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

Operator: This is Conference #: 5688374.

Alina Czekai: Good afternoon. Thank you for joining our May 14th 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 to agency officials regarding CMS's temporary actions that empower local hospitals and healthcare systems to increase hospital capacity, rapidly extend 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 you 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 for CMS can be directed to our e-mail box, which is covid-19@cms.hhs.gov.

And we'd like to begin today's call with some follow-up questions from our call this past Tuesday.

The first question is – when will Medicare start take backs on advanced payments? And CMS will begin recoupment of advanced and accelerated payments 120 days after the payment is issued.

And we also received a question on whether the annual wellness visit could be furnished via audio-only communications technology. And we wanted to clarify that it can indeed be furnished audio-only.

And we'll now begin with audience Q&A. Please do keep your questions to one question or one question and a follow-up. As you all know, we have many people on the phone, and we want to give everyone a chance to ask their question.

Operator, let's open up the lines for Q&A. Thank you.

Operator: As a reminder at this time, if you have questions and would like to ask over the phone, you can press star then the number one on your telephone keypad. Again, if you have questions, you can press star one on you telephone keypad. Please stand by while we compile the Q&A roster.

Our first question is from a phone line with phone number ending in 6780. Your line is open.

Female: Hi. Thank you. I believe that's me. I have a question, hoping to get clarification on the originating site fees of Q3014. I was wondering if we are able to bill this Q code for – as the hospital component for any of the professional telehealth codes listed on the current list.

Male: Yes. So, that Q code is to be reported when – for the originating site facility fee for any of the services that are furnished via telehealth.

Female: OK. So, as a follow-up, I just want to make sure that we don't have to file a temporary relocation request to – in order to report that Q code for our provider-based apartment, is that correct? We can just bill those…

Tiffany Swygert: So, the…

Female: … as we apply.

Tiffany Swygert: … in order to bill the originating site fee as a hospital, it has to be from a registered hospital outpatient and the service has to be furnished in the hospital. So, if the patient is at home while receiving the telehealth service and not in the hospital, that would not be an appropriate use of the originating site code.

But if the patient is in a hospital department – provider-based department – such as the patient's home during the public health emergency and is a registered hospital outpatient, then it is fine to bill the originating site fee when the patient is receiving a telehealth service from a professional.

Female: OK. I think I understand what you're saying. And then, additionally, in regard to the Q3014, would those on the facility claim be subject to reporting condition code DR?

Diane Kovak: So, basically, our guidance on the DR condition there in the CR modifier is that if those related to a formal waiver that is not something that's went to legislation that's been passed, then you should submit it on the claim.

Female: OK. I'm still not totally clear because I feel like sometimes the guidance has – there's been nuances between the waivers and flexibilities. And as I understand that this – the ability to report the Q code is listed on the hospital flexibilities for COVID-19. So, I was just hoping to gain some clarification if you regard that as under waiver.

Tiffany Swygert: In case it's helpful, I think the part that is under a waiver in the scenario that you're describing is making the patient's home provider-based to the hospital. That is under 1135 waiver in effect for the public health emergency so to the extent that the DR condition code is appropriate for use of any of the waivers in effect during the public health emergency. Then it sounds like it would be an appropriate use of the DR condition code.

Diane, did you want to add anything to that?

Diane Kovak: No. I think that – I think that covers it. Thank you.

Female: Thank you.

Female: OK. Thank you.

Operator: The next question is from Jean Russell of Epoch Health Solutions. Your line is open.

Jean Russell: Hello. Thank you for taking my call. So, it's kind of a follow up from the last person's call. So, I now- understand from the answer that you gave that person that if want to use Q3014 for an institutional provider clinic visits, we have to register the patient's home as soon as a provider-based clinic.

Can you explain when we would use Q3014 with a PO modifier versus Q3014 with a PN modifier? And if we would use those modifiers on the Q3014, what would be the reimbursement?

Tiffany Swygert: Sure. So, the regulation talks about when use of a PO versus the PN modifier would apply. And I don't think we have enough time on this call to go through all the various permutations. But essentially, the PN modifier is what applies for non-accepted hospital outpatient departments that are off campus of the hospital.

