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

Operator: This is Conference #: 4474407.

Alina Czekai: Good afternoon. Thank you for joining our June 2nd CMS COVID-19 Office Hours. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the office of CMS Administrator, Seema Verma.

Office Hours provide the opportunity for providers on the frontline to ask questions of agency officials regarding CMS's temporary actions that empower local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote telehealth 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 media inquiries form, which can be found online at cms.gov/newsroom. Any non-media COVID-19-related questions for CMS can be directed to covid-19@cms.hhs.gov.

And I'd like to begin today's call with a brief update on the agency's latest guidance. Last week on May 27th, CMS published updates to the FAQs related to COVID-19 Medicare fee-for-service billing. This updated guidance can be found on CMS's current emergency's COVID-19 webpage under the section billing and coding guidance and it's the document titled, Frequently Asked Questions to Assist Medicare Providers.

Several updates to the FAQ documents are relevant to questions raised on previous Office Hours including appropriate use of the CS and CR modifiers for telehealth and other coding clarifications, update on which telehealth services can be furnished by RHCs and FQHCs, telephone-only service codes

that can be used during the public health emergency, updated guidance on providing therapy services via telehealth in various settings and reported on UB-04, updated diagnosis codes for COVID-19, guidance on transferring patients to temporary acute care locations, ITPS waiting factor and associated payments for COVID-19 diagnosed individuals, and updates on rural health center productivity requirements during the public health emergency.

Additionally, last week, CMS issued an updated fact sheet for care in hospital alternate care sites, and this document contains detailed instructions and helpful links for enrolling hospitals to furnish services to beneficiaries at off site locations and contains the prerequisites and covered services for various types of care facilities including acute care hospitals, long-term care, hospitals, inpatient rehabilitation facilities, ambulatory surgical centers, and free-standing emergency departments.

And this guidance can also be found on the CMS current emergency's COVID-19 webpage under billing and coding guidance.

And before we open up the call for questions, I'd first like to turn it over to Diane Kovach at the Center for Medicare to provide a summary on the latest guidance on the use of the CR modifier and DR condition code for submitting claims related to waivers. Diane, over to you.

Diane Kovach: Thank you very much. So, this is another area where we've received some questions over the past Office Hours call. So, we wanted to give you an update. And usually, when there's a public health emergency, we have a relatively short list of blanket waivers and flexibilities that facilitate claims submission and processing for impacted areas.

And we always, in those cases, require the CR modifier or the DR condition code for the applicable claims. But we have gotten a lot of questions on whether or not the same is true under the COVID PHE just given the volume and the scope of the blank waivers and flexibilities and the fact many don't directly impact claims processing.

So, we have given this some serious consideration. And as a result, Special Edition Article 20011 and the title of that is Medicare Fee-for-Service

Response to the Public Health Emergency on Coronavirus was updated on June 1st. And this update identifies which waivers and flexibilities specifically require the use of the modifier CR and/or the condition code DR on claims.

And like the other updates as Alina mentioned, the article can be found on the cms.gov current emergencies COVID-19 page under the billing and coding guidance heading.

Since this is an update to an existing article, all of the new information is in red type so it will be really easy for you to find, also in chart format, so hopefully, easily understandable the way we published it.

So, we do urge everybody to review the article update if you haven't already done so. But I did want to give you a couple of highlights.

It includes, as I've said, a chart that specifies when the CR and/or the DR are required for claims submission. And any claims tied to waivers or flexibilities that are not listed in that chart do not require either of those codes.

But note that if you've submitted or plan to submit the modifier or condition code on claims for waivers and flexibilities that aren't on the list, as we've said many times on these Office Hours calls, those claims will not be rejected or denied due to the use of these coverage and there is no need to resubmit the claims to remove the modifier or the condition codes. They're fine as is.

And also, I want to note that you do not need to resubmit and previously processed claims that per the updated guidance, I just mentioned, should have had either the condition code or the modifier reported unless you believe your payment was impacted or you've been directed by your MAC to resubmit the claim. And if you have questions about specific claims, please do contact your MAC directly.

So (relatedly), one of the items in the article addresses the Interim Final Rule with comment that stated that clinical indications for certain national and local coverage determinations will not be enforced during the COVID-19 PHE. And some of you specifically directly impact (to be post) suppliers.

And the DME MACs sent out via their list serves an article for supplier billing for these items and that was released on May 7th. And it details billing guidance such as the requirements for the use of the modifiers CR in addition to some other coding requirements. And this is on our chart as well that the CR is required. And it specifically identifies in the article the impacted MCDs and LCDs.

