Centers for Medicare & Medicaid Services
COVID-19 Office Hours
August 25, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 8579003

Alina Czekai: Good afternoon. Thank you for joining our August 25th 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 health care systems to increase hospital capacity, rapidly expand the health care workforce, put patients over paperwork and further promote telehealth in Medicare.

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

Please do keep in mind the questions discussed on this call are general representative questions and your specific circumstances may be different. Therefore, the information provided may not always be applicable to your unique situation. You are always welcome to reach out to the COVID-19 mailbox for further assistance.

And today, the Administration issued the third interim final rule as part of our unprecedented efforts to combat COVID-19. Specifically, we have announced sweeping regulatory changes that require nursing homes to test staff for COVID-19. They are also requiring laboratories and other performing

COVID-19 testing, including nursing homes using point-of-care testing devices, to report diagnostic test results as required by the CARES Act.

The new rules also require hospitals to report COVID-19-related data to the U.S. Department of Health and Human Services. And, also, as part of the announcement, CMS launched a new unprecedented National Nursing Home Training Program for front-line nursing home staff and nursing home management. All of this information can be found on our news room if you go to cms.gov/newsroom. And it's also listed on the CMS Current Emergencies page.

Additionally, over the past two weeks, we have updated two guidance documents, including a new document outlining key components for continued COVID-19 management for dialysis facilities as well as an updated toolkit for states to mitigate COVID-19 in nursing homes. These documents can be found on our Current Emergencies page under the section for health care facilities and survey and certification guidance.

So, those are the important updates that we wanted to share with you all today. Operator, let's open up the lines for some questions. Please do keep your questions to one question or one question and a follow up today. Thank you.

Operator: To ask a question via the telephone, please press "star" "1." And if you would like to withdraw your question, please press the "pound" key. Thank you. Excuse me, (Ali Bakani). Your line is open.

(Ali Bakani): Thank you. Thanks for this opportunity. My question is regarding (specific) requirements during the public health emergency. We know that CMS expanded the definition of direct supervision to include virtual presence through audio-visual real-time communications. And we understand that this policy applies to direct supervision whenever that standard is implicated.

But, the Medicare Benefit Policy Manual states that direct personal supervision is substantively identical to the standard for direct supervision, meaning that the physician (doesn't have to be) in the same room but must be in the area immediately available to provide assistance (in direction to the time) and – while the procedure is being performed.

So, I guess my question is can CMS confirm that the policy authorizing a physician's virtual presence for direct supervision also applies to the equivalent standard of direct personal supervision that's established for certain radiation therapy services, for example, in the context of non-invasive superficial radiation therapy delivered in the office setting?

CMS - Male: Hi. So, we certainly appreciate the question. I think that one we are going to have to take back for another call. I understand the question. But, I think we want to take a look at this specific language to see what the flexibilities might be ...

(Ali Bakani): OK.

CMS - Male: ... given that – given that the definition is really specific to that benefit. But, we certainly understand the question and we will – we will address it as soon as we can.

(Ali Bakani): Thank you very much.

Operator: Our next question comes from the line of Sarah Warren. Your line is open.

Sarah Warren: Hello. My name is Sarah Warren, and I'm calling on behalf of the American Speech-Language-Hearing Association. I just want to thank you for taking my call today and for all that you guys have done during the public health emergency including holding these stakeholder calls and the development of the numerous waivers and flexibilities to ensure Medicare beneficiaries maintain access to the services they need and deserve.

I'm calling about the authorized telehealth services list for the public health emergency. ASHA has made numerous requests for additional audiology and SLP services to be added to that list for the duration of the PHE. But, it appears that no codes have been added for any clinical specialty in the four months since the second interim final rule was issued. Can CMS shed any light on if and when it will expand the authorized telehealth services list for the public health emergency?

CMS - Emily Yoder: Hi. This is Emily Yoder. So, I definitely hear the question and appreciate the concern. And all I can say is that we are still working on it. And hopefully, we will have something posted – have an update posted soon. But, I definitely understand the concern. So, thank you.