However, during the public health emergency, if there was an on-campus department or an off-campus department that was accepted and was still billing under the hospital outpatient perspective payment system, that relocates for purposes of the PHE into, for example, the patient's home.

We do outline if there's a relocation request submitted that the PO modifier can continue to be used. But for any off-campus department that was already non-accepted and was already billing the PN modifier, they should continue to bill or to use the PN modifier throughout the duration.

There are more details and you can certainly work with your MAC and the appropriate regional office to submit that request. But we can't give more detail in that on this call I'm afraid.

Jean Russell: That's OK. So, if my patient – if the clinic that my provider usually works in and that's the clinic that the patient is having a telehealth visit for, and we've made that patient's home a provider-based clinic but my clinic is typically a non-grandfathered clinic in billing PN, then we would bill the Q3014 with a PN?

Tiffany Swygert: That's right.

Jean Russell: And would we get 60%? Typically, Q3014 is not paid on Outpatient Prospective Payment System, so it's a little confusing. Would we get just a 60% reduction on the usual payment for Q3014?

Tiffany Swygert: We'd have to check. I don't – I think that's right that we have not applied a reduction to the originating site.

Male: Tiffany, that's right. There's no reduction. And the originating site facility applies – it's a flat national rate for – regardless of the institutional setting.

Jean Russell: Thank you. That's what I wanted to know. Thank you.

Operator: Again, ladies and gentlemen, as a reminder, please limit to one question and one follow-up.

The next question is from Arlene Pacheco of HonorHealth. Your line is open.

(Arlene Pacheco): I wanted to know if you have any reimbursement information available for the antibody testing codes 86328 and 86769 yet?

Male: Was the question about pricing or...

(Arlene Pacheco): Correct – reimbursement information if you have any of that available as of yet.

Male: We have not posted that, but we are working on posting that.

(Arlene Pacheco): OK. Thank you.

Operator: The next question is from Kathi Austin of SMM – pardon me – SM – SSM Health. Your line is open.

Kathi Austin: Hi. Thank you for taking my call this afternoon. Arlene beat me to the punch. That was actually my question is if the reimbursement has been posted yet for the serology testing especially the 86769, which is the one seems to be pretty heavily used.

It's been in effect since April the 10th and you say you're working on it. Is there any estimated time that we could possibly get this versus the claims being all held up because there's no reimbursement?

Male: Soon.

Kathi Austin: Hello?

Male: Sorry about that. My answer might have been too short. Soon is the answer. Really, we're – we have seen that we've issued some prices in the past for some of the other tests and then made some modifications. And we're working closely with our MACs to make sure that the posting reflects the full consideration of what the appropriate pricing is.

Kathi Austin: You mean the reimbursement – I'll set the price and we'll hope that you'll reimburse it appropriately. OK. Great. We'll look for that. Thank you so much.

Male: Thank you.

Operator: The next question is from Krista Barnes of MD Anderson. Your line is open.

Krista Barnes: Hi. This is a question about the telephone visits. And my first part of the question is – can they ever be used in an inpatient setting? I noticed that the – on the new list of telehealth codes that you guys issued, they had some of the inpatient consults were listed as being appropriate for audio only but not initial or subsequent inpatient encounters.

So, I wondered whether you could ever bill a 99441 through 99443 in the inpatient setting or whether that was intended to be solely in the outpatient setting.

Male: Sure. So, for most – most of the E&M codes, the general principle is to report the service that is being furnished regardless of the status of the patient. And so, the same thing would apply to the telehealth E&M codes or the telephone E&M codes rather.

So, if that code best describes including the audio-only modality of care even if the patient is an inpatient, that could still be an appropriate code to report.

Krista Barnes: OK. Great. And then the second part of my question is – I noticed that on the long list of telehealth services, 77427, which is the weekly radiation therapy management service was not listed as one that's appropriate for audio only. And I didn't know if that was intentional because it's a multi-component service that you do once a week.