The DME MAC posted that May 7th article to their websites. And again, if you haven't seen that article, we do urge you to go to their website to take a look and also to contact your DME MAC if you have any further questions on submitted – submissions for those claims.

And then finally, I wanted to bring up one other item that has come up on these calls and that is that the Special Edition Article update includes the waiver for certain beneficiaries who exhausted their SNF benefit and authorizes renewed SNF coverage without first having to start a new benefit period.

And as a reminder, that waiver only applies for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period. In this case the DR condition code is required for proper claims processing. But we do continue to work with the MAC on the final instructions for these claims.

And I do apologize for the time it's taken to work this through. It turns out this is actually quite a complex (system) issue much more than we anticipated, but we are close to having a resolution. So, I'm hopeful that we'll have an update for next week's Office Hours call.

So that ends my update. Back to you, Alina.

Alina Czekai: Great. Thanks so much, Diane. Operator, let's open up the lines for questions from the audience please. And as a friendly reminder, please do try to keep your questions to one question or one question and a follow up today since we have many people joining our call. Operator, we'll take some questions. Thank you.

Operator: Our first question is from Jim Collins from Cardiology Coder. Your line is open.

Jim Collins: Yes. Thank you very much. So, the question I have is specific to a Q&A that was just updated today but the part that was clarified was on May 27th. It was a question asking a physician assistants could provide inter-professional consultations and it specifically list 99451 and 99446 through 9.

The way that this Q&A was written, it looks like it just includes PAs. But is it safe to say that also includes nurse practitioners?

Male: Yes, for purposes of that coding, those practitioners would be treated similarly.

Jim Collins: OK. That's great. Thank you very much.

Operator: All right. And our next question is from Robert Latz from Trinity Rehab Service. Your line is open.

Robert Latz: Thank you very much. I have a couple of quick questions. First off, I want to say thank you for the clarification related to billing for therapy – telehealth therapy services and UB-04. Very much appreciate that.

The two questions related to that – we are making the assumption that is retro to March 1 just like the other statements you have made. Are we correct with that?

Male: That is correct. For those services that's retroactive to the same date that the waiver that adds therapists or allow therapists to furnish this insight, telehealth services.

Robert Latz: Perfect. Thank you. And then the second part of that, when the patient is Part A instead of Part B, can we – and we assume yes. We just want to hear it and all. But putting the minutes on the MDS for those services?

Male: This is in regard to a Part A stay in a skilled nursing facility?

Robert Latz: Yes. We know that it's not billable. But it's tracking the minutes of the care provided and demonstrating what we are doing with that patient and that's why we believe that we can put them on there. We just wanted the clarification.

Male: Yes. I think you would follow the manual as you would typically interpret it for completing the MDS. And as you know, that it's not information that will directly affect the payment amount for Medicare.

Robert Latz: Correct. And that's why we were pretty sure. But we – I appreciate that clarification. One last really quick follow-up with that, on the CPT codes that are there related to the telehealth services, the dysphagia codes, I know, are not included right now. And I'd like you to reconsider that. That's the 92526 and the 92610.

In the instances when we have a speech language pathologist who might be calling in from home to provide a telehealth service with the patient at the building and maybe that speech therapist can't come in for a medical reason, so maybe they were sent home because their temperature was high but they're asymptomatic, everything else related to COVID, they may be working through, for instance, a certified occupational therapist assistant or a physical therapist assistant working with that patient who needs some follow up related to swallowing.

So, we're still using their knowledge while they are providing that telehealth service and just would like you to seriously consider allowing those codes in those situations.

Male: Thank you very much for that request. And we will definitely consider that.

Robert Latz: Thank you.

Operator: Thank you. The next question is from (Sandra Quiksel) from (Bluestone).

(Sandra Quiksel): Hi there. Thank you. Regarding the Interim Final Rule published on April 30th, specifically the availability for providers to bill the lowest level office

visit code, CPT 99211, for collecting COVID-19 swab, could you please confirm if this applies for any place of service.

For example, we're a primary care practice serving patients in their home – group homes and assisted living, so places of service 12, 13, and 14. But we've received some denials from our MACs due to place of service error.

Male: So, let me just make sure I understand the question. So, you're reporting the 99211 when you're seeing the patient in which kind of setting did you say?

(Sandra Quiksel): Twelve, thirteen, and fourteen, so homes and assisted living facilities. It's not related to the evaluation management visit. It's when we are collecting swabs from our patients. Just that act alone from the Interim Final Rule, we were understanding that we could bill for that using the 99211.

Male: I see. I think that's the intention. We'll get back to you with the answer to that question.

(Sandra Quiksel): OK. Great. Thank you so much.

