Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
Moderator: Alina Czekai
May 21, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 9984433

Alina Czekai: Good afternoon. Thank you for joining our May 21st CMS COVID-19 Office Hours. We appreciate you taking the time out of our busy schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the office of CMS Administrator Seema Verma.

Office Hours provides an opportunity for providers on the front lines to ask questions of agency officials regarding CMS' temporary action that empowers local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork, and further promote telehealth and 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 online media inquiries form which can be found at www.cms.gov/newsroom.

Any non-media COVID-19 related questions for CMS can be directed to covid-19@cms.hhs.gov. And as a friendly reminder, beginning next week, we will be holding Office Hours only on Tuesdays at 5:00 p.m. Eastern going forward.

Please do try to keep your questions today to one question and a follow-up since we have many people on the line today. We really appreciate your cooperation. Operator, let's open up the lines for questions. Thank you.

Operator: Ladies and gentleman, we will now begin the question-and-answer session. If you have a question please, press "star" then the number "1" on your telephone keypad. Again, if you have a question, please press "star" then the number "1" on your telephone keypad.

We'll pause for just a moment to compile the Q&A roster. Our first question is from Veronica Zyke. Please state your company name or organization. Your line is open.

Veronica Zyke: Sure, thank you. This is Veronica Zyke, and I'm calling Cobleskill Regional Hospital in Upstate, New York. I have a question, if I have a physician in a hospital provider-based department who performs the clinic visit virtually for a patient at home so using audiovisual technology, are there any scenarios that would allow me to bill a G0463?

Tiffany Swygert: Hi. Thank you for your question. I think we've answered this one on a few Office Hours before but I know it can be a little bit confusing to understand the permutations. So for this one, the relevant factors I think are – in the scenario that you just described, there's a physician furnishing a telehealth visit to a registered hospital outpatient.

And if that is the case, the hospital would bill the originating site fee not a visit, unless the hospital is furnishing a clinic visit via in person, not using telehealth on the professional side. So in general, we would expect only the originating site fee to be billed by the hospital under the scenario that you just described.

Veronica Zyke: OK. And just so I'm clear, when you say in person, so that would be if the physician actually went to the patient's home, is that correct?

Tiffany Swygert: I mean non-telehealth.

Veronica Zyke: OK, thank you.

Tiffany Swygert: Yes.

Operator: Our next question is from Sarah Gainer. Please introduce your organization or company name as well. Thank you. Your line is open.

Sarah Gainer: Thank you. I'm Sarah Gainer with the American Physical Therapy Association. In relation to furnishing remote care but billing as a furnished in-person, the April 30th interim final rule discusses non-accepted off-campus

departments don't need to follow the relocation process, approval process, whereas hospitals that relocate accepted on or off campus, PDDs to off-campus locations need to notify their CMS regional office following the relocation process in the rule.

And so my question is for those departments providing therapy that is always billed under the fee schedule like therapy furnished under a therapy plan of care that is always reimbursed under the fee schedule, does the accepted or non-accepted status matter for purposes of seeking relocation approval?

Meaning I'm trying to understand, does provider-based departments that provide outpatient therapy and always bill under the fee schedule, do they need to follow the relocation approval process and list each patients' location in an e-mail to the CMS regional office?

Tiffany Swygert: David is going to respond to this but before he does that, I want to clarify one thing you just said. It matters if the bill that's being submitted or the claim that's being submitted to Medicare is an institutional or professional bill, so can you clarify when you say is billing under the TFS, are you saying that there's an institutional claim form, a UB04 that's being billed but then it says the ...

Sarah Gainer: Yes.

Tiffany Swygert: OK, so that still considered a hospital institutional claim forms so I will turn it over to Dave to explain, OK?

Dave: Sure. So the temporary extraordinary circumstances relocation requests are only necessary for departments that are seeking to be paid under the OPPS. So if the only thing that will be provided from the department you're discussing is not something that's paid under the OPPS then you don't need to do a temporary relocation request.

Tiffany Swygert: You would still bill the PN modifier and I think as Dave is just saying, those claims are still hospital claims.