The doctor – there's a bunch of stuff looking at images online and planning. And then, they're supposed to have an evaluation with the patient once a week. It is on the telehealth video list but it's very similar to an established patient – outpatient visit, which we know could be done audio only. So, is there any reason that one can be – that evaluation portion of that weekly visit couldn't be done audio only?

Male: So under the – under the current policy for that particular service, in order to meet the requirements, you're right, it would have to be audio and video and that's certainly something that we can take back and consider.

Krista Barnes: OK, thank you.

Operator: The next question is from Emma Bender of Mount Sinai Hospital. Your line is open.

Emma Bendor: Yes, hi. Thank you for taking the call. I had a question about swing beds, SNF waiver for the hospitals. Is the – is the intent of the hospital must follow the same rules that the SNF are currently doing without the waiver? And is there going to be maybe a training session for the hospitals who are interested in setting up the swing beds that's set up under the waiver?

Karen: Hi, this is Karen. The requirements for swing beds are a subset of the overall SNF requirements and includes things like admission and discharge and the minimum dataset to provide some additional assessment for residents. And that's all within the regulation that's outlined in the waiver which is 482.58 subpart B and so we recognized that with this waiver there are going to be some – hospitals are going to be fitting on swing beds that may not have

experienced this in the past and we're going to be doing some additional FAQs and training relevant to that coming shortly. Let me stop and see if probably (see), if have anything else they like to add on that.

Male: No, Karen. I think you made the right points and that we will have some additional education material forthcoming to help hospitals looking to set up swing beds.

Emma Bender: Thank you. And then just as a follow-up just so I understand (clearly), so if we're going to bill our Q3014 code, the rules for enrolling patients in the extension of the hospital with the regional CMS office would apply to that code as well as any other hospital remote services.

And do we just use this e-mail address listed on the website for regional office where there's just address and then there's an e-mail address? Do we send the list to that particular e-mail with the – all the requisite information? Would that suffice?

Karen: The details in what's required in the e-mail are outlined in the regulation and we also expect to have some additional frequently asked question guidance on that as well. In terms of the first part of your question about billing for the Q3104 with the PO or the PN modifier, just noting that the PO or the PN modifier used applies at the provider-based department level of the hospital. So, it's not service specific, it would apply for all services furnished from …

Emma Bender: No, no, I …

Karen: … that particular – OK. OK, you …

Emma Bender: No, I wasn't questioning about PO, I just want to make sure that the – any services for any patients that are now home and they get the service through the telehealth, that we have to enroll those patients' addresses in the same way as we would for hospital remote services, that we just have to include them before we can bill the Q-code on those claims.

Karen: You do have to include them but the way that you include them has been streamlined for the PAT and the ability to include a relocated department.

You have 120 days to do that after you've already made it provider-based to the hospital. So again, the specific details are outlined in the regulation but you do have time to do that and we've noted that it would be the main campus hospital address that you use for purposes of the claim.

(Emma Vendor): OK, thank you.

Karen: Thank you.

Operator: Our next question is from Nikki Whaley of Restore Therapy. Your line is open.

Nikki Whaley: Yes. My question is specific to Medicare Part A and skilled nursing facilities. With the understanding that Medicare Part A and the SNF, we billed – there's consolidated billing and knowing that the minutes for therapy evaluations are not reported on the MDS, would a remote therapy evaluation facilitated through audio-visual communication meet the RAI guidelines for completing initial evaluation as long as it also meets the skilled, the medically necessary service requirement? And what I mean by remote is that the PT, OT or SLP is not in the same building as the patient.

Male: And if understood your question correctly, it was – it's with regard to the initial assessment, is that correct?

Nikki Whaley: Yes, the initial therapy evaluation.

Male: We may need to take that back. That maybe a different set of colleagues than maybe on the line at this time.

Nikki Whaley: OK, thank you.

Operator: The next question is from Cathy Lapeyre from UCI Health. Your line is open.

(Cathy Lapeyre): OK, thank you for taking my call. I wanted to find out, my question is regarding the intraprofessional e-consult. Our providers would like to find out if you are considering or would consider waiving the 14 day restriction that states that they cannot – the patient before or after the consult is initiated after 14 days?