Operator: Thank you. The next question is from Mark McDavid from Seagrove Rehab Partners.

Mark McDavid: Thank you so much for taking my call and thank you for holding the Office Hours call. These are great. I wanted to follow up on Bob's question about therapy – telehealth therapy services inside of a skilled nursing facility.

In the FAQ that was published last week, it talked about outpatient therapy services and that's really, I think, where we see that new therapy language on the FAQ unless I missed it somewhere else, which is possible.

But as it relates to Part A services, as Bob pointed out, that's not a separately billable service and we're not asking to be able to do that. We're just asking for access to beneficiaries or for that beneficiaries have access to care.

In his example, he talks about a speech therapist or possibly a PT or OT who's unable to be in the building due to health reasons or whatnot. Could we be providing a telehealth service to a Part A patient from outside the building and

count those minutes on the MDS? Evaluation minutes don't count on the MDS. That's clear in the RAI manual. But treatment minutes do.

And so, if we had an OT who was out of the building doing an evaluation via telehealth with maybe an OTA in the room with the patient, then the OTA is kind of the hands of the therapist, so to speak. But the OT is making that assessment and evaluation judgment as they see and respond back and forth with what the OTA is reporting.

So, those minutes for evaluation would not count. But any follow-up treatment minutes, we just want to clarify that those minutes would be counted. And the only reason there's a question is because of the telehealth piece. Again, it's clear in the RAI that treatment minutes count in the MDS. I just want to be clear that telehealth treatment minutes would also count since the FAQ addressed outpatient and not Part A.

Male: Yes. Part A is not expressly addressed in those questions. As you know, that is related to outpatient therapy. And so, we would – we'll just note that the Part A therapy is required to be reasonable and necessary and it's the responsibility of the skilled nursing facility and that the receiving payment is part of the Part A consolidated billing, and so would defer to them in the manual in working through that. And I do not know if we have any colleagues on from our Quality Group that would have anything further to add.

Mark McDavid: So, assuming that we meet the requirements in the RAI manual, obviously, the RAI doesn't address telehealth because that wasn't a thing last time RAI was updated in the SNF world. Assuming we meet all of those requirements, medically necessary and so on and so forth, then those treatment minutes via telehealth could be included, correct? I think that's what you're saying. I just wanted to be clear.

Male: I think, at this point, we haven't spoken to it not being permissible.

Mark McDavid: Haven't spoken to it not being permissible. OK. Got it. I can work in the gray. Got it. Thanks so much for taking my call.

Male: Thank you.

Operator: The next question is from (Denise Weaver) from UHS Hospital.

(Denise Weaver): Good evening. I'm sorry. First question I have is surrounding the hospital outpatient department extensions and telehealth services even within the environment. Are we permitted to split bill the UB and the professional charge using the G0463 for the telehealth component given the support that our Clinical and Administrative Staff are still providing to be sure care is still rendered? Hello?

Male: So…

Male: (Inaudible) (David) or (Ryan), one of the two of you.

Male: Sure. So sorry for the delay there. Are you asking about in a situation where both the patient and the physician or other professional are both located within the hospital even using the construct of the alternative sites?

(Denise Weaver): Yes. Typically, under normal circumstances in a face-to-face environment, we would have our professional charge (drop) on our 1500 form and then we would submit a UB for the facility component using the G0463 when it is an E&M service.

There's been a lot of back and forth on the originating site with the Q3014 versus whether or not the G0463 could actually be utilized for those situations related specifically to the hospital outpatient department where the hospital incurring the administrative support of rendering telehealth services in lieu of the face-to-face encounters.

Male: So, (David), you should feel free to weigh in. I think what we've said in the rule is that in cases where the professional and the patient are both located within the hospital, and as you're pointing out, the hospital is incurring the cost associated with furnishing the visit, then they could – in that case, there could be both professional and the facility fee for that visit.

(Denise Weaver): Perfect. That was our interpretation. And just spinning off for a secondary clarification, the preadmission testing on the COVID, for elective procedures, are we rolling up the cost of the COVID testing into preadmission testing as a whole or should the COVID testing still remain separate?

Male: (Inaudible). What's the timeframe in terms of how far preadmission?

(Denise Weaver): The preadmission testing is the test for the COVID is being done within three days of the procedure. If they're positive, we're not proceeding with the procedure. So, we have to have a turnaround time in order for – to get those resolved on all surgical patients. But we are not comfortable putting any patient in a surgical environment who could potentially be a positive patient.

So, the billing portion of it really is – are we still allowed to bill that as a separate test or is that bundled into their preadmission testing package?