Sarah Warren: Thank you.

Operator: Our next question comes from the line of (Jenny Stuart). Your line is open.

(Jenny Stuart): Hi. Thank you for taking my call. I'm calling from Legacy Health in Portland, Oregon. And my question centers around proper billing when an employed physician is in a hospital-based clinic, not a distant site, and provides a virtual visit such as 99213 to a patient who is in his home and we've properly documented that the patient's home as an extension of the hospital outpatient department. Do we bill a professional component of the 99213 as well as a facility component, G0463, both as we would have for such a hospital outpatient department prior to the public health emergency?

CMS - Male: Yes. So, if – in the case you are – you are talking about, there is not a (inaudible) distant practitioner, as you mentioned, billing for a service on the telehealth services list. But, it is a service that the hospital can furnish remotely to the – in the patient's home. Then, the hospital can bill for that service on the UB04 as they would for that (inaudible) that service is provided in the – in a hospital department setting.

(Jenny Stuart): So, in the provider-based or hospital-based clinic example, prior to the public health emergency, we are able to (inaudible) facility component on the 1500 with the 992XX code as well as the facility component, the G0463. If we are providing that visit virtually, the physician is in (our) clinic and we have documented the patient's home as an extension. Are we able to bill both components? (Inaudible)?

CMS - Male: Yes, again, given the – given the sort of caveat that this does not qualify as a – as a service under the telehealth – the expanded telehealth process and under which that they would bill with a 95 modifier on the claim (point). If it doesn't qualify for that, then you would bill it as you would normally bill a hospital service in the off-campus setting.

(Jenny Stuart): OK. Thank you.

Operator: Excuse me. We have the line of (Linda Clarke). Your line is open.

(Linda Clarke): Hi. Thanks for taking my call. So, my question is now that we have clear guidance on when to bill a G0463 and when to bill a Q3014 for our telemedicine visit, my question is up until this date we have billed neither one and we'd like to go back and look at billing for the facility portion for previous telemedicine visits. And I'd like to know how far back we can go for each of those – each of those codes based on where the provider (inaudible).

CMS - Female: Sorry. (Inaudible) I had a moment trying to get off of mute there. Just in terms of going back, I mean for any retroactive (code timely filing of the year – so, you would have a year from the date of service to submit a claim. But, (Ryan), if there is more you wanted (to add), please do.

CMS - (Ryan): No. That's all I had, too.

(Linda Clarke): So, for each of those codes, if we haven't billed that facility portion to date, we could go all the way back to the beginning of the (PAG) if we can get our claims (inaudible) (timely filing)?

CMS - Female: Yes. (Back to) whatever the effective date was of the code.

(Linda Clarke): Of the code. OK. Thank you so ...

CMS - Female: Yes.

(Linda Clarke): Well, so when you say the effective date of the code, that's what I am really asking. We really didn't have guidance to bill for the G0463 until 7/28. Does it – does that start on 7/28 that we can now bill for G0463 if the provider is in the hospital setting and the patient is at home? Or can we look back at other telemedicine visits prior to that day where we have the same situation but we only billed for the professional piece?

CMS - Male: So, again, I just want to clarify that if the service is a service on the expanded telehealth list using the 95 modifier, then you would bill the originating (site)

with that service for the – for the location and not the G0463. Again, that's only if the service being provided is not on the expanded telehealth services list. So ...

(Linda Clarke): But, just – I'm sorry. Could you – could you repeat that?

CMS - Male: So, for the – go ahead, (Ryan).

CMS - (Ryan): So, I think – I think another way of phrasing the same policy would be that if the – if the professional claim is submitted under the telehealth rules, then the – then the appropriate facility fee to report would be the telehealth originating (inaudible) facility fee, which is the Q code.

And if – due to the Hospital Without Walls that the service that's furnished using remote communication technology wouldn't be a telehealth service on the professional claim, then, at that point, the hospital would report the G code clinic visit as the same as if the – both were in the exact same physical location because under that scenario, both the patient and the individual professional would be in the same hospital.