Male: Thank you for the question. So, I do want to clarify that the – I think the rules is that those services will be considered to be bundled into the visits but understood as a practical matter. That means that they're not separately payable and there's no change in those coding or billing rules at the moment but we appreciate hearing the question and we can consider it.

(Cathy Lapeyre): Great, thank you.

Operator: The next question is from Brian Kelly of Tufts Medical Center.

Brian Kelly: … from the billing perspective …

Operator: Your line is open.

Brian Kelly: Right. Can you hear me? Hello?

Alina Czekai: Hi, yes, we can hear you. Hi there, we can hear you. What is your question?

Brian Kelly: OK, sorry. Yes, hospital without walls, some of the recent directive now that is available for inpatient settings or inpatient care rather under arrangement, et cetera. I want to understand some details, if possible, about billing related to that, like anything that needs to be done differently for example.

Female: I am not sure there – I'm not sure I understand exactly what your question is. I think one, you would still bill for the services as if it were part of the hospital. So if the question is if there are any specific requirements for billing that were different than traditional inpatient billing requirements, I don't believe they are.

I may ask my colleagues on the phone from the side of billing group if the CR/DR modifiers are required since the care would be provided pursuant to a waiver of the provider-based rules, if you're providing care to inpatient care to a beneficiary in their home.

Brian Kelly: Correct. No (BD) ideas if there are any kind of different requirements, I mean in the scenario specifically would be yes, under arrangement but leveraging resources from a third party who are sort of providing that care then to the

patient in their home still under the direction of the hospital physicians and such. I just wanted to understand what the requirements might be, if there are any changes to the billing for that.

Female: So there ..

Female: I don't believe there is – I'm sorry.

Female: Right, I'm sorry, they know – there are no changes to billing. Like you said you would bill as it was a hospital service.

Tiffany Swygert: Right and this is Tiffany. I would just say you bill as though it's a hospital service but again the hospital conditions of participation that we'll waive in accordance with the public health emergency. If you're taking advantage of those waivers to furnish care in the – in an alternative setting, then you would use the appropriate condition code as applicable. But in terms of the actual claim form that you use and the billing, the ICD-10 codes in the case of inpatient, there would be no change there.

Brian Kelly: OK, so review the waivers, otherwise there's not like there's a special code or anything like that, that's been set up for this particular scenario.

Tiffany Swygert: That's right.

Brian Kelly: Thank you.

Operator: The next question is from Joanna Bennett of Baylor Health. Your line is open.

Joanna Bennett: Hi, thank you for taking my question, my question really is to the originating site fee. Can hospitals report the originating site fee that Q3014, when an approved telehealth professional service is performed via an audio only in a situation when a patient does not have video capability?

For example, an annual wellness visit which could be one of the services performed via audio only, and I guess the follow-up question would it also apply to services like phone visits. Can we drop that originating site fee as well?

Male: So again, the Q-code can be reported when a professional telehealth service is furnished and reported and that would include during the public health emergency, the codes that can be reported that are audio only. So, that includes the telephone evaluation and management codes and as you point out in your example, the annual wellness visit as well as any other codes that are noted or designated as audio only on the list of telehealth services website.

Joanna Bennett: Perfect, thank you.

Operator: Our next question is from Laura Sullivan of WVU. Your line is open.

I apologize, the line of Kristi Stockslager from Kingston Healthcare. Your line is open.

Kristi Stockslager: Hi, good afternoon. My question is related to skilled nursing facility and I'm just looking for some guidance. We have a Medicare Advantage payer who is denying all of our Medicare Part A request for individuals who have a positive COVID-19 diagnosis. And it's very clear that the Medicare policies manual Chapter 8 under observation and assessment of a patient would cover any COVID-19 positive patient but they are not allowing that as a reason to scale under the Part A benefit.

Demetrios Kouzoukas: Can you clarify a little bit, is this a prior authorization or a payment denial or some kind of other situation?

Kristi Stockslager: It is a prior authorization.

Demetrios Kouzoukas: And the situation is one where the denial is based on medical necessity criteria or some kind of coverage policy?