Male: I think we're going to need to give that one a little bit of a thought in terms of timeframes. I know we've done some (correlated) questions that we're working through and we can come back to you on that.

(Denise Weaver): OK. I appreciate giving it some consideration. We look forward to your answer. Thank you.

Operator: Thank you. The next question is from (Ina Bender) from Mount Sinai Hospital.

(Ina Bender): Yes. Hi. Thank you for taking my call. I just had a two quick questions. Do you know if the CMS added the new codes that were issued in April for antibody and the high-speed testing? Are we allowed to start billing those codes to Medicare because our OC editor is still (taking) them out as invalid? But I'm not sure if the CMS has made some special arrangements or we have to wait until July (editor) gets updated. That's my first question.

Female: So, the OCE editor, you said, is rejecting the U003 and U004?

(Ina Bender): No. It's rejecting the antibody test 86769 and the C9803 because those were issued in April after the April or (inaudible) was implemented already.

Female: That's interesting. Let us follow up on that. I'm not sure why C9803 would be rejecting that assessment collection test. I don't have at my fingertips when the antigen test code would be effective in our system, but I can certainly follow up on that. I know we were trying to get it moving as quickly as possible. I don't know if there is anybody else on the line who might be able to speak to that.

Diane Kovach: Yes. Hi. This is Diane Kovach. And you should be able to bill those codes to the Medicare contractor. So, if you're having an issue with those codes, those claims actually being rejected from the MAC, that should not be happening.

There are some things that we're catching up with implementing in the OCE itself. But we're still able to accept and process those claims.

(Ina Bender): So, we should be able to bill all these codes and get them processed?

Diane Kovach: Yes. That's that the two you mentioned. Yes.

(Ina Bender): And then the – OK. And then just a quick follow up on a question I asked in previous calls, I'm still trying to get some clarification from CMS whether the providers are allowed to bill for antibody testing being done on the donor patients who are tested to determine if they are donors for the convalescent expanded use program.

Female: So, thank you. I did receive that inquiry. And I think we are still working with our coverage area. There was a multiple part question. I think there was some tighter testing related to that.

(Ina Bender): Yes.

Female: We (inaudible) research that and we will make sure we get that answer back to you as soon as we have the pieces pulled together.

(Ina Bender): OK. Thank you. Appreciate it.

Female: Sure.

Operator: Thank you. The next question is from (Brett Dillings) from Baptist Hospital.

(Brett Dillings): Good afternoon. Thank you for taking my call. And thank you for the recent clarifications that you sent out. I do have a question on one of them and it has to do with that outpatient therapy services.

I was a little bit confused when it said that we can bill on institutional claims with (moderate inaudible 95). I seemed to recall in other calls for hospital outpatient department that services weren't considered telehealth services. They were considered services being provided to a remote location.

And I thought I recall that we were not supposed to use the 95. So, I'm a little bit confused by this answer that came out on May 27th. So, I'm hoping that you can help me understand what hospital outpatient department is supposed to do.

Male: Sure. I certainly understand your confusion on that point. I think for hospital outpatient departments, there really are two ways that the outpatient therapy services could be reported when they're furnished remotely in it. It's sort of depends on whether or not the patient's home would be designated as part of the hospital for purposes of that service. So, hospitals have that flexibility under the hospital without walls.

For certain other institutional providers that don't have the same flexibility, the way that they would report those outpatient therapy service furnished via telehealth would be through the telehealth reporting using 95 modifier because hospitals would have the flexibility for both approaches to the extent that they're using the hospital without walls or temporary expansion sites, designated beneficiary's home, for example, a temporary expansion site.

Then that wouldn't be a telehealth service. That could be service furnished within the hospital in the cases – in a case where they weren't making that designation. Then those services could be furnished via telehealth similarly but reported as telehealth using the 95 modifier.

(Brett Dillings): OK. (Inaudible) that mean that if we choose a hospital outpatient department choose those 95 modifier that we don't – we no longer have to notify the

regional office of expanding to a remote location of an on-campus department?

Male: For purposes of meeting the requirements for that service, you wouldn't have to do that.

(Brett Dillings): OK. Thank you very much.

Operator: The next question is from Nancy O'Leary from (Northville) Health Systems.

Nancy O'Leary: Hello. Thank you for taking my call. I have a question but based on the previous answer, I just have to add something else, if I can. It was my understanding from previous calls and from the information that I've read from CMS that the condition code 95 related to telehealth was reportable only on a 1500. So, is that wrong? Are you saying that condition code 95 is reportable on a 1450 in the event that a patient's home has not been designated as an off-campus provider location?

