Centers for Medicare & Medicaid Services
COVID-19 Office Hours
June 9, 2020
5:00 p.m. ET

OPERATOR: This is Conference #: 4892554.

Alina Czekai: Good afternoon, thank you for joining our June 9th 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 provides an opportunity for providers on the frontlines to ask questions of agency officials regarding CMS' 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 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 cms.gov/newsroom. Any non-media COVID-19 related questions for CMS can be directed to COVID-19@cms.hhs.gov.

We'd like to begin our call today with some brief updates on recent CMS publications and guidance. Last week, CMS published the first COVID-19 nursing home data release, which includes results from over 5,000 surveys, as well as the data that nursing homes have been reporting to the CDC's National Healthcare Safety Network. The data as well as FAQs around the methodology, and an overview of the initial results can be found online at cms.gov/newsroom, under the press release link for nursing home COVID-19 data and sections results.

Additionally, last week, HHS announced the new laboratory data reporting guidance for COVID-19 testing. The standardized reporting outlined in this guidance will help capture critical data to better monitor disease incidents and trends. The new laboratory reporting guidance and FAQs can be found on

cms.gov coronavirus website under the section, Clinical and Technical Guidance for Labs.

And today, we also wanted to address a couple of questions at the top of our call. We received a request for clarification on outpatient therapy provided to a patient at home. And we wanted to confirm that hospitals can indeed bill one of two ways.

The first being the therapy is treated as telehealth, and the hospital bills a UB for institutional claim with the 95 modifier. Or alternatively, under Hospital Without Walls, the hospital can bill OPPS with the requirement to make the extraordinary circumstances temporary location request listing the home address.

And we received another question. In the last iteration of CMS's COVID-19 FAQs, CMS clarified that PAs could provide and bill for inter-professional telephone/internet/EHR consultation, which is codes 99446 to 99449, and 99451. And the question was, it is our understanding that CMS had clarified that these codes could be bill by practitioners that can bill Medicare independently for E&M services in the 2019 Medicare fee schedule final rule, and that this policy would not be limited to the public health emergency.

And we wanted to clarify that the response is yes, that FAQ explains existing permanent policy. So those are the questions that we wanted to ensure we addressed at the top of the call.

And with that, operator, we are glad to open up the phones to take questions from the audience. Thank you.

Operator: All right. Again, just a reminder, to ask a question you'll need to press star then number one on your telephone. To withdraw your question, press the pound key.

Your first question from the line of Arik Galenda. Your line is now open.

Arik Galenda: Hi, thank you. My question is in regards to a physician-owned practice that employs a physical therapist, and I'm going to bring up the in-office ancillary

services exception that allows them to do that. And they can hire a physical therapist. A PT can treat a Medicare patient, and then bill for those services either under the PT's NPI number, if they're enrolled in Medicare, or incident to the physician if the physicians on the premise.

My question is, can a PT, in part of physician's own practice, also go to a Medicare beneficiaries home, treat them as an outpatient in the home, bill under their NPI number with the money reassigned to the physician group that they're employed with? Or would that be in violation of the in-office ancillary services exception? Hope that makes sense.

Demetrios Kouzoukas: So your question really is a Stark question, so then the reimbursement side.

Arik Galenda: Correct. Because these people wanting to go into their homes to treat them as outpatients now because of COVID, maybe not coming into the office. So not only I guess, during the COVID-19 pandemic, but even after that. Because to me, I thought it would, quote, "(body) that in-office ancillary exception that they'd have to come into the doctor's office."

So I guess the question is, can that happen? Can they go into a person's home if they're employed by a physician? Yes. So, I guess, it comes down to the Stark and office answer exception.

Demetrios Kouzoukas: OK. I don't think we have our Stark folks here on this call today, but we can definitely take that question and go back. I know, we did provide it a long set of Stark waivers, but I'm not sure I'm recalling any of them really addressing this particular point. So we'll take that back.

Arik Galenda: Correct.

Demetrios Kouzoukas: Yes.

Arik Galenda: OK. And I guess I would not only ask this for the Stark waiver during COVID, but even I guess once the COVID pandemic is over, would that even be allowed as well? I think I'm asking for both ways.

Demetrios Kouzoukas: OK. Understood.

Arik Galenda: OK, thank you. I appreciate it.

Operator: All right, thank you. For our next question from the line of Brad Boldings. Your line is now open.

Brad Boldings: OK, thank you. So I have a telemedicine question. I think you've addressed before, but just want to be clear. So is there any situation where CMS would reimburse for a telemedicine procedures, say for example the physician at his house, the resident and the patient in the office. And it's a minor procedure, say, dermatology, taking out a mole, freezing a mole or something like that. And there's video and audio capability.