There's not a payment differential regardless of whether you use the PO or the PN modifier but if there are other services that the hospital is billing that our subject to the PN modifier payment reduction, it would be important to make sure that your appropriately using that PN modifier so that we can make sure that we're making appropriate payment. We'll take our next question please?

Operator: The next question is from Rebecca Moore. Please state your organization as well. Your line is open.

Rebecca Moore: Hi, this is Becky Moore from University of Michigan. My question is in regard to HRSA COVID-19 claim reimbursement for the uninsured. We know from the Q&A that for a COVID test that's part of pre-op testing. Only the testing would be reimbursed.

When we submit this claim, do we do a split bill and only submit a claim to the HRSA program for the test itself?

Demetrios Kouzoukas: So the HRSA program, if you're talking about the provider really?

Rebecca Moore: Yes.

Demetrios Kouzoukas: Hospitals in terms of the 100 billion that Congress had appropriated and was being released in various projects, that's the program you're referring to?

Rebecca Moore: No. This is the COVID-19 claims reimbursement program for the uninsured. Yes.

Demetrios Kouzoukas: OK. I think we'd have to talk to the HRSA folks have been referring to that program to give a sense of exactly what their requirements are, we don't have them here today, but if you get the question to Alina, we can work to get the question to Alina, touch it to right people there.

Rebecca Moore: OK, all right. I'll do that. Thank you very much.

Operator: Our next question is from Tim Accord. Your line is open. Please state your company name or organization as well. Thank you.

Tim Accord: The Next Event Physical Therapy. Before I get to my question, I just had a follow up question that I think Cara Gainer had asked about the PN modifier because therapy in an institutional study for a hospital is always paid under the physician fee schedule.

Is the PN are still needed even though it's always paid them the fee schedule or is it not? I guess departed to my other question. I'm just confused by the response, sorry.

Dave: So the modifier will only make a difference for a service that was paid under the OPPS. So the PN modifier, well, it could be put on there, it would be paid the same way either way because it's not an OPPS service.

Tiffany Swygert: Yes, so to say that a different way, the PN modifier applies at the department level. So if it's a non-accepted department, all services being billed by the hospital should append the PN modifier.

If it's not accepted or I'm sorry if it is accepted, then we would use the PO modifier. And that's irrespective of whether there's a payment differential.

Tim Accord: OK. And then to my question, CMS release transmittal 10139 this past Friday that added the CTBS code I believe the G-code and the telephone service codes. Should CTBS code to the sometimes therapy service list.

Now in the transmittal, it says it's finished by therapist or therapy providers but in the med learn matters, a company article it does say institutional providers. And I know in previous Office Hours calls, you had said that the G2061 through G2063 and the telephone service codes could only be on a professional claim on a 1500, because of the kind of the language being used of the therapy providers and then say institutional providers, that does now mean these codes can be paid, billed and paid by institutional providers or not?

Dave: So I think your interpretation is correct that when the practitioners who could otherwise report the claim when their services would be reported by the institutional provider and institutional claim, then they would be able to be paid then.

Tim Accord: OK, and they do need to see or modifier on any addition to the discipline specific modifier or it doesn't matter?

Dave: That's a good question. We'll have to take that and get back to you on that one.

Tim Accord: OK, thank you very much for your time as always.

Operator: The next question is from Kristine May of Tennessee Orthopedic. Your line is open.

Kristine May: Hello. I have a last asset question in April and I know that they were still working, the CMS was still working on this in considerations. But it's pertaining to MIPPS and the fact that for 2020 we have – we are not where we should be on MIPPS collections obviously as I'm sure other practices as well.

Do you know if there has been a determination on how this timeframe will be handled for providers whose collection of the MIPPS has greatly decreased due to the pandemic?

Demetrios Kouzoukas: Yes, I know that something that we're working and you may see something in upcoming evaluations of one server or another. We're also making, to our end the rulemaking amount for the 2021 year including with regards to the physician reschedule where you often see changes in the MIPPS program.

Kristine May: OK. Are you anticipating changes to all to appropriate use criteria as well in being ...

Demetrios Kouzoukas: That's something that's being discussed, I don't know if I have new information since the last time on that but definitely under consideration.

Kristine May: OK, thank you so much.

Operator: The next question is from Robyn Shimping of UNC House. Your line is open.

