Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
Moderator: Alina Czekai
May 12, 2020
5:00 p.m. ET

Operator: This is conference # 8968295.

Alina Czekai: Good afternoon. Thank you for joining our May 12 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 provide 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 in Medicare.

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

And today we'd like to begin our call with some recent guidance issues and updates. First in regards to telehealth, the Medicare Learning Network published a YouTube video recently that answers common questions about the expanded Medicare telehealth services benefit under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. And the link to the video can be found online at cms.gov under the current Emergencies page under Telehealth Guidance.

And that video reviews services that are eligible to be furnished through telehealth, eligible providers that can furnish services through telehealth, when and how hospital should bill for services furnished remotely, the usage of appropriate codes for different provider types and when the modifiers are appropriate to use.

And in regards to additional blanket waivers, in addition to the new flexibilities offered in the interim final rule issued on April 30th, CMS has also provided several additional waivers as of this week including the expansion of hospital's ability to offer long-term care services or swing beds, waived distance requirements, market share and bed requirements for sole community hospitals.

Waive certain eligibility requirements for Medicare dependent, small rural hospitals and update specific life safety code requirements for hospitals, hospice and long-term care facilities. Additionally, last week we received a question on the Medicare payment rates for the COVID-19 serology test. And these are still under consideration and we will share this information as soon as possible.

Additionally last week, we received a question that we want to follow up on. The question was, at SNF increased time spent donning and doffing PPE and can SNF count those minutes as a set up part of the therapy visit. The question was on recording the minutes and whether or not those can be reimburseful.

So, I wanted to turn that question over to Jeanette to address that question.

(Jeanette): Yes, thanks Alina and thanks for following – allowing me to follow up on this question. The answer to whether or not that time can be recorded is yes. Donning and doffing PPE can be recorded as set up time in the Section O part of the MDS where the therapy minutes are recorded. So, go ahead and include that time when you're reporting your therapy minutes in Section O.

Alina Czekai: Great, thanks Jeanette and we'll now move to live questions. And today we want to – please request that you keep your question to one question or perhaps one question and a clarification or follow-up. Since we have so many people on the phone, we want to give everyone the opportunity to have their questions answered, so thank you for respecting that today.

Operator with that, we will move to live audience Q&A. Thank you.

Operator: All right. As a reminder for our phone participants, to ask a question, you will need to press star then the number one on your telephone. To withdraw your question, please press the pound key. Please stand by while we compile the Q&A roster.

Your first question comes from the line of Ling Joseph. Your line is open.

(Ling Joseph): Hi there. Can you hear me? Hello?

Alina Czekai: We can. What's your question please?

(Ling Joseph): Hey, so we are doing a COVID test kind of pre – PAT to outpatient procedures. If they are negative, then we go ahead and bring them into PAT. If they're positive, then we reschedule. So, my question is, is that COVID test part of the PAT, should they be billed on the same claim or they – should they be billed as a separate encounter from the PAT and surgery?

Diane Kovach: Hi, this is Diane Kovach. And I actually don't think I know the answer to that question, so we'll have to take that back and verify.

(Ling Joseph): OK. But – so I'll keep it to one question. I have others but I will – hopefully someone else will answer my others. Thank you very much.

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

Operator: And your next question comes from Robert Glass from Trinity Services. Your line is open.

(Robert Glass): Thank you very much for taking my question and for this call. My question is really around understanding what is stopping CMS from explaining how I can bill from my professional services as a doctor of physical therapy on the UB-04 claim in the nursing home.

And I want to explain this further by sharing that I can with my same doctor of physical therapy and my same license and certification and training, I can go down the street to the private practice clinic and you've explained how I can bill for my professional services because they used the 1500 claim form. And also, I can walk down the street to the outpatient clinic at the hospital and

with my same license, same certification and training, billing the same CPT codes.

You've shared the way that I can bill for my professional services on the form there. And now I walked back to my nursing home with my same certification, license and training and with billing for the same CPT codes and I'd still don't know how to bill for my professional services on the UB-04 form. And this is after the release of the first interim final rule on March 30th which have the same – shared the same CPT codes that could be used in each situations above.

And that was seven weeks ago and again, we still don't know how to do this in the UB-04 in the nursing home. There's been a second interim rules since then on April 30th and I truly believe that CMS understands the need for this clarification and I believe CMS does not want us to seek in – or see any further risk of spreading COVID in the nursing home.