I haven't seen any guidance to that effect. But I was just wanting to check and see if there are any circumstances where you all would reimbursed for that?

CMS: So, the rules have changed relative for teaching physicians to allow for virtual presence to take the place of the direct supervision, that's required but not necessarily for all procedures. And I think for individual services, you'd have to look at which group of services. And I don't have it off top my head, but there's a description of the various scenarios in the second interim final rule. And we can go back and take a look at where best to point you for the individual procedures.

So, overall, when the direct supervision requirements could be met, they could be met virtually. But in cases where the physician – there are certain services where the physician needs to be physically present in order to bill. And again, we can take a look and identify the right place to send for that information for specific codes.

Brad Boldings: So where would I go to get that follow up?

CMS: We can try to get you that, either later in this call or before or for next week's call. Or you – Alina, I don't know if there's an email.

Alina Czekai: Sure thing, you can ...

CMS: If you have it there, let me know.

Alina Czekai: Absolutely. You can direct it to COVID-19@CMS.hhs.gov.

Brad Boldings: OK, I appreciate that. But I have submitted questions that, before, and they seem to go into a black hole, but I know you're getting inundated with questions, but I can try that again. And I appreciate it. Thank you.

Alina Czekai: All right, thank you. Thank you. We'll take our next question.

Operator: All right, thank you. For our next question from the line of Canyes Webber. Your line is now open.

Canyes Webber: Hi, good evening. We actually had a follow up question to last week's call. And we did clarify with you that for hospital outpatient departments where we have the patient's home registered as an extension of our facility, and we meet the definition of our CPT codes where appropriate, we would split bill the G0463 on an institutional claim or UB-04.

The question that came up after the call is whether or not that telehealth service E&M, when it's done virtually and does split for the G0463, UB-04, do we need to utilize Modifier 95 as an informational modifier in addition to the PO and PN, or is it strictly the PO and the PN necessary

Tiffany Swygert: Hi, this is Tiffany. And I think we're – there a lot of parts to your question, so we're trying to figure out who best should answer it. It sounds like the crux of your question is whether the Modifier 95 should be appended to the hospital claim when there is a professional who's billing a telehealth service, is that right?

Canyes Webber: Correct, yes.

Tiffany Swygert: So the professional claim, as I understand it, and others on the line should correct me if I get this wrong, that service is the telehealth service. And if there is a telehealth service being furnished to the patient who's a registered hospital outpatient, the hospital in that instance would be billing the originating site fee, not the clinic visit code. And so, I'm not quite understanding the scenario, but if there was an instance where the hospital was billing a payable service that the hospital was furnishing, that's not considered a telehealth service. So the 95 modifier would not be required in that instance.

Canyes Webber: OK. So I believe the understanding we had previously is the telephonic services, when rendered would qualify for the Q3014. But where we would meet an interactive virtual visit where a traditional E&M service would be billed in a normal place of service being 22, as the hospital outpatient department that CPT code pre-COVID would split with the UB, and we would bill professional component on the 1500. And we would bill the facility component using the G0463 on the UB.

So you're stating that's not true during the COVID, that we would need to use the Q3014 even though we've met the definition of a standard E&M, although it would be rendered virtually, through the PHE.

Tiffany Swygert: Yes. Marianne may want to also expound on this, but the critical piece that was mentioned in the interim final rule, the second one that we issued, talked about the hospital's ability to build for the originating site fee when the telehealth service was being furnished. So if the hospital is sending folks out to the patient's home, which is functioning as a provider based department of the hospital, that's a different scenario. But in the scenario that you're describing, what – the regulations that we've established for that situation would allow the hospital to build the originating site fee in that instance.

Canyes Webber: And is the 95 required on the originating site fee?

Tiffany Swygert: No.

Canyes Webber: OK.

Tiffany Swygert: I don't think so. Diane, correct me if I'm wrong on that.

Diane Kovach: You're correct.

Canyes Webber: And that originating site fee will go on the UB while the professional goes on the 1500, correct.

Tiffany Swygert: That's right.

Canyes Webber: OK, perfect. Thank you very much.

Tiffany Swygert: Thank you.

Operator: All right, thank you. For our next question from the line of Nicole Humphreys. Your line is now open.

Nicole Humphreys: I wanted to follow up on a question that I submitted online and it relates to new patient versus established patient. So in the previous visit was phone visits with 99441 through 99443, was the next visit and the outpatient clinic be a new or established patient visit?

My understanding of new patient versus established has always been a new patient is one who has not received a previous face to face visit within the last three years. And I think where we're getting confused is, the example in Chapter 12 basically gives an example of an E&M service or other face to face service. And some of us are taking that as the E&M service being face to face or non-face to face.