Male: So, the newest updated FAQ explains the way for outpatient therapy services that the – those services when furnished via telehealth and reported on institutional claims can be reported with the use of the 95 modifier.

Nancy O'Leary: On a 1450?

Male: It would be on whatever the appropriate institutional claim form is for the institution that would ordinarily report the outpatient therapy.

(Brett Dillings): OK. That seems to be different from what I understood previously. OK. So just…

Male: And that makes sense. This is – again, that's a recently updated FAQ in we had not previously issued instructions that would have allowed the outpatient therapy to be reported on institutional claim as these policies sort of evolved pretty rapidly. And so, it's consistent in a way. What you previously heard reflected the fact that there hadn't yet been instruction developed and that the instructions have since been developed.

(Brett Dillings): Right. But it had previously been my understanding that the fact a patient's home had not been designated as an off-campus provider location (inaudible) address that those services should be reported with a (PN). So, where I'm confused about where the 95 comes in.

Male: So, the 95 would be for Medicare telehealth service.

(Brett Dillings): (Inaudible) on these calls, like what was not an outpatient hospital service (inaudible). I think that's even in some of the office call transcripts.

Male: Maybe the issue here is that sort of a question of whether what's the service is being provided is a telehealth – Medicare telehealth service versus a hospital without walls…

(Brett Dillings): Correct.

Male: …(inaudible) home (as) a hospital and which is the question about or is it a service that you think might fall into either category depending on the circumstance.

(Brett Dillings): Correct – whether or not the patient's home is designated as an off-campus provider location. It was my understanding if that was the case, then the services where hospital outpatient services not telehealth services.

Male: And that's still correct. I think, again, - and it is a confusing circumstance. But the – for hospital outpatient departments, reporting the outpatient therapy services when furnished remotely they can be done either as a telehealth service with the telehealth rules and the telehealth reporting requirements or in cases where the patient's home has been designated as part of the hospital then they wouldn't necessarily be telehealth services and that's when the other modifiers would apply.

(Brett Dillings): That's when PO would apply if it was a designated hospital outpatient, correct?

Male: Right. If it's a…

(Brett Dillings): Unless a location had been previously identified as a PN, the originating site.

Male: Right. If the outpatient department has relocated to that location, then it should be billed with the PO modifier. And then, they've sought the temporary relocation request.

(Brett Dillings): OK. If I could then just get to the question I had originally wanted to ask, and it is kind of tied into that, and it was to ask your guidance on, again, from a Medicare outpatient billing perspective on the appropriate revenue code for the reporting of HCPCS 30 – Q3014, the originating site C.

And in that same context, would it ever be appropriate (inaudible) to report the 78X Series revenue code with (inaudible).

Male: (Inaudible).

Alina Czekai: Hi there. I think we're having some background noise, if you don't mind muting your phone.

(Brett Dillings): Hello?

Alina Czekai: Hi there. We can still hear you. Sorry about that.

(Brett Dillings): Yes. I don't know where that was coming from. It wasn't from here. Sorry. Did you hear my question?

Male: I think we missed it (inaudible).

(Brett Dillings): OK. Sorry about that. So, it was a question, again, as it relates to hospital outpatient billing for guidance related to the appropriate revenue code to report on, again, 1450 claim related to HCPCS Q3014, the originating site C.

And the reason that question is being asked is because there is a revenue code series 78X related to telehealth. So, based upon the conversation we previously had, I just want to know if that 78X series is ever reportable on a hospital outpatient claims? And would it be appropriate, as I mentioned, in the context of reporting Q3014 specifically?

Male: I'm not sure that anybody has to – the reporting requirements for the Q code in front of us at the moment, but that Q code is reportable by hospital outpatient departments under ordinary circumstances. And there are instructions regarding how hospitals would report that code. I don't know if anybody has that information at their fingertips. If not, we can certainly follow-up.

(Brett Dillings): Yes. We just haven't seen any instructions as to revenue code reporting.

Male: We can take that one back.

(Brett Dillings): Thank you. I appreciate it. Thank you.

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

Operator: Our next question is from (Kim Trebelmiku) from Johns Hopkins Health.

(Kim Trebelmiku): Hi. Thank you for taking my call. I had asked previously on a call that for hospitals in Maryland did we need to append the PO or the PN modifier, and we were instructed that we do not. To follow up to that, since we are not reporting the PO or the PN, do we need to submit the list of patient addresses to our regional office?

Male: So, that submission is part of the temporary relocation request is only to – for hospitals that are paid under the OPPS. So, since the Maryland hospitals will not be paid under the OPPS, they wouldn't have to submit relocation request.

(Kim Trebelmiku): Great. Thank you so much.