And I believe CMS is aware of the many very appropriate situations where the use of telehealth via a PT, OT or speech in the nursing home or assisted living would be very appropriate. And I just don't understand what is stopping you from explaining how we proceed with our billing for our professional services using this important tool of telehealth. So would you please help me understand what stops – stops that?

Alina Czekai: Ryan, would you like to take that question?

(Robert Glass): Please do share why we can't just make the explanation as to how to do it right now.

Ing Jye Cheng: Hi, this is Ing Jye Cheng. It sounds like, Ryan who has planned to answer this was having some connectivity issues on his side. So on his behalf, I'll just say that we do understand the importance of this. As you mentioned and outlined a number of scenarios that we have tried to address and this is one that unfortunately we are still working on.

Outpatient therapy is a very complex area of Medicare. It's a very important benefit and has provided in a variety of settings and we want to make sure

we're getting this right. And so today, we don't have an update but we are continuing to work on this issue.

(Robert Glass): So, I think getting that right is important but I guess for not having perfection be the enemy of letting us go forward and doing something, we've already seen some precedence in the past. I think it was Rick Ruanda a couple of weeks back mentioned it. Noridian and Cigna were paying for the services. So I – what stops it? I understand to have to look at things and you have to get it right but each day we're dealing with this and I just don't understand what the hold up is.

Ing Jye Cheng: I wish I had something that I could say that would answer your question in a more satisfying way. This is something I think you'd been very clear with outlining the issue to us and we've been trying to take it off as best we can and craft a solution that would be appropriate and be able to announce it in the appropriate venue.
And so unfortunately, today we don't have that information but it is something that we are continuing to look at.

(Robert Glass): Thank you for your …

Alina Czekai: Thank you for your question. We'll take our next question please.

Operator: All right, your next question comes from Patti Austin from SSM Health. Your line is open. You may ask your question.

(Patti Austin): Hi, thank you very much for taking my call this afternoon. I'm curious regarding the high-throughput technologies for the HCPCS code U0003 that replaced the 87635, based upon the ruling that CMS had sent out, notification date was April 14th but yet the ruling referenced effective March 13th. We started utilizing the high-throughput technologies on March 22nd. We sent thousands of claims into our MAC and they are all rejecting.

The rejection notice says, HCPCS and we thought, oh, well it's not loaded in the OCE. But upon further investigation and speaking with them, i.e., we're being told that the U0003 is not effective until the same date as the ruling date

that came out which was April 14th. Is there clarification that you can give us on this please? Thank you.

Ing Jye Cheng: Yes, thanks for your question. The ruling is effective on April 14th and the codes are also effective as of that date. So if tests were performed using high-throughput technologies prior to April 14th, those would not be payable under U0003 or U0004, depending on which code it fit better.

And the payment rates, the $100 payment rates are also in effect for those codes starting on April 14th. I believe if we – if it's not posted already, it should be coming shortly at that. We put that onto our website but I can double check to make sure because I think that question has also come up before and we've been able to answer that one.

(Patti Austin): OK, so I'll have to just resubmit all those done with the old code, is what it sounds like.

(Ing Jye Cheng): That's right.

(Patti Austin): OK. I appreciate it. Thank you so much.

(Ing Jye Cheng): Sure.

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

Operator: And our next question comes from Fina Hender from Mountain High Hospital. Your line is open.

(Fina Hender): Yes, thank you for taking my call. I have actually a couple of questions as a follow-up. In the actual ruling from – regarding the 003 code you just mentioned, in the ruling itself it actually says effective March 13th or 18th, these codes can be used. So, I think there's a little bit of confusion within the ruling itself, so maybe that somebody can take a look at the ruling versus what you just mentioned regarding the effective date.

But, they also had another question for titer test. Our facilities performing titer test on the COVID. So if you have COVID positive antibody test, you

should be doing the titer test. Is there any plans to have a specific HCPCS codes? Because, currently there seem to be no code for that component of the test, so we're not sure how can we bill for the test including use of miscellaneous code.

(Ing Jye Cheng): So, thank you for your questions. With regard to the mention of the March 13th date in CMS ruling 2020-01-R, I think …

(Fina Hender): Yes.