CMS: I think just to make sure that we understand your question. So the scenario is that, the telephone evaluation management services furnished to a patient who's new to the practice, or at least within three years new. And then subsequently there's an in-person visit, and the question is about whether or not the that subsequent in-person visit would qualify as a new patient visit or should be reported and established. Is that the question?

Nicole Humphreys: Correct, correct. Yes.

CMS: OK. So I think we're – we still need to make sure that we can answer that question rightly. I mean, I think that the issue for Medicare purposes is that the telephone evaluation management codes weren't separately payable prior to the PHE. So I don't know that we've definitively answered that question.

I think – though, in general, I would say that we defer to CPT when we don't have specific guidance as a general principle for correct coding, and the CPT codes for the telephone evaluation management visits do exist. And so, if there's applicable CPT guidance, then I think Medicare would adhere to that. And other than that, I think that's something that we need to continue to work on.

Nicole Humphreys: OK.

CMS: Apologies that it's taking a little bit of time, but it is a new repayable service, and that's why.

Nicole Humphreys: OK, sounds good. Thank you so much.

Operator: Your next question comes from the line of Matt Strange. Your line is now open.

Matt Strange: OK, thank you. Can you hear me?

CMS: Yes.

Matt Strange: Can you hear me? OK, great. My question was in regards to CMS's ruling from April 14th on high throughput technologies for laboratory testing. And I know you've talked about this a couple of times on these calls, but we just wanted to confirm our interpretation.

Our understanding of the 200 test threshold is that all needs to be on the same platform. We have an advisory opinion from one of our vendors that even if it's under multiple modules, or multiple machines, as long as it's the same platform and as long as we meet the 200 tests a day threshold then that would qualify as a high throughput technology. Can you confirm that for us?

Ing Jye Chang: Hi, this is Ing Jye Chang. I think that we can certainly confirm the definition that we included in the ruling, which is as you described the 200 tests per day. I think that, you know, we are not in a position to advice as far as individual specific machines. The ruling did provide some illustrations and examples of some machines that are out there. But certainly technology is evolving very quickly.

And so, would defer to you to make that best judgment about whether or not the 200 tests per day threshold would be met.

Matt Strange: OK, that's fair. Thank you.

Operator: All right, thank you. For our next question from the line of Stacey Hill. Your line is now open.

Stacey Hill: Hi. Thank you for taking my questions. My request is in regards to transitional care management. For the well-being of our patients, have CMS considered allowing transitional care services as a phone only visit by chance?

Ryan: So, we did consider the visits that are contained within the bundled codes like the transmitted external care management services. But I think for simplicity purposes under the context of the of the PHE, the use of the audio only or the telephone evaluation management visit codes, we think are the most appropriate.

Stacey Hill: OK.

Ryan: For potential audio-only, understood that the Transitional Care Management, they are not face to face work, and they certainly need to continue for the patient's sake as you're pointing out. And so, I would suggest that you take a look at the other care management services that might be relevant. For example, chronic care management services, which describe the non-face to face services without the visit packaged in, as you probably well know.

But I think in certain cases where patients are requiring the non-face to face care following discharge from the facility, it could be that some of those other non-face to face care management codes along with the (tele) could be

reported. And then the visits could be reported to the telephone evaluation management calls.

Stacey Hill: OK. And also one other thing is, is there an end date for all of these temporary policies? Are we still just kind of flying by the seat of our pants?

Demetrios Kouzoukas: The policies are almost all linked to the end of the public emergency, so there's not a defined date.

Stacey Hill: OK.

Demetrios Kouzoukas: But I hope not quite seat of the pants, but I appreciated a definite date, there is a marker though.

Stacey Hill: OK, perfect. That's what I needed to know. Thank you.

Operator: All right, thank you. For our next question from the line of Margaret Harts-Grove. Your line is now open.

Margaret Harts-Grove: I had to unmute, I'm sorry. I apologize. My question was already addressed and I am confused with the response. I am confused with the understanding of the split billing on from a hospital provider-based department that has expanded into the homes.

I did have the understanding from the prior call, on June 2nd, that there was an opportunity to bill the G0463, and I know that that was just a draft, you stated, no, that it should be the originating site fee. So I'm probably not the only one that was confused with the response that was provided on a prior call. So, either have to re-listen or has there been definitive a question and answers published yet, with regards to all these various questions with the expansion in the home locations and the billing opportunity that's more defined in the Federal Register?

CMS: So, first of all, I want to apologize for any confusion. I think this is a, as you all are facing the challenge of reporting the services appropriately, we're certainly listening and taking all of that into account.

And so, I think what's clear is we need to issue additional verbiage that will help clarify, under which scenarios the Q code would be reported for by the hospital versus the clinic visit. And I think, not to belabor the point, but I think the – it becomes complex, given the flexibilities, the intersection of flexibilities under telehealth reporting with the Hospital Without Walls.