(Linda Clarke): So, then ...

CMS - (Ryan): And that ...

(Linda Clarke): So, this – go ahead.

CMS - (Ryan): Just to – just to make it clear that it – that it's not just the kind of service but whether or not the professional claim would be appropriately reported with a 95 modifier (or not) ...

(Linda Clarke): Yes.

CMS - (Ryan): And that – and that the date of service – the guidance that we – that we released several weeks ago clarified the policies that became effective for date of service related to the interim final rule. So, it would be back to the beginning of the PHE, not merely for the dates following the issuing of the – of the clarifying guidance.

(Linda Clarke): So, let me see if I truly understand. So, if a provider has conducted a telemedicine visit where that provider is in the hospital setting and the patient is at home that has made – has been made provider-based to the hospital, we can bill – we should bill the G0463. And if we haven't billed that portion, that G0463 portion, we can look back and – as far as we are allowed to make that patient home provider (base)? Is that – is that 120 days?

CMS - Male: So, again, I think going back to what (Ryan) mentioned, the first thing that sort of – (need to be determined) about that service is if it is a service that should properly be billed as a telehealth service on the professional side using the 95 modifier. If it is – if it's one of those services, then you should bill the originating site fee on the – on the facility claim. Otherwise, if it is not and – you can then bill it as a G0463 visit on the – on the facility claim.

(Linda Clarke): So ...

CMS - Male: And what's the timeframe for the submission of the – of the list of patients' addresses or the alternative sites?

CMS - Male: So, for a temporary extraordinary circumstances relocation request to move a hospital department to a new location including a beneficiary's home, the request needs to be submitted within 120 days from when the service was furnished in that location.

(Linda Clarke): OK. That answers my question, then. Thank you very much.

Operator: We have a question from (Beth Gibbis). Your line is open.

(Beth Gibbis): Hi. Good afternoon, and thank you for taking my call. I am calling about the resumption of post-payment reviews. In the April 20 FAQ that was posted to suspend post-payment reviews, it says current post-payment, MAC, SMRC and RAC reviews will be suspended and released from review. Then, in July, the FAQ was posted announcing resumption of post-payment reviews.

I was hoping that you could give us some insight into the instructions that have been given to the RACs regarding resuming reviews. For example, today

we received a 67-page latter from the RAC regarding claims that were under review prior to the public health emergency.

And so, now they are asking us to – let me see exactly what they want from us. They want us to respond regarding their determination. (Since the original) FAQ says that current post-payment reviews will be suspended and released from review? We are a little bit confused about whether this is something that CMS has allowed them to do.

And the second part is in a phone conversation with the RAC, they said that we should have submitted any record that were requested and then fell under this suspension, that we should have gone ahead and submitted those records anyway. So, I was hoping that you could provide us some guidance as to what is allowed from the RAC perspective with the resumption of reviews.

CMS - Male: Jennifer, I know – I think we've got you on the call. I think you could take that one.

CMS - Jennifer Dupee: Yes. Hi. So, I am from the Center for Program Integrity. Unfortunately, I'm not a RAC expert. But, I'm not sure, Alina, what we can do to follow up on this question specifically. We'd be happy to get this information.

CMS - Alina Czekai: Sure. Then you can submit this question to our COVID mailbox, which is covid-19@cms.hhs.gov. And we will be on the lookout and route that to the appropriate subject matter expert. Thanks so much.

(Beth Gibbis): I did submit it to the mailbox, and I response already that didn't really answer my question. So, should I submit – forward that response or you want me just to start all over from scratch and submit it?

CMS - Male: Jennifer, how would you like it to come to you?

CMS - Jennifer Dupee: I am happy to receive it directly. My – or I am happy to provide my email address if you are ready for it.

(Beth Gibbis): If you want to do that, yes, that's fine.