(Ing Jye Cheng): That was raised by a couple of other individuals and in fact the effective date stated at the end of the ruling is April 14th, 2020. That's the effective date of the payment rates, that's the effective date of the codes. I understand there are some confusion about that and I have not been able to confirm if there's an FAQ up on our website yet but we'll make sure that is strictly clear. And the MACs are in fact paying correctly for that.

With regard to your second question, there are a number of codes right now currently available. CPT has three of them as you know and there is still the U0002 code available for testing of means that are not specifically identified either by one of the CPT codes or U0003 or U0004.

(Fina Hender): Yes, by the titer test is a different component. You're basically doing antibody testing. So it's not even a COVID test, it's really antibody testing and once you have positive, the second test that they're performing is to determine the titer which is the amount of the antibody you have in your blood. So, it's nothing to do with the 002 codes, it's really more to do with antibody test. There is no specific code for titer of the COVID antibodies.

So, it's only one code out there for blood testing when you're doing transfusions but there seem to be no code for the titer. And our facility had approval to do that test, so maybe that's something CMS can look into it because (otherwise) we're performing a test, there's no way of billing for that test currently, unless we can use a miscellaneous code.

(Ing Jye Cheng): Well, I think that would be helpful – what will be great is that you could send over us a little bit more information on the test specifically.

(Fina Hender): Sure.

(Ing Jye Cheng): Through the e-mail box that Alina mentioned and we can respond to you.

(Fina Hender): The COVID-19 box …

(Ing Jye Cheng): See what we had opened and look into it. Yes.

(Fina Hender): And the other question can – CMS since they announced the swing bed announcement today or yesterday, are there going to be any clarifications of how exactly the hospitals can utilize this waiver to bill for the swing bed setup? A lot of hospitals have never done that, so if there's any clarification that could be, that would be really helpful as well. And is there any (inaudible) that you show a new code for the new antigen test that the FDA just approved?

Operator: All right, your next question comes from Toni Fitzman of Family HealthCare. Your line is open.

(Toni Fitzman): We are physician network and we bill on the 1500. And when we collect the specimen of the patient from their knowledge for the COVID test, what code do we use to bill for the collection of the specimen? And also if the patient comes in just for that and then if they come in and see the physician and also have the specimen collection on the same day, what codes are we to bill? I know there's a G2023, is that the appropriate code to use for the specimen collection?

Male: So that code – that code is for use by independent clinical labs when they go to collect the specimen. Generally, nasal – specimen collections for nasal swabs are generally included in the – in the appropriate visit code, so the evaluation and management office code. And so that's whatever level of E&M would be reported, the specimen collection would be considered part of that services and general principle.

I wouldn't – I think we need to have more information to give you specific coding advice and – which we generally wouldn't do but that is the general principle. And in the interim final rule that was released at the end of April,

we clarified that even for new patients, if the purpose of the visit was just to collect the specimen that the CPT code 99211 could be used even for new patients, in the case for example where the billing practitioner did not see the patient.

(Toni Fitzman): So if we have – we have multiple clinics and we set up like a drive-through clinic for patients to go to because we didn't want to have all of our clinics collecting specimens because they have to really gear up and have all the protective equipment on in order to get that specimen. It's kind of a risky procedure.

So if the patient isn't even seen by a provider at all that day but there – they have an order to get the lab test done as our drive-through clinic location and they're not being seen by a provider that day, can't we get reimburse for that lab tech's time for dressing up and going out and collecting those specimens?

Male: For under that scenario, the level 1 office is a code for established patients could be used.

(Toni Fitzman): So level 1 if they're having just the test only.

Male: Right.

(Toni Fitzman): OK, thank you very much.

Male: Thanks.

Operator: Next up we have John Riley from Intermountain Health. Your line is open. You may now ask the question.

John Riley: Yes, thank you for taking my call. I had a question regarding the provider-based departments and the – we have a system where we have hospitals obviously and then a wing that is home health. And my question is, do you guys or does CMS foresee any issues with us using home health staff to conduct this provider-based department type visits? It's an issue that (inaudible) or anything like that.

(Ing Jye Cheng): So, this is Ing Jye Cheng. I think what I'm hearing in your question is and tell me if I'm not hearing your question correctly. I think in the rule, in the IFCs we've done – we talked about how a patient's home could be considered provider-based to a hospital and …

John Riley: Right.