And so, for all the same reasons, that it's challenging for you and you need answers. We're working hard to make sure that we have the nuance is clearly delineated. And we'll continue to do that. But we appreciate all of the questions and the continued feedback.

Margaret Harts-Grove: Would these be, as a follow-up, would these specific questions to the expansions and the confusion, would they be posted in a separately identifiable Q&A? So would they be bundled in with the Medicare fee-for-service or an existing listing already for question and answers?

Diane Kovach: Hi, this is Diane Kovach. They'll be bundled into the larger FAQ document that already exists, but there are headings that should be able to make it easy to find the questions. And there are also indicators for when a question has been added.

Margaret Harts-Grove: OK, thank you. We're just getting variants of holded claims and was ready to submit claims as we thought were appropriate.

Operator: All right, thank you. For our next question from the line of Christina Marciano. Your line is now open.

Christina Marciano: Hi, thanks for taking my call. I'd like to get some additional clarification on the billing for an HOPD in a telehealth environment or extending into the patient's home specifically with billing the Modifier 95 on the UB-04. Most of the documentation indicates that you have to bill a place of service 02 with that Modifier 95 when you bill on telehealth or as an extension of the HOPD into the patient's home.

So on the UB-04, there's not a place of service. So the instructions that came out, you know, are asking us to do something that's not even physically possible on the claim form. So is the interpretation then, since it's not an

available filled on the claim on the UB-04 that we just bill with the Modifier 94 – 95, excuse me, and then the type of service is implied?

CMS: So the – just for a couple of clarifying points. For Medicare telehealth services, under the – for the duration of the public health emergency, Medicare telehealth services should be reported with the 95 modifier and not the place of service code 02, but rather the place of service that the – should be used where the service would have taken place had telehealth not been necessary. But that really applies to the billing for what are technically both from a legal perspective and a claims perspective are, technically, Medicare telehealth services.

So those are professional services billed on the professional claim and in certain other cases on institutional claims. But generally, the services reported by the hospital wouldn't be technically Medicare telehealth services, even if they're furnished using the technology that would be used to furnish telehealth services.

And those are – that's why those would be reported even if they're furnished using that same kind of technology, under the flexibilities, under Hospital Without Walls, et cetera, those will be reported not as telehealth services. And I'll let others weigh in to make sure I've gotten it right.

Christina Marciano: Yes, please. Because – that would be great because the – I did actually email my question in last week in the response that I got back was even more confusing. So I'm really looking and I feel like a lot of others have similar questions around this. So – and I can – yes.

CMS: I think one of the – one of the clarifying points, and this is a little speculative on my part. But we recently issued guidance, making it clear that for outpatient therapy services when billed by an institution could be furnished and reported for telehealth and that would be using the Modifier 95. So that would – that allows for institutions like hospitals to report for outpatient therapy services using the 95 modifier.

And it's a nuanced distinction, but those outpatient therapy services are in fact Medicare telehealth services from the both a legal and a claim's perspective.

But the – that modifier really would be used for those cases, the hospitals would be using that modifier. But I don't think that they would use the modifier for other services.

And so that may be part of the point of confusion, and we can certainly take that back and try to continue to work on how to talk about it in a way that's clear.

Christina Marciano: OK. And that would be great because on the – because there's – so if we bill as a telehealth, say we do physical therapy, PT/OT speech as a – under telehealth, then we would bill with Modifier 95. So how would we accommodate that site of service requirement that was in the most recent FAQs. Because that's where I'm struggling, that's not physically possible on a UB-04 because that fills in box that doesn't exist.

CMS: Understood. And so, that's an important distinction. And so, for telehealth services like outpatient therapy services that are claimed, that there is no requirement for place of service coding, even for telehealth services. And so that's true for any of the telehealth service reporting an institutional claim.

And if it's helpful, another example under – cost billing under method two report, their professional services on institutional claim and the same policy where would apply for those, where the place of service coding rules wouldn't apply for those services either. But we can go back and look and make sure that we clarify that.

Christina Marciano: OK, that's a great clarification. Thank you for that. And then just to tandem off of that. Now, we can – for specific outpatient therapies and I'm talking speech, PT, sleep, you know, nutrition counseling and diabetes management counseling. So with those therapy types of care, you know, we can bill them as telehealth and/or we can bill them as a Hospital Without Walls as a temporary relocation request.

And the difficulty I have is, there – is our – is one paid differently than the other? And I understand the – PN and – that's outside the PN and PO modifier clarification. But I'm trying to delineate when should I bill this telehealth and when should I bill it as a relocation of the hospital HOPD?