CMS - Jennifer Dupee: Sure. Yes. It's jennifer.dupee@cms.hhs.gov.

(Beth Gibbis): OK. Thank you so very much.

CMS - Jennifer Dupee: You are welcome.

Operator: Our next question comes from the line of (Brenda Schoke). Your line is open.

(Brenda Schoke): Sorry I was on mute. I apologize. I had to unmute myself. Thank you so very much for taking my call. This is (Brenda Schoke). And I wanted to follow up off of the gal that was just speaking about the post-payment audits. I actually have to say that we've received several phone calls. We didn't receive a 67-page letter from our RAC. But, we have received several phone calls in regards to requests that they sent out after CMS stated that they were halting any post-payment reviews.

And when I asked them to rescind it – I had emailed them previously saying to please rescind that they said they weren't going to, that they were just going to contact us afterwards after they have been given information by CMS and that they would just expect us to have multiple – that we just needed to send them the record that didn't matter.

So, I think that there is some conflicting information being given. I have HMS as a – who is our RAC. And, so, it's very frustrating when you get multiple phone calls. They can't do more than one call or more than one letter reference number per call. So, I got – what – six phone calls and asking to call back. They wouldn't give you anything but the letter reference number or your hospital.

So, it really is very difficult as a provider on the receiving end. If you guys – if CMS said that you are not going to have any post-payment audit and that you are halting it due to the public health emergency, in my personal opinion, you should not – there should be no request that we as providers should have to submit to the RAC if it was after CMS provided that specific guidance. If they want to really re-request those records, (have at it?)

But, it's really frustrating as a provider because I'm kind of like in the same boat that the gal just – that just – Jennifer you gave your email address to. It's

that we are now being told, "No, no, you should have sent it in the medical record." So, I just would like to, A, ask how would you like us to proceed with this? I get that you need to audit post-payment. I get it – SMRC, RAC, QPE – I get it. Totally understand.

But, I think that there is still a difficult task out there of what the information we are receiving as providers and what the MACs, SMRCs, RACs are being provided. So, I – Jennifer, I am happy to send you my information as well to kind of piggyback off the last gal. But, I don't know if you really want to get 18,000 emails. I don't know how many people are on the phone. But, if that makes sense.

CMS - Jennifer Dupee: Fair enough. I will say, though – and I will speak with Alina on this to make sure that as people submit to the COVID mailbox that we are – we are getting that information. I do apologize. I happen to be from the area that handles these situations but not directly.

But, given the frustrations, we do hear you. We do understand these things and we do hear from providers often on this. So, if there is anything specific that I can help facilitate, I am happy to get that directly. Or like I said, we will work with Alina to make sure we get that information from the – from the mailbox.

(Brenda Schoke): Great. Thank you so very much.

CMS - (Demetrius): And I'll just add that the – our sense has been that sometimes these things are very contextual and maybe something about ...

(Brenda Schoke): Sure.

CMS - (Demetrius): ... a particular batch of letters or what was happening at one RAC versus another, how people understood our guidance since we are all moving quickly. So, we are just happy to have this feedback loop so we can get to the bottom of it. But, I don't know that we will have a universal answer for everybody.

(Brenda Schoke): . Totally

CMS - (Demetrius): But, glad to know of the individual circumstances being brought to Jennifer's colleagues' attention.

CMS - Female: Thank you, (inaudible). I totally agree.

(Brenda Schoke): Can I ask one more follow-up question to that, which is I thought a different topic. And if you need me to put feedback in the queue, I am happy to do that as well.

CMS - (Demetrius): I think we are allowing one follow up. Yes.

(Brenda Schoke): OK. One follow up. Here we go. It will be fast. So, in regards to actually submitting the addresses to the CMS regional offices – your favorite topic – I do have a question in regards to – specifically, can I ask why are we needing to send in the patients' home addresses to the CMS regional office?

Are you guys ever going to try to cross reference what was sent in versus what was billed? Because, as you can imagine, the amount of visits and the amount of home addresses that these people are getting – I can't even begin to fathom. So, I am just trying to understand, A, why we have to do it if it's validly we are under a public health emergency. Right?