(Ing Jye Cheng): … in those – in those instances, I think we tried to be very clear that it is a little bit confusing, right, because the patient isn't changing locations and certainly some beneficiaries could go – need home health services or qualified for those as well as need outpatient hospital care. And so if a beneficiary is receiving hospital outpatient care at their home when that home is provider-based as part of the hospital, the home is serving as the hospital at that particular point in time.

John Riley: Right.

(Ing Jye Cheng): So at that time, the beneficiary may not be receiving home health care services.

John Riley: Right.

(Ing Jye Cheng): And vice versa, when the patient is no longer registered outpatient, the home goes back to simply being the home. The home is not functioning as a provider-based department of the hospital at that point because patient is not a registered outpatient. So at that point, home health care services could resume. We don't specifically kind of get into the exact scenario you're raising about how best to staff the hospital services and I'm not sure that …

John Riley: Right.

(Ing Jye Cheng): … we have sort of staff on the call to answer that, unless there's somebody else who's willing to – who's able to.

John Riley: Yes, so obviously the patient wouldn't be on the home health – home health agency at all. The question that came up is whether or not we can use our home health agency nurses or whatever to conduct those visits or if there will

be some kind of a contracting issue between the hospital side and home health side or (inaudible).

(Ing Jye Cheng): Yes, I think – yes, the question does make sense and I was more trying to get at sort of the benefit, what services are the – is the patient receiving and it sounds like here they're receiving the hospital services because they're registered as patients.

John Riley: Right.

(Ing Jye Cheng): I don't know if we got the staff on the phone from our survey and certification area or patient participation area who could really talk about what the appropriate staffing might be for hospital services and whether any of the waivers they've issued might address this.

John Riley: OK.

James Cowher: This is Jim Cowher from survey and cert, so we can take that question back and look at it.

John Riley: OK.

James Cowher: We have looked at the hospital staffing requirement but we can definitely take that back and then look and respond later.

John Riley: OK, that will be great. And I guess it – if there's any – is there any guidance or direction from CMS on how best to validate a patient's home for the patient or provider-based department as far as the COP that they still have to meet? Is there any kinds of direction on that? And I know a lot of it – some of it had been waived in that regard but …

(Sara): This is Sara and my ask would be if you could send that question to the mailbox and we can talk to the appropriate SME and get your answer for that.

John Riley: OK, I will do that. Thank you so much.

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

Operator: Your next question comes from the line of Brad Willbanks from University of Texas. Your line is open.

Brad Willbanks: Hi guys, thanks for taking my call. So, my question (inaudible) centers around the use of the DR condition code, that there are still a lot of confusion about when that code is supposed to be used.

And I know that you stated that is for the blanket waivers and the state approved CMS waivers but there's the – the confusion has come around, well do we apply it with all of the diagnosis codes for COVID, if there's testing done or the (inaudible) are there because there's cost sharing. But, I just think the provider community needs more clarification about when to use that code. Thanks.

Diane Kovach: Hi, this is Diane Kovach and I do, there has been a lot of questions on these, about condition code. I will say just the presence of the COVID ICD-10 code does not mean that the DR condition code needs to be used. It is just in this case is where there has been a formal waiver that's been approved.

So – and those waivers of course are all posted on our website and we do continue to look for ways that we can provide clarification. I will say though that if you have a question, you can certainly include the DR condition code. It will not have a negative impact on the processing of your claim, if you include it even in the case where it may not be required.

Brad Willbanks: OK, well that's good. I mean the simplest thing for providers to do is to put that on the Medicare claims for the duration of the PHE and move on as opposed to trying to figure out where exactly it should be applied, but if you all probably don't want us to do that.

Diane Kovach: That would not be our preference though but I do understand the confusion. So as I said, we are trying to look for ways to continue to clarify these issues.

Brad Willbanks: OK, thank you.

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

Operator: All right, your next question comes from Reece Fitzgerald from Baylor Scott & White. Your line is open.

Reece Fitzgerald: Hi, thank you – thank you for these calls and for giving us the opportunity to ask these questions. I know you clarified just a moment ago about the specimen collection on the place of service (11) side and how it was considered a part of the E&M and shouldn't be reported separately.