David: So, in the case of billing it as a relocated hospital provider-based department, that would be the case when that provider-based department has submitted a temporary relocation request for the department that's providing the service. But, as you know, or the PO and PN modifier only have a payment different – make a payment differential for OPPS services. So if it's a service that isn't paid under the OPPS, you know, those modifiers wouldn't have any impact for something like therapy service, which is not paid under the OPPS.

Christina Marciano: OK. Last question will be, it's just – I'm struggling with understanding when I should bill those services as telehealth and when I should bill them as a temporary relocation. So what would you recommend as a decision tree for that? Because it looks like we could do it either way, and both would be acceptable or is that the answer?

I'm trying to ensure that we're really compliant so I apologize for the repeated question.

CMS: No, it makes a lot of sense. And I think it's – we would all agree that it's relatively confusing scenario when there's an option and it's not clear which – which is – which we would recommend. But I do think because hospitals have both the flexibilities for the Hospital Without Walls and the billing for the professional services for – under the outpatient therapy. I think that those intersect.

And so the – it really is, for the most part, assuming that the rules have been met for both. One of those flexibilities, it would really be at the discretion of the hospital as to which of the – which approach they take to exercising those flexibilities under the PHE.

Christina Marciano: OK. Thank you. That's helpful. And then lastly, if we bill as a, under telehealth, what's the related fee schedule that goes with the telehealth? Is that the physician fee schedule?

CMS: Right. So for telehealth services, they're paid under the rates for the physician fee schedule.

Christina Marciano: OK, perfect. Thank you so much. I really appreciate the clarification. I just want to make sure above all that we're as compliant as we can be as rules change. So, thank you.

CMS: Thank you.

Operator: All right, thank you. For your next question comes from the line of Barbara Caboze. Your line is now open.

Barbara Caboze: Hi, how are you doing? Thanks for taking our calls. We were listening to an NGS webinar on the telehealth, and they indicated that when doing phone calls because of the definition of not being able to having that seven-day limit, that you're unable to do a phone call with a patient within seven days. So if the patient needs follow-up, within seven days, they wouldn't be paying for it.

And I'm addressing a patient that does not have access to video, not that it's convenient for the doctor. The provider has the ability to do audio video, but because the patient doesn't have audio video, they're doing telephone calls. And the concern I have is, there are patients that sometimes need follow up, you know, like that virtual check in or follow up that, you know, maybe the change in the blood pressure medicine is working and they're doing OK, or the patient may have another condition that needs to be addressed within that seven-day window. And NGS is saying because of that CPT definition of these codes, which really weren't designed to handle a long term telehealth type situation that we're in, that we can't charge them within that seven-day window.

And they sort of implied that we should add the time between multiple calls in that seven-day window, add them together and just charge one and use prolong services for all the time. And this doesn't seem right to me.

CMS: So it sounds to me you understand the way that the bundling of the telephone evaluation management codes works. And I think that this – in cases where patients and beneficiaries require additional time that is, in fact, what the prolong services code are designed for. I think we certainly understand that under the context of the PHE, the – sometimes the technology limitations for in particular circumstances might result in coding and billing not being

exactly the way that the codes were envisioned outside of that context. And that's part of the reason why we are continually updating the guidance and changing the rules.

That's all to say that I'm not sure that the – that the questions that you're asking are answerable here in terms of the current policy, but we'll continue to think about that. And when we certainly do recognize that, that in the broad range of patient and provider circumstances, that all of the flexibilities may not be optimal in all cases.

But again, I think that the coding prolong services is intended to address the circumstances where beneficiaries need particular amounts of care.

Barbara Caboze: So, so using time, extended over multiple days, and just doing it on a single day, with prolong services would be acceptable?

CMS: So I think you need to look at the ...

Barbara Caboze: From a coder's point of view, that's raising the hair, my hair, and like ...

CMS: Sure.

Barbara Caboze: Like no.

CMS: No. And thank you for the opportunity to clarify. I think that my intention there is just to point out that the way that the coding is intended to reflect the ordinary circumstances where patients need additional time, and I think a lot of the flexibilities that we've tried to provide during the PHE are meant to account for as many of the particular circumstances as possible. But in some cases, aren't able to do that.

And so, I think that that's sort of an inherent limitation and we can go back and think about whether or not there are additional flexibilities that we can offer. But I do think that the – not that the coding rules shouldn't be followed, but that you really need to go back and look at the coding rules.

And if there are additional flexibilities that are needed, I think we can continue to think about that and appreciate hearing about.

Barbara Caboze: Something that may be considered is, especially if the patient has a new problem, you know, will it be appropriate to pay for it with a 24 modifier? Because basically as a seven-day global and, you know, would it be appropriate that if the patient has a different problem in that seven days, a 24 modifier would indicate that but it's unrelated to the prior service.