I get that there are bad apples. Let me be crystal clear – I get that. However, a good 99 percent of the people are not. So, I am just wondering why we need to – I mean I can't even imagine how many – how many addresses that they are getting. And, then, what is being done with it? Are they just sitting on it? Is somebody going to come down six years from now to audit to see if we actually correctly did that? Do you know what I am saying? I just want to understand the thought process behind that. So, I apologize. But, there you go.

CMS - (Demetrius): It's all right. I think this is a question we have gotten in some form before, too. And the – just to provide a high-level response. (David) may have some more to add to it. This is (Demetrius) here. But, my reaction a bit is that, really, the issue for us is that in order to be able – to get as far as we did in terms of the flexibilities, we needed to redefine the location of the hospital in

a way that perhaps wasn't – is not how we traditionally approached the interpretation on the application of the statute given the unique circumstances.

(Brenda Schoke): OK.

CMS - (Demetrius): And, so, in order to do that, we need to be able just to – for purposes of fidelity with the statute ...

(Brenda Schoke): Sure.

CMS - (Demetrius): ... to be able to say that we – to be able to know where the hospital is as a physical location. And, so, having the address enabled us to comply with statutory requirement.

(Brenda Schoke): Got it.

CMS - (Demetrius): It's sort of the way I've been thinking about it. I don't know, (David), if you have some more to elaborate.

CMS - (David): No. I think you covered it, (Demetrius). Thanks.

(Brenda Schoke): Well – and, so, to be clear, if the person – if the patient (Brenda) has multiple appointments on multiple days of service, I am going to have to have my address sent in multiple times. That is correct, yes, because it has a different DCN and a different date of service and all of that, correct?

CMS - Male: So, for each location at which a service is performed, you only need to submit one temporary relocation request. And, then, that location becomes a relocated part of the hospital department. So, you only have to ...

(Brenda Schoke): For the remainder of the PHE. OK.

CMS - Male: Correct.

(Brenda Schoke): Thank you. I apologize (I had a few) questions.

CMS - (Demetrius): We can express some sympathy with you, all, too. So, we are – we are the subject of audits as well from others at times, too. So ...

(Brenda Schoke): (Good times). It's fun.

CMS - (Demetrius): Yes.

(Brenda Schoke): Job security.

CMS - Alina Czekai: Thank you.

Operator: We have a question from (Deborah Walsh). Your line is open.

(Deborah Walsh): Hi. Thank you for taking my call. My call has to do with if a registered nurse is allowed per CMS to be the service provider of the non-face-to-face, non-physician services CPT code 98966 through 98968.

CMS - Emily Yoder: Hi. This is Emily. So, those services are – actually, they are limited to professionals who can independently bill Medicare for their professional services. And, so, I do not believe – and (Ryan), please correct me if I'm wrong – that a registered nurse could bill independently for these services.

CMS - (Ryan): Right. So, the description in the – for the CPT code describes a qualified non-physician health care professional, which generally wouldn't include a registered nurse unless that registered nurse also had a separate qualification.

(Deborah Walsh): OK. Thank you. Can I ask a follow-up question to that? The scenario that we are struggling with to keep our patients safe as well as our staff safe is when the registered nurse is doing teaching or education to a patient that is on Coumadin and we don't – and this would be for our non-provider-based clinics – so, for our freestanding clinics. So, typically, we would do a 99211. But, unfortunately, that code is not on Medicare's telehealth eligible list to be audio only. So, we are wondering ...

CMS - (Ryan): I see.

(Deborah Walsh): ... what we could ...

CMS - (Ryan): So, one suggestion what I would make is to – and you may already be doing this. But, in case you are not, I would recommend looking at the chronic care management codes and other care management codes where there is the time

where clinical staff would spend talking with patients over the phone could be counted toward the minutes for those codes.