Kristi Stockslager: Correct. Yes. Yes, they're saying that a COVID-19 – we – yes, we are in the appeal process and they are to get back with us by June 3rd. But in the meantime, we have patients in our skilled nursing facility who are receiving the services and need the care that clearly should be covered under a Medicare Part A benefit.

Demetrios Kouzoukas: So, I wouldn't be in a position here to sort of opine on the coverage policies of the payer and the individual patient circumstances. Obviously, the

appeal process is designed to do that.

If what you're looking for is kind of general guidance or to bring to our attention some awareness of something that's happening, I'm happy to have you send that information to Alina on our team and we can get it to the right place internally. Hard to sort of weigh in or be helpful without knowing the particular circumstances of the patients and the policy that are being applied.

Kristi Stockslager: OK. And how do I find her contact information?

Demetrios Kouzoukas: Alina, do you want to show that?

Alina Czekai: Sure, I can give you – yes, thanks Demetrios. Our e-mail box is covid-19@cms.hhs.gov and Kristi, I've taken note of your name, so we'll all be on the lookout for your e-mail from Kingston.

Kristi Stockslager: OK, thank you. I appreciate it.

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

Operator: Again to all participants if you have a question, you can press star one on your telephone keypad and please limit to one question and one follow-up. The next question is from Laura Sullivan of WVU Physician Services. Your line is open.

Laura Sullivan: Hello. My question is regarding the annual wellness visit that you spoke of at the beginning. You said it can be billed as audio only, number one, I assumed is the 95 modifier but does that mean you're waiving the blood pressure documentation or can it be patient reported?

Male: So, there are no – there are no waivers regarding the requirements but some of the information can be reported by the patients.

Laura Sullivan: OK, that's all I wanted. Thank you.

Operator: Our next question is from Jenny Lin of Providence Health. Your line is open.

Jenny Lin: Hi, good afternoon. I – my question is around incident-to, the allowance of incident-to performance. I know in the last clarification it was opened up to

pharmacists. It was clarified that pharmacists are allowed to perform incident-to services when all those criteria are met, and this is just for Part B professional billing. I'm wondering if clinical staff like an RN can perform, let's say, a 99211 via telehealth, assuming all incident-to criteria is met, and the supervising provider is immediately available.

Male: So, I think you're asking about just sort of – to tease the question out a little bit in terms of the pharmacists, the rules that were released for the most part are clarifications of existing policy. That pharmacists can provide services under a physician supervision and assuming that the appropriate relationships in terms of employment or at least employment, et cetera are met, then the services of a – that are directly provided by pharmacists could be reported by a supervising practitioner under the incident-to benefits.

In terms of the second question, when there – for (initially) a telehealth, the same thing is true. The provision of the service via telehealth doesn't change the rules and so in the case where the supervision requirements are met and the – so if the level 1 office visit, if there's direct interaction with staff present for example, clinical staff, other billing practitioner is operating within their – within the rules of the applicable state guidance and rules, then those services could be billed by the supervising practitioner, even when they're furnished remotely, the telehealth service.

Jenny Lin: Wonderful. Thank you.

Operator: Our next question is from Beth Gilitte of Baptist Health. Your line is open.

(Beth Gilitte): Good afternoon. I wanted to follow up on guidance on swing beds for acute care hospitals. I understand what you said that it should be coming out quickly. Does – is it CMS's expectation that we should wait for this guidance before moving forward or is there going to be some allowance for us to go ahead and implement what we think we should be doing and have those services covered?

Karen: So, this is Karen. I think – here's a question for you, is it – the questions around what SNF requirements need to be met in the swing beds that is – you

feel like you need some additional guidance on or payment or something else? I just wanted clarify that.

(Beth Gilitte): No, we've looked at the conditions of participation and we think we're good there. It's more around operational issues such as the payments and then the MDS data. Do we need to submit that? Do we need to follow all the requirements under SNF PPS?

(Karen): So, I'll start and then – and then I have my colleagues to continue. For the conditions of participation as I mentioned in that regulatory section at the subsection of them or MDS, there is a specific form related to swing bed MDS that is different than the normal MDS requirements that are within that. I believe it's a little bit shorter. For any requirements related to the SNF PPS, I'll turn it over to my colleagues from CM.