CMS: I think on specific questions like that, I think it'd be really helpful to have that conversation with your MAC, who I think you mentioned at the beginning, but I don't recall, but ...

Barbara Caboze: NGS.

CMS: I think talking with NGS about under particular circumstances what – how they might respond to that, would be worthwhile and, again, we'll continue to consider.

Barbara Caboze: Thank you.

Operator: All right, thank you. For next question from the line of Arlene Kozar. Your line is now open.

Arlene Kozar: Hi, thanks so much for taking my call. You know, I was pulled into usually handle just our physician offices and I was asked to help out with an off campus outpatient hospital behavioral health clinic. And I've heard, you know, different conversations on here and I'm trying to understand this, but I want to make sure that I can help my organization bill these services correctly.

If I have this understanding correctly, and I did read the final rule and I was a bit confused but – so we have this off campus outpatient hospital behavioral health clinic. And our psychiatrist will do either telephone calls or video visits with their patients. And it's my understanding we would report those services on a 1500 Claim with the place of service we use would be 19, I believe, because it's an off campus outpatient hospital. We wouldn't use 02 because it sounds like with Medicare regs. You want us to use the place of service that we normally would, so that would be 19.

And what I'm trying to understand then is, in this instance, are we able to report this originating site facility fee on the UB, the Q3014, if we're – if we I don't know what we – I'm just trying to understand what we would need to do in that instance, like, are we able to report that facility fee or not in this situation?

Tiffany Swygert: I think this is what we were talking about earlier when we said, we probably should give some clarifying guidance, so I'll just reiterate that. And also that the hospital bill, you're correct, that there is no physician for a place of service on the hospital claim form. So that's not expected or required there, nor is the Modifier 95 which indicates that the service was a telehealth service and hospitals are not telehealth providers in general.

So, we will work and endeavor to issue some clarifying guidance and hopefully we can clarify some of the scenarios that are being asked about today to make sure that we're being as clear as possible. Thank you for your question.

We'll take our next question.

Operator: All right. Our next question from line is Ken Hawk. Your line is now open.

Ken Hawk: Hi, thank you for taking my call. So I just wanted to get clarification for physical therapy, particularly for therapists and the Code 99441. My understanding is that because the provider is not an MD, a nurse practitioner or a physician assistant, the 99212 should be utilized instead of the 99441 for a telephone-only visit. Can you give me some additional clarification because they think there's some misdirected communication and confusion out there that I just wanted to confirm on pertaining to Code 99441.

CMS: So, I should preface again with – I wouldn't want to give specific coding advice not having all the details. But the general principle, the 99441 code is the interprofessional, is that the one that you're talking, the interprofessional telephone?

Ken Hawk: Correct. Because clearly, basically the 99441 through the 4434 telephone related only visits, and then the clear definition within this PT guideline is

stating that it should be basically a provider-only, so it wouldn't be a therapist. And I just wanted to get some clarification because in some of the forums and I think from consultants that are out there, there's been kind of some relaxation.

But from everything that I'm reading, that code should not be utilized for a physical therapist or occupational therapist, or a chiropractor for telephonic related care.

CMS: I think, to be clear, I think some of the clarifications were making it clear that that code could be used by some of the non-physician practitioners who report E&M codes in general. But as you're pointing out, that wouldn't – those kinds of clarifications wouldn't apply to physical or occupational therapists for example.

Ken Hawk: OK, thank you. That's all I needed.

Operator: All right, thank you. For our next question from the line of Kelly Walsh. Your line is now open.

Kelly Walsh: Hello. Sorry if this question has been asked already, I jumped on the call a little bit late. But is there a date yet determined when like the ending of when telehealth extensions are going to end, when we're not going to be able to bill telehealth for all the new ways that we've been able to? Is there an end date yet been determined?

CMS: To the flexibility (inaudible) we have the public health emergency.

Kelly Walsh: Correct.

CMS: Right. So right now there's a current public health emergency that is in effect until, I believe the date is July 26th. But, of course, it can be extended. It's already been extended once so we don't know the precise end date at this time.

Kelly Walsh: OK. So we're at least good through July 26th as of now.

CMS: Correct.

Kelly Walsh: Perfect. Thank you so much.

Operator: All right, thank you. For our next question from the line of Nadine Heidemann. Your lines now open

Once again, Nadine, your lines now open.

Nadine Heidemann, your line is now open. You may ask your question.

All right. If we can proceed for our next question from the line of Candice Chaffin. Your line is now open.

Candice Chaffin: Hello. Thank you for taking my call. My question is in regards to incident two services. In the ambulatory setting, if the nurse practitioner in the office sees the patient and wants to perform that service incident to the provider, can the provider be available via video? Or does the provider still need to be available in the office? Has those rules changed for incident two during the pandemic?