But, I was hoping you could clarify if the same thing is true using the C9803 HCPCS for hospitals billing on the UB-04 or set a little bit differently. Is it appropriately – is it appropriate to report the specimen collection CPT in addition to an E&M on a UB-04?

(Ing Jye Cheng): Hi, so if the specimen collection is the only hospital service happening, then we would just expect to see that along with the laboratory test. If a visit or other service happened at the same – during the same encounter, we would expect those to show up on the claim, noting that HCPCS code C9803 is conditionally packaged. So if it is reported with another primary service, the payment for that specimen collection would be packaged into the primary service.

Reece Fitzgerald: OK and that aligns with we were thinking. We just wanted to clarify that it – it's a little bit different than on the professional side where we shouldn't report the separate 99211, if another E&M was performed on the same day.

(Ing Jye Cheng): OK, thank you.

Operator: All right, next up we have Julia Luz from Catholic Health. Your line is open.

(Julia Luz): Hello. Can you hear me?

Alina Czekai: We can. What is your question?

(Julia Luz): Thank you. So, we understand that the telephone E&M service codes, the 99441 through 99443 have had reimbursement increase to more closely mirror the E&M codes for office visit. But, the question we have though is that all we've seen is a range of reimbursement amounts from I believe it was $41.00

to $116 and we can't find any further information as to what those codes would reimburse at.

Do you have any information about where we would find that? Is there anything that will publish? Can you help us draw any correlation between those and the five levels of E&M codes that they are supposed to be more closely corresponding to?

Male: Sure. So, we're updating the payment files and I think others could probably speak to the timing of those updates and the locations which, if we can't get – if we don't have that information at hand, we'll certainly add that to our list for Thursday. But the – for those three-telephone evaluation management codes that the – that physicians for example would use, they are direct crosswalks from evaluation perspective and a payment rate to the level 2, 3, and 4 established patient office visits.

(Julia Luz): Thank you. That helps a lot, OK. OK. All right, thanks very much.

Male: My (pleasure).

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

Operator: All right, next up we have Christine from University of Iowa. Your line is open.

(Christine): Thank you. My question is, if the hospital has the therapy department and it relocates part of that department to a patient's home through notification to the CMS regional office and then the hospital therapist provides therapy services to the patient through audio-visual telecommunication.

Does the therapist have to separately enroll directly in Medicare, if they have not been enrolled in PEP and they would just be billed on a UB and not on the 1500? Does the therapist have to enroll directly in Medicare or can it just be that – the normal hospital way of billing those services? And does there need to be a modifier on the code?

Male: So, under the circumstances that you described generally, then the billing would – could be the same as it would be if the therapist came in to the hospital and the patient was a registered hospital outpatient. And it would be billed the same regardless of the service was furnished using technology that allowed the therapist to provide the service in the patient's home.

In other words, assuming that the patient is a registered outpatient and that the patient's home has been appropriately designated, then it would be billed the same way that outpatient therapy would be ordinarily billed by the hospital.

(Christine): OK. So, no enrollment and no modifiers.

Male: Right.

(Christine): Correct, thank you.

(Ing Jye Cheng): I just want to clarify no 95 modifier for – to denote telehealth in that situation but the PO or the PN modifier that normally applies for off-campus hospital services would still be required on the claim.

(Christine): So, the normal hospital – so the therapy department is in the hospital normally, so there wouldn't normally be…

(Ing Jye Cheng): Right but – right but if under hospitals without walls, if they're using the patient's home as an off-campus provider-based department at the hospital, the regulation that was really (fit) at the end of April talks about that process. And you mentioned submitting a relocation request to the regional office, so that means that one of those modifiers would be required.

(Christine): OK, thank you.

(Ing Jye Cheng): Sure.

Operator: Next one we have Dave Henriksen from Prime Healthcare. Your line is open.

(Dave Henriksen): Hi, good afternoon. Just a very quick question, when do you expect that Medicare will start take backs on the advanced payments?

Alina Czekai: I don't believe we have our OFM colleagues on the phone but we can definitely take this question back and address it on our next Office Hours. Thank you for your question. We'll take our next question please.

Operator: Next one we have Sarah Thomas from University of Kansas. Your line is open.

(Sarah Thomas): Hello. I'm also calling about the telehealth with the provider-based clinics and I appreciate you taking my questions last time and I'm back again. I read in the May 8 Federal Register that CMS remains concerned that – had been accepted PBD that was previously paid under OPPS relocates off-campus due to COVID.