Robyn Shimping: Hi, good afternoon. I again want to echo our appreciation for CMS holding these calls. We continue to have, I guess some ambiguity around incidents to billing and then particularly related to professional services on a 1500.

Based on prior conversations with CMS on our earlier calls, it seemed that ancillary staff such as an RN or clinical pharmacy practitioner cannot bill and send it to the physician for evaluation management services say the 99211 because they were not in a preexistent site provider.

Can you provide clarification whether or not ancillary staff, auxiliary staff such as these can go lower level ENM services underneath the physician via incident two assuming all the incident to requirements are met? Thank you.

Dave: So what we've stated in the second interim final rule relates to the intersection of the changes to telehealth and the virtual supervision or virtual preference that can be used in meeting the direct supervision requirements.

So, basically the short answer is yes, clinical staff providing services that are on the telehealth list that when the supervision requirements would ordinarily allow those services to be billed under incident two, they could be billed under incident two at telehealth services.

So that wouldn't mean for example that an individual who wouldn't be able to report a higher level E&M code could be able to report it merely because it was done via telehealth but for example, a nurse providing a service to a patient directly under the supervision through virtual presence of supervising practitioner could report the Level 1 E&M office.

Robyn Shimping: OK. Thank you very much. That's very helpful. Appreciate the clarification. I have no follow up. Thanks.

Operator: The next question is from Kathy Napeer of UCI Health. Your line is open.

Kathy Napeer: Hi, thank you for taking my call. We have a patient who is Medicare advantage or an HMO patient that was COVID positive in the hospital. The hospital physician is taking care of that patient and the patient was fortunately discharged home.

The hospital physician wants to follow up by telehealth but patient is out of their network normally. Do you know will they get paid for those follow-up services?

Demetrios Kouzoukas: Is that an HMO or PPO plan? What coverage?

Kathy Napeer: HMO.

Demetrios Kouzoukas: So it will depend on the plans policies or some flexibility that HMO plans have been provided to modify how they treat other network in COVID emergency. And the plan will be in a position to address that as well as the availability of exception request which is also at times appropriate irrespective of the patient coding.

Kathy Napeer: OK. Yes. All right, thank you very much.

Demetrios Kouzoukas: Welcome.

Operator: The next question is from Remy Kerr. Please state your organization. Your line is open.

Remy Kerr: Hi. Thank you for taking my call today. I'm with American Medical Rehabilitation providers with a patient. I would like to know when does CMS expect to issue greater clarification on the DDS DR coding issues and can you provide precisely which forms they should be included on? Additionally, should the E-modifier ever be used?

Diane Kovach: Hi, this is Diane Kovach. So I'm not sure of the E-modifier, the CR and DR clarification is in process so we hope to get that out soon. But I'm not familiar with the E-modifier.

Remy Kerr: OK. Thank you so much.

Operator: The next question is from Bob Bianchi of ClearSky Health. Your line is open.

Bob Bianchi: Hi, good afternoon. This is Bob Bianchi with ClearSky Health. We do inpatient rehab care for people with functional disabilities. And I think there

was a clarification today regarding swing beds and whether or not inpatient rehab hospitals qualified to request swing bed to use within the inpatient rehab hospital setting. Can you let me know is that accurate that they are able to do so?

Dave: Yes, that is correct. Inpatient rehab hospitals would be among those eligible hospitals to consider swing bed arrangement.

Bob Bianchi: Very good. I really appreciate that decision. I think it's helpful for the circumstances where skilled nursing facilities are not able to accept or willing to accept our patients. And so, I appreciate that clarification. Thank you.

Operator: The next question is from Gayle Tricoff. Please state your organization. Your line is open.

Gayle Tricoff: Hi, my name is Gayle Tricoff. I'm from Houston, Texas and I work with Memorial Hermann. We're a large hospital system and we bill on the UB-04 form. And my question is actually related back to Cara and to Rick's question.

Could you provide a little bit more clarity on the use of the PN modifier? Did you say that it was attached to be expected or the non-expected billing?

Tiffany Swygert: So accepted are... Go ahead, Dave.

Dave: Sure, yes. The PN modifier is for non-accepted off-campus provider-based departments. For an accepted off-campus provider-based department, you will bill the PO modifier.