And for some of those codes, there is coding stratification by number of minutes. And, so – but, in any event, almost all of those codes have threshold for minutes. And those minutes could count towards those codes. I don't think that there are necessarily other separately payable services that would apply in the audio-only case but certainly in the care management monthly codes.

(Deborah Walsh): OK. All right. Thank you.

CMS - (Ryan): Sure.

Operator: We have a question from (Natalie Billow). Your line is open.

(Natalie Billow): Hi. Thank you for taking my call. I have a question on the self-isolating consulting. I had raised the question through the help desk and I believe the last response was to get with my MAC, which I will do. But, I'm just curious if this is something that has – that you guys have seen. We are planning on using this, whether it's at a clinic or a (drive through the) 99401 code.

And when we go to the E&M documentation with this being a consult – and from my impression, the crosswalk is for telehealth. And I'm just curious what that reimbursement is. It seems like it's not reimbursable for Medicare. So, I was just looking if I could get more insight on that.

CMS - Male: (Inaudible) could you – were you asking about the preventive medicine (counseling) code?

(Natalie Billow): Yes. We are – yes. We are – we are calling it the self-isolating consultation, I believe. And (released) July 30 that it would be payable. But, (inaudible) trying to find the code, which we found – we believe it's the 99401 to be used. But, we are trying to get more information on the reimbursement because it's not reimbursable when you do – when you go to the Physician Fee Schedule. And we were pointed to – I was pointed to the E&M documentation, which in there talks about the consultation more than 50 percent. And just trying to figure out what the reimbursement piece is because – for that code.

CMS - Male: Sure. So, those particular CPT codes are not separately paid by Medicare. So, if it's purely preventive service, then that wouldn't be part of the Medicare Part B benefit unless there is a specific national coverage determination. I think for the guidance that you are referring to related to COVID counseling, particular for things like self-isolation, I think in that guidance we refer generally to the E&M guidance.

(Natalie Billow): Right.

CMS - Male: And that would include using the – for example, the office outpatient visit codes where the – in cases where the visit would be to treat exposure risk and things like that for a particular patient and that in cases where those codes would be appropriately billed, the amount of time spent counseling to be used to determine the appropriate level of the code.

(Natalie Billow): I guess my comment is that it seems a little misleading because the guidance was updated to include this and it made it sound – it made it sound like – whether it was in-person, whether it was in the clinic or any kind of situation, that it would be reimbursable. So, it didn't indicate in there that it had to be with like an ED level or within an office visit.

But, basically, someone (inaudible) came into the drive through, got their test and the doctor – or if they came in for clinic and they got their COVID test and they were just to counsel them. It just seems like the information that was provided in the update from CMS seemed all indicating that it would be reimbursed. So, now, it's not going to be reimbursed in this situation because it did point to the E&M documentation, but then you are saying the E&M documentation (sent to the council) – it can't be reimbursed.

CMS - Male: I think all of that is right, except that I would – I would caution you that the setting of care wouldn't necessarily preclude use of office outpatient codes. So, you wouldn't necessarily need to – based on that guidance, I don't think that there was anything that would be – necessarily prohibit using an office outpatient visit code during a drive-through clinic scenario. So, it wouldn't necessarily.

(Natalie Billow): OK. I think the – for a driving clinic, I think what we are finding – and I'm sure (inaudible) were not the only provider that – to have a doctor or a mid level there might not be feasible but maybe at a clinic. And, so – or where they would do a lab test or testing somewhere in the site.

So, I think that was the question just to get the – what the reimbursement (would be) from the article and from the information that was updated about – that there is going to – there is announcement that they are going to be able to be reimbursed for counseling patients to self-isolate.

CMS - Male: Understood. And I think we can – we can take a look at the guidance to verify. And I think – but, certainly, I understand and appreciate the question.

(Natalie Billow): OK. That would be great. I think maybe the clarification would help. I appreciate it very much because it's something that we are trying to (hold the pole) and get the right answers. Thank you so much.

CMS - Male: Sure. Thank you.