Male: Yes, thank you and I would emphasize that yes, you are billing under a swing bed arrangement under the SNF PPS as long as it is not a CAH and I think in your circumstance you're not describing a critical access hospital. So one of – part of the education would be to try to provide that context and additional information about how to bill under the SNF PPS and we recognize that's going to be new for many hospitals around the country that maybe interested in pursuing this waiver flexibility.

Much of the information that will be shared is already available on our websites – on our website and you might just Google Medicare SNF Swing Bed Providers, particularly around the phrase swing bed providers, and that will provide you with much of the same information that we will be putting out educationally soon. We'll just have it back in just in a way that's more specific with regard to this waiver.

(Beth Gilitte): OK, thank you very much.

Operator: The next question is from Ileana Gonzalez of Cleveland Clinic. Your line is open.

(Ileana Gonzalez): Hi, thank you. I just have a question in regards to the telephone visits, if that's allowed for visits by our providers in the skilled nursing home setting and if the seven-day lookback period is waived.

Male: I think it would be helpful, can you sort of describe the – what you mean by the seven-day lookback period?

(Ileana Gonzalez): So, our billing department is telling us that currently a telephone – a telephone visit cannot be performed within seven days of a prior E&M which we're experiencing limited access to our patients and the facilities currently. So, when we only have an audio option, that's becoming a constraint for us.

Male: Right, so under the – thank you. I appreciate the clarification. So, under the current rules, the telephone E&M codes would be considered bundled into the other visits when they're taking place so close together, and those rules would continue to apply. If the video is used, then the visits, the audio-video visits could be reported separately regardless of the seven days.

(Ileana Gonzalez): So – in follow-up, if we're only able to access our patient with audio and we need to follow up on an acute issue within the same week, are those – the telephone encounter is bundled together or is there something else differently that we should be billing?

Male: They would be bundled together, assuming that the – that – depending upon which services are being furnished. So if the – if the service the – if the coding that best described those services, the telephone and evaluation management, those two codes would be bundled together and paid once.

(Ileana Gonzalez): OK, thank you.

Operator: Our next question is from Cheryl Kinstall of Moffitt Cancer Center. Your line is open.

(Cheryl Kinstall): Yes, my question is regarding inpatient visits in reference to using the G0425 through G0427 and wanted to know what are the criteria or what is the difference in using these codes over the CPT E&M codes that ranked from 99221 through 99223?

Male: I think we'll have to take your question back, taking a look at the specific questions in terms of the codes. Is this – this is referring to demonstration?

(Cheryl Kinstall): No, this is for telehealth for a physician who is seeing a patient through a virtual visit and wanted to know what are the criteria versus the G-codes that are set up for telemedicine. It says it is used for inpatient telemedicine consultation …

Male: Thank you.

(Cheryl Kinstall): … and emergency room.

Male: I see, so what are the difference between the G-codes for telehealth versus the – versus the evaluation and management codes that might be used in that setting of care typically?

(Cheryl Kinstall): That's correct.

Male: OK, so I think the – so I'd say I think you have to look at the individual codes and the individual circumstance. I don't think that we give a – that I could give a blanket response to that. I would point out that the – that ordinarily the evaluation and management codes in many of those settings that would ordinarily be used in person aren't on the telehealth list outside of the public health emergency.

And so it is possible that there's some overlap between the G-codes and the CPT codes for that reason that the – that the G-codes would be applicable outside of public health emergency and then maybe some overlapping coding there. But, I think you have to look at in individual case and report the code that still best describes the service.

(Cheryl Kinstall): OK, so can that – will that be clarified in like the upcoming frequently asked questions?

Male: We can certainly take that back and consider the best way to answer the question and certainly appreciate it.

(Cheryl Kinstall): All right, thank you so much for your time. I appreciate what you all are doing. Thank you.

Operator: Our next question is from Katie Boykin of Lake Mead Health. Your line is open.

(Katie Boykin): Hi, thank you for taking my call. Can you hear me OK?