In the case of these departments that are temporarily relocating and are seeking an extraordinary circumstances, temporary relocation request, those would bill the PO modifier to signify the expect to be accepted from the payment reductions.

Gayle Tricoff: OK, so if you are expected and you're using the PO modifier then we need to send that 10 regional offices the list of temporary addresses otherwise known as the patients addresses?

Dave: Correct. If you expect to be accepted off-campus provider-based department under the relocation, you would need to send the temporary extraordinary circumstances relocation request to the regional office providing the list of addresses at which you expect to be providing services in a different location than the normal department.

Gayle Tricoff: OK. And then if the PN and we're off-campus then we do not need to send the addresses, is that correct?

Dave: Right. If it was a non-accepted off-campus provider-based department before any relocation but then we continue to be non-accepted and we continue to bill with the PN modifier and would not need to submit a list of locations to the regional office.

Gayle Tricoff: Thank you. I appreciate your clarity.

Dave: No problem.

Operator: The next question is from Tricia Williams. Please state your organization. Your line is open.

Tricia Williams: Hello. I'm with CHS Therapy. My question is regarding during the Office Hours of 5/12, it was stated that don and doffing of PPE by therapist could we put it on the MDS as setup minute.

Other than the Office Hours transcript has this guidance been written, if so where is this documentation guidance located? If it has not, is there a timeframe of when it will be available? Also, will or does the written guidance specify whether the ability to count don or doffing PPE will end after the emergency or will it continue?

Karen: Hi, this is Karen. I don't have any specific answer for you on that but I can take that back to the MDF team for clarification.

Tricia Williams: Alright, thank you.

Operator: Your next question is from Tasha Osaso. Please state your organization. Your line is open. Thank you.

Tasha Osaso: Hi. I'm from the University of Chicago. I have a question in regards to codes U0003 and U004. According to CMS's ruling, these types of technologies require more intensive technician training.

We have a machine that we believe can be configured to meet the processing requirement of more than 200 specimens a day but we're not certain how to assess the more intensive technician training part of the requirement. Can you shed any light on that?

Ing Jye Cheng Swygert: Hi, it's Ing Jye Cheng. Sorry.

Male: There you go. Go ahead Ing Jye please.

Ing Jye Cheng: The ruling itself really talks about the quantity of test that can be performed in terms of defining the high throughput technology and I think the reference that you indicated to the training and the technician is really part of the rationale.

But the ruling, the code and the payment are specific to whether or not the high-tech throughput technology meet the definition in the ruling. And it sounds like you've gone through a process of assessing that.

So part of that intensive technician training and more time and intensive processes are not part of the definition of the high throughput technology, rather there's just in there to provide context about why CMS issued that ruling.

Tasha Osaso: Great. Thank you very much for that clarification. Appreciate it.

Operator: The next question is from Susan Stink. Please state your organization. Your line is open.

Susan Stink: Hi, Susan Stink with Baptist Healthcare System Inc. Our question is related to the swing beds in the new waiver. If we are – we don't qualify for swing beds normally so, the question is can that bed swing because the regulations are kind of conflicting as to whether we can have an acute care person in there one day and then swing beds skilled level patient in there the next day, and then when they're discharged use it for acute care again?

Karen: So this is Karen. So I think if I understand your question correctly that you don't normally qualify for swing bed but you're looking to see if you would qualify under the waivers to allow to that swinging as it works between the SNF level of care in PTS and the acute care. Do I have your question correct?

Susan Stink: Correct. We're just not sure if the beds can truly swing for us like they do for other facilities.

Karen: They can and that is that the intent of the waiver. There's some other criteria in there but you would be able to reach out to the care administrative contractor to enroll but that's really the intent is to allow for those individuals who are unable to be placed in a nursing home to be able to be retained in a hospital in that same bed and have the SNF level of care.

Susan Stink: OK. So there's a statement that says something to the effect of you can't have an acute level person in a swing bed but I think what they mean is you can't take an acute level person and bill them as a swing bed.

Karen: And that's right, and if this is would be after their hospital stay where they would normally be discharged and that's the intent of that statement. If others want to from CMS want to chime on that, please feel free to jump in.