Operator: We have the line of (Stacey Stevens). Your line is open.

(Stacey Stevens): Hi. Thank you for taking my call. My question is similar to an earlier caller regarding clarification for hospital-based clinics when medical doctors perform clinic services via telemedicine and the doctor is on site and the patient is at home.

And my question is similar regarding professional billing because I am looking at a question from last week's call where somebody asked for clarification about G0463 and Q3014 and the response that they received – it just says CMS email – was that if there was a professional claim for the service, then the hospital would bill for the Q code.

If there is no associated professional claim, then the hospital would bill for, in this example, the visit code, (B code). So, you did say today that in both scenarios, if the doctor is onsite, you would bill the G0463 with (PO) or PN. And you said there is a professional bill associated with that. I would not have modifier 95. Is that correct?

CMS - Emily Yoder: So, I can start – this is Emily – and others can chime in. So, in instances where there is a separate professional claim, then the hospital would not – would bill for the originating site facility fee because that would be a telehealth service. However, if there is not a professional claim, then the hospital would bill for the clinic visit. Does that answer your question?

(Stacey Stevens): So, you are saying whenever there is a – when the doctor is onsite, there can be no professional claim associated with that visit? Because it sounds like you gave the earlier caller (inaudible).

CMS - Male: So, I think – I think – I think I can – I can clarify a little. In cases where the professional service is appropriately billed as a telehealth service, then the facility would report the telehealth originating site facility fee.

(Stacey Stevens): (OK).

CMS - Male: In cases where the physician and the patient are both located within the hospital, even if that scenario is due to the Hospital Without Walls construct, then that professional service would not be reported as a telehealth service and, therefore, the clinic visit code (inaudible).

(Stacey Stevens): (Inaudible) The professional billing component would be billed as a 99213. Is that correct?

CMS - Male: Sure. If the visit is a 99213 and it's reported as a 99213 but not with a 95 modifier and not the telehealth rules because both professional and the patient are located within the hospital, in that case, then, the Q code would not be reported for the facility fee and that the Q code (and the) facility fee is ...

(Stacey Stevens): I just want to (inaudible) no billing. Professional billing is allowed when you bill the facility G0463 because that previous question (inaudible) there was no professional claim you would always use the Q code – the G code.

CMS - Male: Right. And I think – I think we would refine that just to add that no professional telehealth claim.

(Stacey Stevens): It needs to be clarified. Thank you. I have – so the G0463 could be with a PO or a PN, correct, depending upon whether we provided our addresses to CMS?

CMS - Male: Correct. Depending on whether or not there is a temporary relocation request submitted to CMS for that location.

(Stacey Stevens): OK. I have one quick follow-up question. I'm trying to be fast. A licensed clinical social worker employed full time by the hospital who does no separate billing – fully employed by the hospital – I've been told that we should bill that on a UB04 under the facility under, say, 90832 counseling either with PO or PN.

My question is why is this different from PT or OT billing and they are – they are allowed to bill on a facility UB04 with two different options – they can bill with a 95 or they can bill with PO or PN? Why is the licensed clinical social worker billing different from that scenario that CM provided for OTs?

CMS - Male: So, that has to do with differences in the Medicare law both in terms of the statute and the regulatory law related to billing. But, one point that might be helpful in that is that for physical, occupational and speech language pathologists, there are different rules that govern the billing when any – when those services are furnished in any institutional setting.

So, that would be hospitals or nursing facilities et cetera. And, so, there is what appears to be incongruency and, in fact, is – for billing purposes, has to do with – the different rules would apply and the different laws that govern. And, so, it's, unfortunately, confusion. But, it's a by-product of the law that we are working with.

(Stacey Stevens): Clinical social workers and any full-time employee of the hospital cannot utilize that – that two different scenarios of billing set aside just for PT, OT therapists.

CMS - Male: That is correct.

(Stacey Stevens): We have to use the PO, PN on the UB04. OK.

CMS - Male: That same rules that would apply in person should apply here as well.