CMS: Yes. During the pandemic, the incident to rules that require direct supervision, so presence of the billing practitioner being physically present in, say the office suite, can be met instead through being immediately available if necessary through audio video or virtual presence.

Candice Chaffin: OK. So those rules mimic the same – they're the same as the teaching position rules.

CMS: Correct, correct.

Candice Chaffin: OK. Thank you for clarifying.

Operator: All right, thank you. For your next question. Once again, your next question from Benjamin Marber. Your lines are open

Benjamin Marber: I am so sorry. I was on mute there for a couple of seconds. So – and I also apologize in advance because I think this question has been covered a little bit, but I did just want to try maybe a different way.

So my question is, going back to the issue of outpatient therapy services. So my question is, does the hospital have to register the patient with the regional office under the extraordinary circumstance relocation policy, if it bills Q3014 originating site fee code? And this question applies for both either telehealth E&M services billed under the PFS or telehealth therapy services billed under OPPS.

And again, really, I guess the bottom line part of the question is just trying to figure out if the hospital can bill that, that Q code, for the originating site fee. Thank you so much.

David: So for the – both the PFS service and the therapy service, basically would be no additional payment from registering a provider-based department as a relocated location in the patient's home as a result of, you know, result of doing that, you know, there wouldn't be any sort of change in the payment for those services that are not paid under the OPPS.

So, you know, that would not – that wouldn't be necessary to provide those services paid under other systems. You know, you would only be if that department was billing for other services at that patients – that patient's address as a relocated department of a hospital that it would, you know, become necessary to register that location as a relocated site of the provider-based department.

Benjamin Marber: OK, great. And if I may follow up there, so just give an example. So for instance, let's say in this case, let's say that the patient is registered in a provider-based clinic. So in that case, my current understanding is for a service, E&M service 99214, I know you'd attach the 95 modifier for telehealth. And so again, would we also add the Q code, the Q3014 facility originating site fee or no?

Tiffany Swygert: No. You're talking about the professional claim?

Benjamin Marber: Yes.

Tiffany Swygert: Yes. So the professional claim would include the professional services and applicable modifiers. The hospital claim, if the patients are registered hospital outpatient, is where the originating site fee Q code would be placed.

And again, to reiterate Dave's point, you don't have to apply for an extraordinary circumstances relocation. But if there are other services furnished from that location, which in this case is the patient's home, by the hospital, that means that all of those services would require the PN modifier. But if the only services that are being furnished from that off campus provider based department are services where the team, there is no payment differential regardless if it's accepted or not accepted, then the hospital can take that into consideration in determining whether they should submit a relocation request.

Benjamin Marber: Great, got it. Thank you so much.

Tiffany Swygert: Thank you.

Operator: All right. For our next question from Marie Hopkins. Your line is now open.

Marie Hopkins: Hi. Thank you for taking my call. I'm actually going to pass because you just answered my question.

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

Operator: OK. For your final question, from the line of Becky Peter. Your line is now open.

Becky Peter: Good evening. You're going to regret mine being the last call, or the last question on your call.

So I want to go back to the new lab data requirements. I had hoped in your initial update that you would have expanded a little bit more on that. So can you tell us again where that FAQ is, that you're referring to, because I'm having trouble finding it. I've been looking while I've listened for the new data reporting for lab.

David: So, sorry. I think you're – we are regretting, yes, but I want to make sure that we're understanding the question. So are you referring to the lab reporting under PAMA reporting, delay in reporting the multiple payer prices?

Marie Hopkins: No.

David: OK.

Marie Hopkins: So at the beginning of the call, when you're doing your updates, you mentioned the new data, lab data requirements that were published on June 4th. And the speaker said that there were FAQs addressing the (apps). And I went to the normal COVID FAQ where the other lab questions are, and I don't see anything about the data reporting elements.

So I wanted her to repeat what she said initially about where we can find FAQs regarding this new data reporting requirement.

Alina Czekai: Hi. I think we can answer your question. I can read you the website at HHS, which is the June 4th release. And within that June 4th release, there's a link to lab data reporting FAQ that hopefully will answer any detailed questions you might have. And I'll just read the link out and hope that I can get all the letters right in order.

So it's http://www.hhs.gov/about/news/2020/06/04hhs-announces-new-laboratory-data-reporting-guidance-for-covid-19-testing.html, that's F-O-R, not the number four, -covid-19-testing.html. And that is the news release the new laboratory data guidance for COVID-19 that the department released on June 4th.

And about halfway through that release, there is a link to the detailed guidance as well as the FAQs. Hopefully that answers your question.