Male: Yes. Just some additional context, more specifically the patient can only be an inpatient or a patient under a SNF PPS at any point in time. So as Karen was saying, the patient would be discharged from their inpatient stay if that was stated there and then be starting their skilled nursing facility PPS day. And they may be doing so in the same bed but they can only be in one status at any point in time.

Susan Stink: OK. And then if they get discharged then, we can put an acute patient back in that bed?

Male: That's right.

Susan Stink: OK, great. Thank you.

Operator: Our next question is from Tara Sosi. Please state your organization as well. Thank you. Your line is open.

Tara Sosi: Hi. I'm an in Oregon with Providence Health Insurance. I have a question about telehealth services. There were seven codes that were added to the fullest of CMS telehealth services, the spreadsheet as temporary additions for the PHE.

There's a column E on that spreadsheet, and it's titled Medicare Payment Limitation. So there are seven codes that when you look under column E, it states non-covered service, not valid for Medicare purposes, things like that.

So, my question is although these codes have been added to the spreadsheet, it would appear that these seven codes actually are not covered by Medicare or are they?

Dave: Right. So that's a really good question. So sometimes there are codes that are within sort of the – for lack of a better term, kind of the broader universe of codes that fall under either physician services or other kinds of services related to physician fee schedule services that aren't covered by Medicare or say pay separately by Medicare either because the program uses another payment policy or they're just not covered services, that stakeholders have requested that we identify as potential for telehealth services. And in that context the PHE, we've responded to those requests by adding those kinds of services that are similar to other services like the ones that would be on the telehealth list.

For more and informational purposes but it doesn't change the coverage of the payment policies surrounding those individual codes more broadly for Medicare part B.

Tara Sosi: OK. Excuse me. That's great. Thank you.

Operator: Our next question is from Jessica Rice of Island Hospital. Your line is open.

Jessica Rice: Yes, I am calling to see if there's been any change on hospital-based dietitians being able to provide outpatient diabetic and nutrition counseling via telehealth?

Tiffany Swygert: Hi, that's already allowed under the hospital without walls waiver not via telehealth but as a remote service. If an employee of the hospital who's not eligible to bill independently for professional services but is providing a service as part of the hospital service,

That's already allowed by virtue of the waivers of the provider base rules. So the patient's home can be determined to be provider-based and that's where the discussion that we were having earlier about the PO or the PN modifier being used comes into play.

Jessica Rice: So just like that the PT, the therapy services I must have missed the dietitian stuff on that.

Tiffany Swygert: Well, here this service the hospital services are still paid directly to the hospital and ...

Jessica Rice: Right. So as our therapy, we're hospital-based therapy as well.

Tiffany Swygert: Got it. OK, so yes.

Jessica Rice: Yes, so that would all be in the same concept anyway for billing?

Tiffany Swygert: It sounds like it, yes.

Jessica Rice: OK, perfect. That's all I needed. Thank you very much.

Tiffany Swygert: OK.

Operator: The next question is from Gina Ruiz of Casa Colonial Hospital. Your line is open.

Gina Ruiz: Hi. OK, I had a question regarding providing the remote service. If we temporarily expand our hospital outpatient department and provide outpatient therapy, since outpatient therapy is only paid according to the Medicare

physician fee schedule and not the OPPS, does it matter if we use the PO or a PN?

Tiffany Swygert: What matter is if the service is accepted or if the department is accepted or not. And so the modifiers apply at the department level. And if there's a relocation involved, you would follow the guidance and the regulation about use of the PO versus the PN modifier.

Gina Ruiz: Right. So we do have – we would normally bill with the PO because we would be accepted but the PO is just saying that we are allowed to be paid according to the OPPS, correct?

Karen: The PO is saying that you're accepted from the payment revisions under section 603 the bipartisan budget act. And so, once there's a relocation under that provision the regulation would otherwise require the PN modifier to apply.

In the case of therapy services, there is no payment change but the fact that that department itself, the department of the hospital if it relocates would otherwise be non-accepted and it applies for all services from that department.

So the PN modifier would be required – it's the only services just to say it another way, it's the only services that are being done are therapy services or services that are not otherwise reduce by use of the PN modifier then it may not be worthwhile for the hospital to submit a relocation exception request because there's not a payment differential but the PN modifier would still be appropriate in that case.