Operator: Thank you. The next question is from (Ken Ho) from NYUHS.

(Ken Ho): Hi. Thank you everyone for taking my call. One question that I wanted to see if we could get some additional direction was for the offsite location in actually the registry or submission for the patient's address.

That was issued, I believe, a few weeks to a month ago and there were supposed to be six attributes or a minimum number submitted so this way once things were cross referenced for the outpatient practice billing for the PBB that the address would be listed so that way that money would not be

taken back afterwards in order to secure for billing the offsite hospital location as an extension.

Can someone provide a little bit more clarification or where to locate that as we've not located that to date for the full listing?

Male: So, is the question for the temporary extraordinary circumstances relocation request what data points need to be provided for that request in the submission?

(Ken Ho): Correct – the data points that need to be provided as I know that they're saying like minimum, but then of a full list of the data points or what the minimum requirements are to be submitted and that's what I'm trying to seek for clarification.

Male: Sure. It mentioned in the (ISE2) the six data points you mentioned; the hospitals' CCN, the date the hospital began, furnishing services at the new location, the address of the original on-campus provider base department or accepted off-campus provider base department, the new addresses that is relocating to, a brief justification of the relocation, and the SS station that the relocation is not in consistent with the state emergency preparedness or pandemic plan.

And additionally, of course, it would be good to have a point of contact; names, title, telephone or e-mail as well on the request. This will – as I mentioned, those six points were in the (ISE2) and we'll be providing additional detail in FAQs as well.

(Ken Ho): Perfect. Thank you so much.

Operator: Thank you. The next question is from (Janet Maves) from Missouri Cardio.

(Janet Maves): Yes. Thank you so much. I have a question in regards to the long-term care facilities, the skilled nursing. It definitely says that telehealth can be used for the physicians that normally visit the skilled facilities.

We are a specialist and we have, in the past, had patients from those facilities that came to our office and we were able to build a professional component and be paid for the professional component of any service that was done. Is there a way that we can do telehealth with these patients and get paid?

Male: I'm trying to think about anything that would prohibit that. I think if under ordinary circumstances you – those patients would visit your office, I presume…

(Janet Maves): Yes, they do.

Male: …and under the circumstance of PHE, those same visits were conducted via telehealth, then I think from a professional claim perspective under the rules for telehealth, then those services could be reported via telehealth. I don't know if any…

(Janet Maves): We have had two that were telephone only and our MAC is denying them saying that the patient is in the SNF.

Male: OK. If you could follow up with an e-mail and we can (both) look into that and look at adding in FAQ.

(Janet Maves): OK. I appreciate that because when I sent my question in before all I got was the long-term care facility information and it didn't really address it. So, I will do so again. Thank you.

Male: Thank you very much.

Operator: Thank you. And we have a follow up from (Denise Weaver) from UHS Hospital.

(Denise Weaver): Hi. Thank you again. I apologize. I did have a secondary question regarding the video precepting that came in from our medical directors when we delivered the information. So, on the last call, I did ask if that was a requirement or if that was just the ability of the preceptor to be available to precept via interactive video.

The answer I received at last week's call was that it was required that the preceptor be available to do that function. The medical directors receiving conflicting information stating that it is an actual requirement that every case be video precepted. Can you please clarify that for me?

Male: Sure. So, the requirement for the interaction between the teaching physician and the resident in terms of their level of interaction would be the same regardless of whether or not virtual technology like telehealth is used.

I think where the helpful – where the clarification probably needs to be made is that during the service, the supervision – the (virtual) supervision – doesn't need to be 100 percent of the service but it would need to be similar to – you basically be using the virtual technology the same way in order to functionally be physically present.

And so to the extent that under ordinary circumstances the teaching physician would need to be in the same room, that could be met via the virtual technology. Similarly, if there's an overall requirement that there be an interaction to review the service, then that review would need to take place where it would ordinarily take place in person. It could take place via video, audio-video technology, during the PHE.

And so, in other words with many words, but in short, the audio-video technology could take the place of what would ordinarily be required to be an in-person interaction. But where those in-person interactions would previously have been required they would – such interaction would continue to be required. It just could be done virtually.

(Denise Weaver): OK. So, resident A is under the primary care exception and performing a 99442 telephone call that is equating to the same level of reimbursement as the 99213. Although we're billing the telephone call that case in normal circumstances, the case would be discussed with the preceptor. The preceptor would not normally have a physical presence, per se, in the service overall. So, we are saying that they do have to video precept every single case.

Male: So, if under ordinary circumstances discussion without the physical presence could be met then that flexibility would still be there.