Alina Czekai: We can, thank you.

(Katie Boykin): OK, great. I was seeking some clarification on when an acute care hospital can bill for Q3014. So for example if the patient is in the emergency room and the provider is at a distant location, can the hospital bill Q3014? And another example would be if the patient is in their home and the provider is at the hospital, can we bill Q3014?

Male: So I think – I think the answer to the question is the same as what we answered earlier in terms of the – I think for an acute care hospital, the same rules would apply as for an outpatient clinic but I'll see if anybody else has a different answer than that.

Female: That's right. It applies for registered hospital outpatient and we outlined the rules of how they apply during the public health emergency. If you're describing the situation that would have occurred kind of outside of the public health emergency, those rules continue to apply for who can bill and what the billing instructions would be as well. But I – it didn't sound like that was a different question from what we answered earlier.

(Katie Boykin): Right. I think I just – I'm still a little bit confused because I thought I heard you say earlier that if the patient is in their homes, that the hospital can't bill with Q3014 but if the …

Female: Right.

(Katie Boykin): … the home is an extension of provider-based department and registered through the regional office, would we be able to bill the Q3014 in that scenario?

Female: That's right, so if the patient …

(Katie Boykin): OK.

Female: … if the patient's home is considered a provider-based department which is allowed under the hospitals without walls initiative and the patient is a registered hospital outpatient receiving a telehealth service from a professional, the hospital may bill the originating site fee using Q3104.

(Katie Boykin): Thank you so much.

Female: Thank you for your question.

Operator: Again, ladies and gentlemen, if you have questions, again press star one on your telephone keypad.

Our next question is from Gina Ruiz of Casa Colina Hospital. Your line is open.

Gina Ruiz: Hi, so we have a provider-based department where one of our physicians is billing 99422 which is online digital evaluation and management. So in that case, would we have a facility fee that we would be able to bill? Would we be able to bill the Q3014 for that?

Male: So, the online evaluation and management service aren't considered Medicare telehealth services because they're not ordinarily furnished in person. So as a – as a general principle, the telehealth rules apply to services that are ordinarily furnished in person and under – outside of the public health emergency can under specific circumstances be furnished using remote communication technology.

But, there are many other services for which the telehealth rules don't apply because those services are ordinarily furnished, say, using virtual communication and things like that. And for those services, there is no originating site facility fee and the online digital evaluation and management are ordinarily, of course, furnished online. And so there would ordinarily be

no originating site facility fee in there. There wouldn't be one during the public health emergency either.

Gina Ruiz: OK. So as the facility, we bill nothing then or do we also bill the 99422?

Male: No, I believe that's considered a professional service only, and so the only payment would be to the professional in that case and that would be true both in the – in the context of the public health emergency and under ordinary circumstances as well.

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

Operator: Again, ladies and gentlemen, if you have questions, you can press star then the number one on your telephone keypad.

The next question is from Jade Cevo of University of Rochester. Your line is open.

(Jade Cevo): Hi, I just wanted to go back, when you mentioned the annual wellness visit we're eligible for the Q-code. Annual wellness visits when they're done face-to-face are not a split charge, they're only billed on either Part A or Part B, but they're never billed on both. So, I just wanted to confirm that we really can still bill facility Q-codes in addition to the – to getting the Part B annual wellness visit payment.

Male: Yes, that's a – that is a great question and understood that the billing for the annual wellness visit is a little bit different ordinarily. But even outside of the public health emergency, when the – when the annual wellness visit is furnished via telehealth, there can also be an originating site facility fee reported.

(Jade Cevo): Great. So – thank you, so you're actually making us better than whole, thanks.

Male: Sure, thank you.

(Jade Cevo): Thank you.

Operator: Our next question is from Lisa Zavala of UT Health Austin. Your line is open.

Lisa Zavala: Yes, I wanted to get clarification in regards to the telephone consultation codes. I was in a recent webinar for my MAC Novitas and they stated that the 98966 should be billed for mid-level providers such as nurse practitioners or PAs. But the code 99441 actually states it's for any qualified provider that is able to bill for an E&M. So, I just wanted to clarify that my mid-levels are able bill that 99441 for the telephone consultation.