Gina Ruiz: OK. So since there were several therapy codes added to the telehealth list, we could just bill our therapy as telehealth? Is that correct or no instead of doing the ...

Instead of telling them to remove that one ...

Tiffany Swygert: Right. Yes, I think that's right and that's a different set of billing rules and Ryan can address that one.

Ryan: Right. We're still working on making sure that we have the guidance correct for release for telehealth services that are therapy services billing institutional claims. So that guidance is forthcoming but otherwise, the billing under the hospital as you've talking about would result or should result in the same payments.

Gina Ruiz: OK. So if we are going to go ahead and temporarily expand the hospital outpatient department, we're going to use the PN modifier just because it would be non-accepted at this point?

Tiffany Swygert: If you're not requesting a relocation, a temporary relocation that's correct.

Gina Ruiz: OK.

Ryan: And understood that this is a confusing set of circumstances but the payments would be the same for the outpatient therapy services that are paid the physician fee schedule rate in either case.

And again we're anticipated being able to release guidance varies in the immediate future addressing the outpatient therapy billed by institutions furnished via telehealth and that would result and should result in the same payment as well. But that guidance is forthcoming.

Gina Ruiz: Well, to be honest, we're not really concerned as much about the payment reduction as we are about the compliance issue so we just want to make sure that we are submitting the billing correctly in case there is an audit in three years and everyone forgets about what happened here.

Ryan: Right. And we certainly appreciate that and that's why we're trying to make sure that we get the guidance right and that guidance is forthcoming.

Gina Ruiz: OK.

Ryan: Thank you.

Gina Ruiz: Thanks.

Operator: Our next question is from Lorraine Taylor. Please state your organization. Your line is open. Thank you.

Lorraine Taylor: Hi, I'm with Ausgrid. My question is for an FQHC that's going to be doing drive-through COVID-19 testing at a high school location. Can they bill the 99211 specimen collection fee and if so, would they bill the normal place of service associated with the – or would they bill the mobile testing place for service 15?

Ryan: It's for physician practice?

Lorraine Taylor: Yes.

Ryan: I think it could depend in scenarios like the one that you described at a high level, I think either of those place of service codes could be appropriate and I'd recommend contacting your local Medicare administrative contractor for more specific advice.

Lorraine Taylor: OK. Thank you.

Operator: The next question is from Krysta Berns. Your line is open.

Krysta Berns: Hi, this is Krysta. I'm from MD Anderson Cancer Center. My question relates to the originating site C but with a twist. So if a patient is on our campus, say they're in the clinic but the doctor is off-campus maybe for infection control reasons or whatever, is there ever a scenario where we would bill the originating site C and the facility E&M or those mutually exclusive? And then depending on your answer, I have a little bit of a follow-up.

Ryan: I'll start and ask Tiffany to jump in if I get something wrong. So I think as a general principle in the scenario where the patient is located in the hospital, if there are hospital services that are being furnished in addition to or distinct from the professional services like the visit experience via telehealth, there's nothing that would prohibit or suggest that you shouldn't report those hospital services.

But if the purpose for the visit is solely the – in the extent of the hospital services is really to serve only at the originating site and the professional service of the distance site practitioner physician is the service and that's a scenario where the Q-code would be billed along with the professional billing of the physician service. But there wouldn't be a separate or additional service furnished by the hospital.

Krysta Berns: OK. So my twist is this, we have cancer patients and they have a bunch of different specialists and we'll have someone on campus and they'll have three visits the same day back to back to help them with their time.

Maybe they go and then they see one of their specialist, maybe they see their oncologist in the office and the oncologist staff rooms the patient and we bill that like a normal visit. And then maybe afterwards, they stay on an extra 30 minute and have a video visit with their radiologist and the radiologist nursing staff is the one facilitating that video visit.

In that situation, would it be appropriate to bill the facility E&M for that oncology visit and then an originating site fee for that radiology visit that came next?

Ryan: So I think as long their distinct services then, it could be appropriate as again, I would want to give specific advice but under the general confines of the kind of scenario you described where there's multiple visits from different professionals, in other words there was distance like telehealth professional service provides to a patient located within the hospital wouldn't necessarily preclude the hospital from in addition furnishing separately identifiable visit from a different professional in person and then billing for that service as well.