(Denise Weaver): OK. I think that clarifies that. And I do apologize, but one last question is back to the COVID testing. We are – is there any limitation of diagnoses that – I'm reading through the 20011 memo that states effective March 18th and through the end of the PHE, if the medical service results in determining the need for a test, not necessarily that they do need the test but as the patient is – I am interpreting that as the patient is presenting fever, respiratory symptoms, provider – patient is worried about COVID. Provider determines no. It's really is an upper respiratory infection. We're not going to test you today.

Does that qualify for the CF modifier? And is there a limitation of diagnoses in which we would apply the CF modifier? I'm not finding anything that specifies specific diagnosis code in which that modifier needs to be used.

Male: You're talking about an outpatient setting here?

(Denise Weaver): Yes. I mean, your list of services include office outpatient, hospital observation, emergency, nursing facilities. And then, there were three criteria. It lists resulting in an order or administration of the test, which is inherent, related to furnishing or administering the test or to the evaluation of an individual for purposes of determining the need for such a test. It doesn't say that it was rendered.

So, they're basically ruling out a COVID on exam and not requiring the test. But because the patient is presenting in fear of COVID with symptoms, would we use the CF modifier without test?

Female: So, I think we (inaudible).

Male: I think we've said something around this issue. But I'm trying to remember exactly what it is and how we worded it because I know there's been certain amount of discussion about the (CF) modifier.

Female: Yes. I think – and we can certainly go back and do some more detailed research. But my understanding right now is the CF modifier is for those that list of services you mentioned when they result in the ordering for the actual administration of a test.

(Denise Weaver): Yes. And I think (inaudible) us up is that third statement – to the evaluation of an individual for purposes of determining the need for a test. But that is clearly separate from a service in which there is ordered or administered a test.

Female: Right. So, I think we're going to have to look into that further. I don't know we can answer that at the moment. But that's something that I think we'll take back.

(Denise Weaver): OK. All right. Appreciate it. Thank you again.

Operator: The next question is from (Kia Jones) from Primary Care.

(Kia Jones): Thank you for taking my call. The lady that just was asking the questions on the tests, I want to go back to her question in the G0463. You advised her that she could use that for telehealth in outpatient setting. Is that correct?

Male: So, I think the question was about in the circumstances where the patient's home has been designated as part of the hospital and a professional from outside the hospital furnishing or a professional within the same hospital is furnishing a service; and therefore, it's not a telehealth service.

And in cases where the hospital feels like – and I think she had language from (inaudible) actually from the interim rule regarding the – in cases where the hospital's incurring the resource cost of furnishing the service as they would ordinarily – and (Dave), you should definitely weigh in on this.

But I think in those cases when it's not a telehealth service and the – because the practitioner and the patient are both located within the hospital, then potentially that service could be billed both with a professional and a facility fee.

(Kia Jones): OK. That's what I thought. On previous calls, you had said the same thing. So, OK. I was – I got concerned. I say, well, I could bill for the G0463 when it's telehealth and I'm an outpatient hospital setting, but I can't. OK. All right. I can only bill for the Q code for the originating site, correct? (Inaudible).

Male: Great. Thank you.

(Kia Jones): Thank you.

Operator: All right. Our next question is from (Joyce Goode) from (Artisan) for Health.

(Joyce Goode): Hi. This is (Joyce). I was looking at the document released for the DR condition code. And the comment that the DR is required in a critical access hospital because they have waived the requirements that the call limit the number of inpatient beds to 25 and length of stay on average annual basis, 96 hours.

So, what I'm trying to determine – I would appreciate your help on – is at what point would you apply the DR condition code? Would you apply it to every Medicare patient in-house when you hit 26 beds? What if it's only for one day of a multiple-day stay? How do you determine when – which patient it should go on? Because if I'm on – if I was in the hospital before we hit 26, should I not have it on my claim?

Diane Kovach: Hi. This is Diane Kovach. So, the condition code should be used for the beneficiaries when the waiver applies. So, for instance, it wouldn't be for everyone. It would be for that 26 bed and beyond patient.

If it's just a day for the stay, it is fine to put it on for those claims, just indicate that at a point in time in that stay the waiver had been invoked.

(Joyce Goode): OK. And then, the other question I have is in the state of Minnesota, Governor Walz has asked multiple sites to help do congregate living testing in nursing homes, assisted-living group homes, and such, where Medicare patients are living when outbreak occurs.

And then the requirement that they're asking us to do is that if there's an outbreak and we test people and they have it, then they would like them to be tested weekly until they have two where they're clear.

Have you had any discussion on patients in congregate living where the state is supporting these sites with outbreaks and potentially you could have maybe five weeks of testing going on?