Marie Hopkins: OK. Because I was looking at that and I didn't see anything that looks like FAQ or what you just read off. Oh, I will need to look through that.

Alina Czekai: There is a link, middle of the page. If you click on it, it's hhs.gov. And the file itself is laboratory-data-reporting-for-covid-19-testing-faqs.pdf. And it

has several pages of questions about how the guidance worked three pages of questions and answers, including, you know, when and how often we will be required to begin submitting testing data, will the required data be integrated into our EHR, what are the methods of submission, et cetera, et cetera.

Marie Hopkins: OK. So does it answer the question of, you know, back on March 27th, there was a bulletin that required data submission that went through the NHSN, and you were to – laboratories were to submit a spreadsheet every Friday by 5:00 pm to a FEMA address that had, you know, a certain – and they provided a template for that spreadsheet. And you were to be, if you perform the testing yourself, you had to submit that otherwise, if you sent it into a (Inaudible) or somebody like that they had to submit it.

So is this new data requirement in addition to this?

Alina Czekai: I'm afraid I don't know the answer to that question. Whether that's the requirement is an additive or replaces the prior data collection. So it's something that we'll try to relay.

Marie Hopkins: Along with that, if I may. So the new guidelines make this statement that says, recognizing what the data elements requested go above and beyond what has been historically requested. This information should be made available in all reporting, including three methods use technical infrastructure such as HIE, to state and local public health departments, and subsequently the CDC as soon as possible, but no later than August 1st, 2020.

So since it says that recognize new data elements go above and beyond whatever might have historically been provided, is that meant to say that we have to go back to the beginning of testing and collect the data that's now being required and submit that by August 1st?

Demetrios Kouzoukas: I think we're going to have to take this one back because the HHS reporting requirements I think are related to the new statutory provisions that were in carers, and you're asking a fair question, which is how do they comport with what we put out. I think with some – under some other communications at an earlier point in time and how they pair up.

And I think we would just want to identify the earlier communication that you spoke to with regards to FEMA, was that the vice president's call to action or was it the CCSQ – was there CCSQ guidance that you're referring to there as well?

Marie Hopkins: It said that there was a bulletin requiring data submission. CMS indicated the White House Coronavirus Task Force is already collecting blah-blah-blah. And then, the bulletin refers to a letter sent by Vice President Pence to hospital administrators with the request for data from these in-house labs, along with instructions for reporting the data to HHS each day into the CDC's NHSN.

Demetrios Kouzoukas: OK. I think we know the one then. We can work on pulling that together. I think it's a couple different communications, neither of which necessarily originated within CMS. But we'll see what we can do to identify the overlap between the two.

Marie Hopkins: OK. And because even if you don't know about the March 27th one, and you're just reading this as, oh, this is a new instruction for all this data. So many hospitals have now set up their own testing and it's not necessarily going out through one of the big reference labs any longer. You know, if we have to go backward to some point in time, where this goes above and beyond historical, and now we need all this information by August 1st.

I mean, that sounds like you want us to go backward to some point in time. And the data elements in this new bulletin that was released on the 4th is pretty expensive. There's a lot of information to be collected there. So, you know, a lot of hospitals have brand, you know, hundreds and hundreds of tests, either through the reference lab or themselves, that they have to go back and collect all this information that's being requested for all these prior tests. That's, you know, pretty labor intensive.

So having some more instruction about this overlap and the going back and correcting any historical data that was previously submitted would be really helpful. And also look at the FAQs and see if they offer any aid in that

respect versus just the questions about the new data elements. I appreciate your help.

I'll just submit this in advance though your email site, so you should have my question.

Demetrios Kouzoukas: OK. We'll see what we can track down from our interagency colleagues as well.

Marie Hopkins: OK, appreciate it. It's a lot of work.

Demetrios Kouzoukas: We appreciate that it is and know that the data is going to a good purpose.

Marie Hopkins: Yes, I'm sure it is. (Inaudible) so I'm happy to figure out how to (Google it though).

Demetrios Kouzoukas: There were go, thank you.

Marie Hopkins: OK. I appreciate you letting me have the last hard question.

Alina Czekai: Thank you for your question.

Demetrios Kouzoukas: OK.

Marie Hopkins: All righty. Goodnight.

Alina Czekai: Great. And thank you everyone for joining our call today. Our next CMS COVID-19 Office Hours will take place next Tuesday, June 16th, at 5:00 pm Eastern. And in the meantime, you can continue to direct your questions to COVID-19@cms.hhs.gov.

Again, we appreciate all that you are doing to patients and their families around the country as we address COVID-19 as a nation. This concludes today's call.

Operator: All right. Thank you, ladies and gentlemen, this concludes today's conference call. Thank you for joining. You may now disconnect. END