Male: I think without sort of answering globally in consideration of different states, scope, rules, et cetera as a general principle the way that coding works is that, you're right, the physicians and the non-physician practitioners who report evaluation and management services report one set of codes. And the billing professionals who wouldn't ordinarily report evaluation and management services report a different set of codes under the G-codes.

Lisa Zavala: OK and then just a follow-up, I know those – the telephone E&M's 99441-443, do require the – you can have an E&M seven days prior, is that something that actually has to be documented or is it something that is just we can tell that the patient hasn't been seen in more than seven days, so we can go ahead and bill this out? Or do providers actually have to document this has – not related to an E&M seven days prior?

Male: I think – so those are – those are billing and payment rules but I think that you want to ask that question to the individual or local MAC or the Medicare Administrative Contractor who might be able to answer a little more specifically about what – what would need to be documented.

Lisa Zavala: OK, thank you.

Operator: Our next question is from Allan Vandermark of Geisinger Health. Your line is open.

Allan Vandermark: Hi, I have a question related to the billing of the originating site fee and the Hospital Without Walls guidelines related to billing for that fee when the

patient is in their house. The reg tells you that you need to register the patient's home as an expansion site of the PBD.

My question around that, is it – do we need to register every patient address which we would deliver a telehealth service to or do we need to submit one request stating that we want to expand to our patient homes from the PBD from each billing location, each clinic?

Male: Yes, so you would need to submit a request to the regional office that includes all of the PBD location addresses at which the services being provided, so that would be – including patient homes. It does not need to be a separate submission for each of those locations. You can have one submission that contains all the locations over a period of time, if that is convenient, but every location at which the service is provided does need to be included in the request.

Allan Vandermark: So as a follow-up just – so just for clarification, all patient home addresses need to be submitted as extension sites?

Male: If you're intending to be paid under the OPPS as part of this – for the service, then it has to be submitted as part of that temporary, extraordinary circumstances relocation request.

Female: And I'll just add that …

Allan Vandermark: OK, thanks.

Female: … that is if you – so it's not mandatory that you file for a relocation exception. You could certainly provide services in an alternate location and bill the PN modifier which would result in payment under the physician fee schedule, and that's totally fine. However, if you are relocating a department of a hospital and you want to continue billing the PO modifier, then we do need to know the addresses of those sites that are serving as provider-based department of the hospital.

So again, we'll (have) the details on that and it's not sending us a patient address and the e-mail that you sent should not denote that it's the patient’s

address. It's an alternate address of an expansion of the provider-based department to continue billing the PO modifier.

Allan Vandermark: OK, so that applies to billing the Q3104?

Female: Again, it applies at the department level, it's not service-specific and I understand that there are services where whether you used the PO or the PN modifier, there's not a difference in payment. But what the modifier tells us is whether it's an accepted or non-accepted department, so the department would still – any off-campus department would still bill either the PO or the PN modifier.

Allan Vandermark: OK, thanks.

Female: Thank you.

Operator: Our next question is from Sheila Rodriguez of McKesson. Your line is open.

Sheila Rodriguez: Hello?

Alina Czekai: Hi there, we can hear you.

(Sheila Rodriguez): Great, thank you for taking my question. My question has to do with the telephone, CPT codes 99441 to 99443. I understand that 99443 is for any call greater – I mean from 20 to 30 minutes and that prolonged E&M services are now added as audio only. Can prolonged E&M services be billed on top of 99443 for the extended time?

Male: We will take that question back and add it to the – for frequently asked questions.

Sheila Rodriguez: All right, thank you.

Male: Thank you very much.

Alina Czekai: Thank you. We appreciate everyone joining our call today. We hope that you'll join us for our Office Hours next week, next Tuesday, at 5:00 p.m.

Eastern. In the meantime, you can continue to direct any questions to our e-mail box covid-19@cms.hhs.gov.

Again, we appreciate all that you're doing for patients and their families around the country as we address COVID-19 as a nation. This concludes today's call. Have a great rest of your day.

End