Krysta Berns: OK, thank you.

Operator: The next question is from Hope Wittenberg. Please state your organization as well, thank you. Your line is open.

Hope Wittenberg: Hi. I'm with the Council of Academic Family Medicine. Thrilled to finally get through to ask my question, appreciate it.

I have two questions both related to the primary care exception. In those interim final rule, a comment has been made that all levels off of outpatient and services furnished in primary care centers in the primary care exception are included in the primary care exception but the list of codes and services that you've included in the second rule do not include the 99204s and 5s and 99214s and 5.

So the question, are those codes actually included in the primary care exception during the public health emergency.

Ryan: I think that they are. Are you putting up that there's a discrepancy in the text in terms of the narrative description on the list of codes, is that ...

Hope Wittenberg: Correct.

Ryan: OK, well ...

Hope Wittenberg: There's the (inaudible) but the actual rule hasn't been updated, it's still the limited complexity.

Ryan: And when you're talking about the rules, do you mean the rules appeared in the Federal Register or I just want to make sure I understand where the locations that you're looking at.

Hope Wittenberg: So both interim final rules as they were published for display had those comments that all levels are included. But then in the second one, when they actually listed the codes for the primary care exception, they did not include those codes.

Ryan: I see. We will take a look at that. I think when the narrative discussion and the intent is follow those rules, would have included them but we will double check and make sure to just take from that.

Hope Wittenberg: So that would be great. Can I have a follow-up on the exception of the question? Since the preceptor can do remote precepting after the visit, the initial rule the supervision can be met with interactive communications technology within the second rule said you're going to make changes,

clarifying changes saying audio, video, real-time requirement for communication.

And does that mean that the preceptor can't supervise following the visit with the resident by phone? In other words, why would the preceptor have to see the resident in order to supervise following the visit?

Ryan: In terms of following the visit so as I understand that the change was similar to the direct – the change for direct supervision so the audio video is focused primarily on the availability during the provision of the service.

And I think, I don't know if anyone else on the call can answer the specifics in terms of the review with the resident following the service whether or not we address that specifically in a – that's something that we can get back and clarify as well.

Hope Wittenberg: That would be terrific. Thanks very much. Appreciate it.

Ryan: Sure.

Operator: The next question is from Lori Digel. Your line is open. Please state your organization, thank you.

Lori Digel: Yes, hello. Thank you. My organization is Traveler Associates. And my questions about rural health. Rural health have to bill telehealth and the G2025, but how would they report annual wellness visit to ensure that the cost sharing is waived and the common working file is updated?

Ryan: Thank you for that question and that's a really important question that we're working on an answer to you actively. Unfortunately, I don't have an answer for you today but we're working on it, hope that guidance soon,

Lori Digel: Thank you.

Operator: The next question is from Johanna Diseleri. Your line is open. Please state your organization as well. Thank you.

Johanna Diseleri: Hello, my name is Johanna Diseleri. And I work for Collaborative Health Systems. I'm part of an ACO. And one of our question is what do we do about wellness visits? Should you have approved the initial wellness visit and also the subsequent wellness visits?

But our providers are concerned about the reporting of the vital signs so we had our members that are not able to have access to a video so as you approve these services under the audio service only also.

So what would you recommend for our providers because their concern of future audits and is then unable to report vital signs for example?

Ryan: So one of the clarifications that we've made is that at this time, patient reported the vitals could be submitted as part of that visit in order to meet those requirements. Beyond that, I would say that at present the requirements of the service both on the coding and the statutory requirements, need to be met in order to report that code.

And so, when the patient reported vitals or other aspects of the service can't be met and they both shouldn't be reported. That's on the list of things that we're actively taking to look at by giving requirements, it's certainly challenging though we understand the importance of the need for beneficiaries to continue to have access to those service. So we appreciate the question.

Johanna Diseleri: Thank you very much.

Operator: The next question is from Heather Clark. Please state your organization. Thank you. Your line is open.