(Stacey Stevens): Yes. We would never use modified 95. We would bill on a facility claim for a fully employed (LCSWs) who do services via telemedicine. We couldn't – we would not use modifier 95.

CMS - Male: Right. That would be the same. Right.

(Stacey Stevens): OK. Thank you.

Operator: We have the line of (Ardis Campbell). Your line is open.

(Ardis Campbell): Hi. I'm glad to be able to ask a question. I have a question regarding the C9803 for the specimen collection and then a follow up. My question is what happens if there is something that happens to the sample that is taken – like the vial breaks – so there is not a sufficient quantity to run the COVID test? Can I still bill for the specimen collection?

CMS - Male: So, I don't know if any of the others on the team have particular insight into this situation. I think this is a coding question in terms of what qualifies for the – for the code or at least for the threshold level. But, maybe others can weigh in as well. Maybe – I am – I think that I'd guide you to the – to the language that accompanies the code for the test as to at what point it can be billed and any kind of coding guidance that sort of further explicate that.

(Ardis Campbell): OK. All right. And, then, if the patient has done their own nasopharyngeal swab and brings the (swabs) into the clinic, am I able to use that specimen collection because the staff still has to gown up and do all of their PPE and stuff? Or is that going to fall into the same bucket as to we will review guidance on other areas?

CMS - Male: I think – I think – I think that would be the same in terms of reviewing this. I think I ...

(Ardis Campbell): OK. Great. Thank you.

Operator: We have the line of (Rosie Fossil). Your line is open.

(Rosie Fossil): Good afternoon. I have a question about convalescent plasma. Now that the FDA has given convalescent plasma in emergency use authorization, do you all know yet if you have any plans to create HCPCS codes for the plasma? Because if it's emergency use, that means we don't have to bill through like a study budget or anything like that.

CMS - Male: I don't know that we are in a position to talk about any new coding in that regard today. The context in which the convalescent plasma is used most often is generally in patients. So, in that context, there – the coding that's available today might well be sufficient. I think it will be interesting to hear if you have – if you or others have thoughts about how we ought to approach it from an (clinical) perspective. I think that's something we'd be open to thinking about.

(Rosie Fossil): Well, I guess it's sort of a technical issue because our chargemaster is set up so that most things that come out of the laboratory like a blood product has to have a HCPCS. So, we have HCPCS on all of our blood products, whether they go to an inpatient or an outpatient. They just might not appear on a claim.

But, when you use revenue code 390 with a price, most edits in our chargemaster anyway are going to kick it out and say, "Where is your HCPCS code" because it's 390. Ultimately, the system wants a HCPCS. But, it would be helpful for tracking purposes for you all also if it had a HCPCS. It would be helpful for us, too.

CMS - Male: Is there a non-specified code that you are using now or ...

(Rosie Fossil): No. We are not – we are not using anything because we are currently not billing for it because we have been using it under an (EIND). There is an unspecified code, but it doesn't really – I had asked about that among other blood bank folks and it didn't really seem to apply. But, we could go back and look at that. The other thing is there may come a day where convalescent plasma is used on an outpatient. You never know what the virus is going to bring in the future.

CMS - Female: Yes. So, there are ICD-10 PCS codes for convalescent plasma. And if you send in the question, we can follow up with the specifics. And I believe per

the FDA, this is considered to be a biologic. And, so, all of the rules I think around that would apply here. But, if you could please send the question in, we can – we can follow up with more detail.

(Rosie Fossil): OK. Sure. Thank you so much. I appreciate it.

CMS - Alina Czekai: And I am happy to repeat that email address again, just in case. It's COVID-19@.cms.hhs.gov. And we are at the end of our time together. We really appreciate everyone dialing in today. Feel free to continue to submit questions to our COVID mailbox. And our next Office Hours will take place two weeks from today. So, that will be September 8 at 5:00 p.m. Eastern. Again, thanks, everyone, for joining our call. Have a great rest of your evening.

End