typically, I think, my understanding – this is Ing Jye Cheng. My understanding is that labs – for the RTPCR tests labs would be billing using the CPT code that was finalized earlier last month and that's CPT87635. So that's the CPT code for most of the RTPCR COVID-19 tests that are out there now.

For the test subject to CMS ruling 2020-01-R where we would be paying $100 for RPTCR tests that are performed using high through put machines. Labs are built for those using U0003. So in general ...

Ina Bender: OK.

Ing Jye Cheng: ... tests that would otherwise be identified that you would otherwise bill using 87635. But as they're done on this high through put technologies the lab would bill using U0003.

Ina Bender: OK because I didn't see that code in any of the announcements so I kept wondering what is the CPT applied? But thank you for clarifying that.

Ing Jye Cheng: Sure.

Male: The ruling is on our website if you look for – there's a place on our website where there are CMS rulings and you can find it there.

Ina Bender: OK.

Male: OK.

Ina Bender: Thank you very much.

Operator: And our next question comes from a Miss Kim.

Kim: Hi thanks for taking my call. The CS modifier, it indicates payment systems that this applies to and non-OPPS or Maryland hospitals are not listed. Was that an omission?

Female: I think – are you talking about the guidance?

Kim: Yeah.

Female: Or the statute? Yeah, I think the guidance tracked right back to the law and so it mentioned exactly what was listed, the providers as were listed in the law. I'm looking now...

Kim: It lists OPPS, physicians, critical access hospitals, rural health and FQHC's. But not Maryland waiver.

Female: Yeah and the statute doesn't specify, so we'll have to that back.

Kim: OK, thank you.

Operator: And our next question comes from the line of a Jean Russell.

Jean Russell: Hello, thank you for taking my call and thank you very much for these calls. I have a question I've asked it before but I'm sure folks are understanding it. Under the guidance they tell us that telemedicine, their telehealth should be billed with place of service that you would be reporting in order to allow the payment of the higher non-facility rate.

It we billed a place of service two we would get the lower facility rate. The question I have is, for hospital-based providers they traditionally bill a 19 or a 22 for off-campus or on-campus services, which are paid at the lower rate.

Should they be billing a place of service 11 like a private physician would be billing?

Male: I can take that one. So the answer is no, you have the policy right I would reiterate though that the policy is intended to maintain the payment to the physician or other professionals for the service regardless of the fact that it was furnished via telehealth.

So, the payment, in other words, the payment to the physician is meant to remain stable in both the telehealth circumstance and to be the same as if it were in person. Now, I think what you're pointing out is that in a provider-based clinic, for example, there would also be a facility fee for that visit and that is not addressed by that policy.

And so, we are actively taking a look at that, we certainly understood that question and we're considering that. But there's no – there's no way to bill for that service or that portion of the service whatever it may be at present but we're actively taking a look at it.

Jean Russell: Thank you I appreciate that you're actively looking at it.

Operator: And our next question comes from a Miss Becky Martin.

Becky Martin: Hi, thank you. We're looking for clarification on the DR condition code for hospice claims. The hospice blanket waivers currently include waiving some requirements that speak directly to our conditions of participation such as, using at least five percent volunteers that has been waived.

And we're trying to understand if we are billing under that waiver then should every claim have the DR condition code on it? Thank you.

Diane Kovach: So, this is Diane Kovach and that is a good question and I will give you a tentative answer, but this is something that I think we need to clarify in writing as well. I don't believe it's our intention that it be on every single claim in those types of instances, it's more so, I think, when it's specific claims that are subject to the waivers. But we will take that back and clarify that.

(Becky Martin): Thank you.

Female: Thank you Oren we'll take our final question please, thank you.

Operator: Yes, ma'am our final question of the day comes from a Miss Barbara Zimmer.

Barbara Zimmer: Hi, thanks for taking my call. I had – most of my questions around the CS modifier have been answered but I just want to make sure that I understood that you said that the CS modifier is to be used on outpatient claims where the share of cost has been waived.

So not only on the evaluation and management or visit code but it might also be applied to, like, a chest x-ray that is done, that is ordered by the doctor as he works up to as it – as that helps him determine if a COVID test needs to be ordered. Is that correct?

Because the current CMS guidance, published guidance is very clear that the CS modifier should only be applied to the visit code or the E&M code. So, can you clarify that?

Tiffany Swygert: This is Tiffany I don't think we answered that specific question earlier we said we would take that back. Again what the law requires is that it's a testing related service, a COVID-19 testing related service and any of the categories that are listed and the guidance that you reference that are furnished during the public health emergency and that results in an order for, or administration of the clinical diagnostic lab test.

And it talks about the, you know, the certain categories that we've already covered. So, the situation that was raised earlier we said we would take that back and see if we could issue further guidance on that.

Barbara Zimmer: OK so I think that your answer for a CS modifier on a chest x-ray right at this moment is you're going to clarify that?

Tiffany Swygert: Yeah, we're going to take that back and see ...

Barbara Zimmer: OK.

Tiffany Swygert: ... if we can clarify how that would work. But again, I strongly encourage everyone to look at the language of the law in addition to the guidance that's out there already, I think …

Barbara Zimmer: The language of the law – the language of the law and your coding guidance is very different. Your coding guidance is very specific that the CS modifier should only go on the evaluation and management services. Whereas the law says that cost-share is waived for the evaluation or the visit and any test or item or service that is done that helps the doctor decide whether a test – a COVID test should be ordered. So the law and your coding guidance are very different. So, I think that's ...

Tiffany Swygert: Yeah so, we – yeah, the coding guidance is intended to follow the law and so to the extent that it looks different that would indicate that we need to further clarify. So, thank you for bringing that to your attention.

Barbara Zimmer: Thank you.

Demetrius Kouzoukas: Just as we close here, I just wanted to say that the agency here is learning both how to have interactions like this and also how to implement some of these changes as we go along. We are really leaning forward and engaging, I think, in a way that is kind of unusual for us.

We appreciate your patience with us, and we are doing these calls really in the spirit of sometimes we may not have the answer but acknowledging that is better than silence. And so, I know it's very nerve wracking for the staff and me sometimes to make sure we don't lead you astray.

We're really glad for the very good questions we're getting, clearly there are times where we don't have the answers. Part of it is really because some of these things are new. There is no particular wizard behind the Oz, if you will, but we really appreciate you all working with us.

Our overall goal is obviously to simplify the program, it has been long before this pandemic and we're just really glad to be able to demonstrate and have the opportunity for you all to engage with us in this very direct way, it's

meaningful to us and we're learning a lot from it, we hope you are getting the same out of it too.

Alina Czekai: Thanks Demetrius and thanks everyone for joining our office hours today. As Demetrius noted, 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 on Tuesday April 21st at 5:00 pm Eastern and in the meantime any questions can be submitted by e-mail at covid-19@cms.hhs.gov. This concludes today's call. Have a nice evening.

End