Heather Clark: Hi, my organization is Fulton County Health Center. And I believe you've answered my question tonight. What my understanding from what you've said tonight, we're a critical access hospital method one and so currently we do not have to report the PO and PN modifiers, so I take it that we still would not have to do that when we're using the patient's home.

And then also, since we're not getting reimbursed in your OPPS, we would not need to do the notifications the CMS regional office, is that correct?

Dave: Right. That would only apply if you were billing solicitors under the OPPS and would not be.

Heather Clark: OK. Great. Thank you.

Operator: The next question is from Melanie Hansel. Please state your organization as well. Thank you. Your line is open.

Melanie Hansel: Hi. I am with Marshall Medical Center in Placerville, California. I have a question about the telephone calls. We are provider-based departments of the hospital and when you designated the 9944X codes as telehealth a couple weeks ago, my question is does that mean we can bill an originating site fee with those?

Ryan: Yes, because those services are now on the telehealth list when all of the other conditions are met, the originating site facility fee could be reported.

Melanie Hansel: Excellent. Thank you.

Operator: The next question is from Margaret Hartscrab. Your line is open. Please state your organization as well. Thank you.

Margaret Hartscrab: Hi. This is Margaret Hartscrab and I am from Central Maine Healthcare Systems in Maine. My question related to a rural health center. With the temporary expansion locations, can that be inclusive for rural health center to have that temporary expansion to the homes and have the ability to charge the Q3014?

Ryan: So I don't know if others want to take this but I think for generally speaking for the rural health clinics as well as the federally qualified health centers, there's specific rules for furnishing telehealth services.

And I think those rules would apply but I don't know if there's any other piece that I'm missing Dave? If you have any other thoughts?

Dave: Nothing else to add from me.

Margaret Hartscrab: I didn't quite understand so you're saying no to the expansion locations from the home to qualify the originating site at the home?

Ing Jye Cheng: Hi, this is Ing Jye. I think your questions has a couple of different parts, right? The first question, the first that is whether or not the rural health clinic can through CMS hospital about walls initiative expand to consider the home, the patient's home part of the rural health clinic.

And I don't believe the waivers that we issued that kind of constitute the hospital without walls initially extend to rural health clinics, we can double check that on our side but they were really specific to hospitals so to the that hospitals were treating a patient, considering a patient's home as part of the hospital, that's what those waivers – the situation those waivers were meant to address.

I don't think they really contemplated a situation where RHC would want to be providing care in the patient home and thus considering the patient home part of the RHC. I don't think those waivers go that far but can certainly take that back to our colleagues and look into that.

Margaret Hartscrab: That would be great. I was just reading the temporary expansions that were allowable but it wasn't in direct reference to the home. Would that be updated in frequently asked question or should I just send an e-mail to obtain that for more answer?

Ing Jye Cheng: I think to be sure that we get back to you, if you don't mind sending an e-mail that way ...

Margaret Hartscrab: Sure, yes. Great. Thank you.

Ing Jye Cheng: ... circle that back. Thank you.

Operator: Our last question is from Watson Ty. Your line is open.

Watson Ty: Hi. Did you say Watson Ty?

Operator: Yes ma'am.

Watson Ty: OK. Hi. I'm from Boulder Community Health. I have a question on outpatient provider-based department providing a PT/OT/speech therapy through using a telecommunication under the waiver without walls.

Do we need to go through that re-location process because they are all paid under the fee schedule?

Dave: Right, so the temporary – extraordinary services is temporary relocation request is only needed if you're going to be billing for services under the OPPS and want to maintain that OPPS rate compared to the PFS rate.

If you only service you're going to be providing is paid at the PFS rate anyway then you can have just bill it as the PN modifier and it will be paid the same rate and you won't have to do the extraordinary circumstances relocation.

Watson Ty: OK. So we still need to put the PN modifier even though there is no payment differential?

Dave: Right. But it will be paid the same.

Watson Ty: OK, great. Thank you. Appreciate it.

Alina Czekai: Thank you everyone. We are at 6:00 Eastern. We appreciate you joining our call today. In the meantime, if you have additional questions, you can submit them via e-mail at covid-19@cms.hhs.gov. This concludes today's call. Have a great rest of your day.

Operator: Ladies and gentlemen, this completes today's conference call. Thank you for participating. You may now disconnect. Have a great day.

End