Some hospitals would have difficulty staying operations, blah, blah, so services that would have otherwise been paid under OPPS, except for 19 will continue to be paid under OPPS. And that doesn't seem to fit with the direction of using Q3014 for those telehealth visits because Q3014 is not an OPPS payment.

Kind of the other side of that question is in our last call, you said that we would use condition code DRs as the previous caller said there's some questions about DR. You said that the hospital would maybe use condition code DR in this example of the patient being in their home because of that service was not really telehealth since that home is now a department of the hospital. So, on one hand you said, do you use condition code DR but then you said you bill under Q3014. Do you have any further thoughts on that?

Female: I think like the first part – I think you have several pieces to your question, so I'll turn it over to other colleagues to address the other pieces. With respect to the originating site fees, for the hospital serving as the originating site, that one applies when there's a telehealth professional furnishing a service remotely to the patient in the hospital which can include the patient's home under the hospitals without walls initiatives. And so that's when the originating site code that you mentioned would apply.

In terms of the DR ..

(Sarah Thomas): But is that same service – if that same service was in the hospital which was originally scheduled to be in the hospital provider-base clinic was rescheduled to the patient's home but would have been paid originally under OPPS and now you're saying it should not, when it's in the patient's home, it should not be under OPPS, right?

Female: The distinguishing factor is whether telehealth is involved or not. So if the hospital is furnishing a service directly which can include some remote services that are described in the regulation, the hospital would bill as normal as long as it's a registered hospital outpatient and the home is serving as a provider-based department of the hospital.

If the hospital is not providing a hospital service and a telehealth professional paid under the physician fee schedule is providing a telehealth service, the hospital – for registered hospital outpatient, the hospital in that case may bill the originating site fee similar to before the public health emergency when the hospital serves as an originating site. The hospital would bill an originating site fees for a telehealth service provided by a professional.

(Sarah Thomas): The difference is in this case the physician is in our hospital not in some distance site hospital, so just – you know the difference between prior to COVID …

Female: Understood. Right, the legal distinction here for health, the law and the regulations are articulated is that if it's telehealth service on the physician or professional side, the hospital can bill the originating site fee. If the hospital itself is furnishing a service to a hospital outpatient, the hospital can bill the hospital service.

And I know that there is a DR condition code question in there somewhere but perhaps the policy answers your question because it sounds like you're already aware that – of the instances under which the DR condition code is applied to the claim, sorry.

(Sarah Thomas): I am still confused about it because in the last call they said we would use condition code DR for this situation because they said it's not really telehealth since it's – that home is now a hospital department. So, we need to use

condition code DRs is how I took the direction last week, is that still the same answer?

Diane Kovach: Hi, this is Diane Kovach and I believe that is just still the same answer but again we'll take those back as one of the items. It would be helpful if we clarified.

(Sarah Thomas): OK. And then the first, addresses, if we enroll all these patient homes as provider-based locations, would we put those addresses on our claim?

Male: No, the addresses – the address of the home will not be on the claim. That would be the – assuming the hospital is submitting to – and have a relocation request to the patient's home, the claim would have the main provider address. The address of the home would be provided in the relocation request to the regional office as the site of care.

(Sarah Thomas): So you won't – CMS will never know exactly which dates of service were provided in that location. There won't be any claims with those addresses.

Male: The home address will not be on the claim, correct.

(Sarah Thomas): OK.

Alina Czekai: The hospital obviously is expected to keep medical documentation of all services provided.

(Sarah Thomas): OK.

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

Operator: Your next question comes from Jim Collins. Kindly state your organization name. Your line is open.

(Jim Collins): Thank you. So, the last time that I called in we had a spirited debate about the CS modifier, its application. I actually got guidance from a really good attorney who confirmed what you guys had said last time. So, I wanted to kind of let you know that and what he said that made it all clicked was the sequence of items 3 and 4 just appear to be out of order.

And if you rearrange and put item number 4, the one that says related to a test in front of item number 3, it makes it click perfectly. It doesn't make sense necessarily to only cover for patients that a test is ordered for but resequencing makes all the difference which brings me to my question which is sequencing of the CS modifier for the visits where we should be using it.

Medicare Administrative Contractors are telling us that they're waiting on CMS to tell them if the CS modifier is a pricing modifier, that they cannot classify it or put punches into their system as a pricing modifier without CMS telling them to do so. So, I'm wondering if that's something that we can make happen or if it's something that's already in process.

Diane Kovach: This is Diane Kovach and in terms of whether CS is a pricing modifier, it is a modifier that waives the copayer or cost sharing for the services as appropriate. So, I'm not sure what you mean by pricing modifier but that is the intent of that modifier and that's what it does in our system.

(Jim Collins): Right, just the MACs are waiting for Medicare to tell them, hey, treat this as a pricing modifier which would make it, so we would sequence it first on the claim form if there's multiple modifiers. So, they're basically telling people we're waiting on Medicare to tell us what to do with the CS modifier. It's just goes round and round.

Diane Kovach: No – sure, I appreciate that feedback. We have given direction to the MACs. We will certainly go back and make sure that they understand the way in which the modifier is supposed to be applied. If there's any particular MAC that is giving you that answer, we'd appreciate that feedback as well, so we can specifically target that MAC or those MACs.

(Jim Collins): Yes, OK. All right, sounds good. Thank you very much.

Alina Czekai: Thank you. Next …

Operator: Your next question comes from Amy Roy from Pioneer Valley. Your line is open.

(Amy Roy): Hi, I just had a quick question and clarification on the annual wellness visits via telehealth and there's a lot of confusion around this and I can't seem to find anything in writing from Medicare. And the question is can they be done via telehealth? Does it have to be audio and video and have they waived the requirement for the biometric stat such as vital signs and things like that during this pandemic?

Emily Yoder: Hi, yes, sorry for the delay. My mute button wasn't working. This is Emily Yoder, I'm an analyst in the Hospital and Ambulatory Policy Group. We definitely heard this question a lot and in terms of whether or not the service can be furnished via telehealth, it can. The audio-video technology requirements remained in place.

And as for the vital signs, well we have or we'll be shortly issuing a clarification that if the patient can self-report the vital signs, then that can count for purposes of the AWV. We're still looking into sort of how best to address instances when the beneficiary cannot self-report their vital signs. So, we're still looking into this question. Thank you.

(Amy Roy): OK. So, does that mean as of right now it hasn't been waived? I'm just trying to know whether or not it can be done or it can't. It sounds like you're still looking into it.

Emily Yoder: Yes, so right now the vital signs must still be reported when the service is furnished via telehealth, that is correct.

(Amy Roy): But, it can be self-reported.

Emily Yoder: Yes.

(Amy Roy): Thank you.

Operator: All right, your next question from Jessica Ree from Island Hospital. Your line is open.

(Jessica Ree): Hello, thanks for taking my call. I just had a question about the collections for rural health. Is there a way for rural health to bill and be paid for collection of specimens for COVID?

Male: Are you referring to the rural health clinics?

(Jessica Ree): Yes.

Male: OK, so for rural health clinics, there's no separate payment mechanism, so the – if the specimen collection were taking place during or part of a service that would meet the requirements for the face-to-face phase visit, then the – then that would be billed per normal but there's no separate mechanism for specimen collection alone.

(Jessica Ree): But normally a 99211 is not billable for a rural health clinic because that implies a nurse only visit. So, you're saying we bill that?

Male: Right. No, so if it's taking – if the specimen collection takes place with other services that would meet the visit requirements, then it would be billable but …

(Jessica Ree): Yes, if we're doing swabs in cars.

Male: Understood.

(Jessica Ree): So good, they're not …

Male: And so at present there's no mechanism for that.

(Jessica Ree): Wonderful, thank you.

Operator: Moving on, we also have a question from Cindy Peterson from Regions Hospital. Your line is open.

(Cindy Peterson): Thank you. I'm wondering if you can provide additional detail around the additional reimbursement for inpatient admissions for the COVID patients. As I understand it's for the two diagnosis codes, the B97.29 before April 1st and then from April 1st on the U07.1 code. This is the DR condition code

also required on those claims and that diagnosis or one of those diagnosis need to be in the primary physician on the claim.

(Ing Jye Cheng): Hi, this is (Ing Jye Cheng). I can start with the diagnosis piece and may have to refer you to some of my colleagues and another part of CMS on the DR modifier know the diagnosis it can be either a primary or secondary, so long as the diagnosis code is on the claim.

Female: And as for the DR question, I may need you to extend that particular – I'm sorry, looks like someone is telling the DR is not required in those cases. So, you should be fine with that, the DR modifier.

Or condition code, rather the DR condition code.

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

Operator: All right, your next question comes from (Carrie Harmite) from Genesis Healthcare. Your line is open.

(Carrie Harmite): Thank you and thank you for conducting these weekly meetings. They had been extremely helpful to all. I'm sure hospitals in the long-term care centers as well as the community-based. My question today is around the clarity for the blanket waivers and the 1135 and 1915 waivers that the states have requested and been approved. There seems to be at least from our perspective some clarity that's needed around the termination of those – of these waivers.

There's some language I know at the bottom of the blanket waivers that relates to – that it begins the effective date of declared emergency, it's retroactive and the termination of the emergency period or 60 days from the date the waiver or modification is published, unless the HHS Secretary extends the waiver by notice for additional periods of up to 60 days.

So, I try to do some research and I have found that Azar did extend on 04/23 but it doesn't give a termination date. Is that an automatic 60 days from 04/23 or can you give some clarity around the terminology that they used?

Diane Kovach: Hi, this is Diane Kovach and that extension was actually for 90 days and so I believe it's until July 26th because it was – even though it was – or at least a couple of days before April 26. April 26 was the effective date of the extension for an additional 90 days.

(Carrie Harmite): And Diane, is that – is that for all of the waivers, for the CMS and for the 1135, so the states do not have to request anything that was already been approved?

Diane Kovach: I can't speak to the states. I don't know if we have anyone from our Medicaid area on the call. I can only speak to the Medicare waivers and those definitely are all – it's all encompassing for all of those. I believe it's the same for the states but I can't speak definitively on that one.

Alina Czekai: Thanks Diane and we can take that Medicaid piece as the question back to our Medicaid colleagues and address that on our next Office Hours call. Thank you for your question.

(Carrie Harmite): That would be – that would be great. Thank you so very much.

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

Operator: All right, your next question comes from Pamela Sharkey from Valley Hospital. Your line is open.

Pamela Sharkey: Hi, thank you for taking my call. Because we're conserving PPE, if we have an APP going in to treat a critical care patient and they bring a tablet, so that an MD can see the patient as well. If critical care documentation is supported at this time, can the APP and the MD share the note? We would only bill for one and the time would only be counted towards one provider. Thank you.

Male: I think that's one that we'll have to take back and we will do so. Thank you for the question.

Pamela Sharkey: Thank you. Thank you.

Alina Czekai: Thank you. We'll take our final question today please.

Operator: All right and your next question comes from Donna Cantlow from New England Quality. Your line is open.

(Donna Cantlow): Hi, thank you for taking my call. My question centers around the use of modifiers for the telehealth codes 99441 through 99443, the telephone-only visit. At one time, these were not considered telehealth services but as of April 30th, they are now considered telehealth services. So, it's two-part question, are we supposed to use the modifier 95 for those codes now? And also, is there a requirement that we use the modifier CR? Thank you.

Male: So – thank you for the question. So, you have the sequence of events right and those codes are considered telehealth services at this point until the 95 modifier should be used. I don't believe the CR modifier is necessary by virtue of the sort of telehealth, the (payment) policies. Those are exempt from the CR from what I understand, unless others want to weigh in on that but there's no general policy for telehealth codes that the CR needs to be applied but the 95 would be applied for the telephone E&M codes.

(Donna Cantlow): OK. Can I just mention a follow-up? How long does it take NGS to get that information from CMS? Because, they don't have that information yet on their website and they are directing use of the modifier CR for those particular codes.

Diane Kovach: Hi, this is Diane Kovach. Thank you for letting us know that. We will follow up with NGS directly.

(Donna Cantlow): Great. Thank you so much.

Alina Czekai: Thank you for your question and thank you everyone for joining our Office Hours today. We hope that these calls continue to be helpful and we really appreciate all that you're doing as we address COVID-19. Our next Office Hours will take place this Thursday, May 14th at 5:00 p.m. Eastern and in the meantime, you can continue to submit questions by e-mail at covid-19@cms.hhs.gov.

Again, we really appreciate all that you're doing. This concludes today's call. Have a nice evening. END