Male: So, we are working on that. I'm sorry. Go ahead. (Is that right)?

(Joyce Goode): Go ahead. I think you have – you know what I'm asking.

Male: I do. We are working on questions that we've gotten around coverage in those circumstances. I think for now as the MACs are – as they do in their usual course – making their reasonable and necessary determinations when they have claims hit their systems or otherwise.

And so, I think that for – well, I don't have anything published to point you to right now. It's (inaudible) to say that the MACs make those determinations in the normal course. But we know that there are questions that have come up about – either this or similar kind of situations and we're working internally and with our colleagues in the public health world to provide some context and direction to.

(Joyce Goode): I think what our – what we're thinking is we're going to submit the claims and go from there. And hopefully, we'll all meet in the middle and be able to take care of this people.

Male: Yes. I think the MACs have been thinking about this issue. So, depending on where you are, (inaudible) maybe – either more or less – they may have had more or less of these particular issues. But you're not the first one who's asked the question. And you'll probably find that the MACs have dealt with it in some fashion. So far, we're working on whether we can layer or should layer in on top of that with anything else from the national level.

(Joyce Goode): OK. Thank you.

Male: You're welcome. Thank you.

Operator: Thank you. The next question is from (Emilia Adachi). Please state your organization. Your line is open.

(Emilia Adachi): Hi. I think this was addressed earlier on during the beginning of this webinar or conference call. But it has something to do with the 1135 waiver for SNF.

And this – I understand this will be clarified further next week and thank you very much for that.

And I just want to know if I'm understanding this or we're understanding this correctly. And this is something to do with the Part A beneficiary (inaudible) – wherein a beneficiary who exhausted their SNF benefit or in the process of exhausting their benefits and because of the emergency, they were not able to start the new benefit period and I'll give an example because I think it would be a lot clearer that way.

We have a Medicare Part A beneficiary who we admitted with (15) Medicare SNF days left from the hospital. So, plan was for him to be discharged home after he had exhausted his benefits. But on day 98 of his benefit period, he became symptomatic and tested positive for COVID. We, therefore, could not discharge him home. Now, is this one of those instances where this waiver applies?

Male: Yes. So, we have not spoken to every scenario with which that waiver would apply to beneficiaries, but we have noted, as you did, that where the emergency – the COVID-19 emergency is causing the disruption that that waiver could be applied.

(Emilia Adachi): OK. And just as a follow up because I think the big confusion is whether there needs to be a gap of a day or so before we can actually have that additional coverage renewed. But it's just does not seem to make sense. I mean, understand that from a claims processing perspective. But in terms of how the waiver is kind of like spelled out, it doesn't seem like they're – they are consistent if that make sense.

Diane Kovach: Yes. This is Diane Kovach. So, what we have said earlier in the call is we are still working with the MAC to make sure that have good and consistent instructions for them on how to handle these claims. So, we do know that there's still confusion out there. We are hopeful that we'll have another update at the next Office Hours call.

(Emilia Adachi): OK. Meanwhile though – thank you, Diane – meanwhile, is that like – because we're now talking about – we're talking about retroactive claims that

will make. So, is it – are we correct in understanding that for certain cases like, I'm sure that these are very rare cases – for certain beneficiaries who were affected by this public health emergency, you really don't need a gap because we're keeping them in the (inaudible) and we are (inaudible) from discharging them home because of the emergency. Diane?

Diane Kovach: I would have to defer to (Jason) on that on whether a gap is required for coverage.

(Jason): No. We have not spoken to other specific needs for a gap to be required to continue.

(Emilia Adachi): OK. So, either way, I'm glad that there is really because everybody that we talked to seems to be so (inaudible) in about their answers. And I'm glad to hear that there is no definitive answer yet, so thank you.

Operator: Thank you. The next question is from (Becky Kadis). Please state your organization. Your line is open.

(Becky Kadis): Hi. Yes. I work for (Inaudible). And the question that surround the FAQ about the outpatient therapy and the modifier 95, I think some of that could be clarified by the use of the word telehealth because hospitals are using the same communication devices as they would use for a telehealth services.

They use that same telehealth word when they ask you those questions. And it doesn't mean that it's a true telehealth services. And I think that's where a lot of this confusion is coming from because if I ask you a question using the word telehealth, you give me a true answer to true telehealth which mean that the service has to be on the list and that the person providing it has to be on the list of eligible providers where hospital outpatient departments that employ (this) are not entitled to the telehealth allowances.

We are operating under the expansion to the patient's home and being paid under OPPS. We're not being paid as telehealth services even though and the hospital people's minds and clinician minds that's what they're calling it because they're using that equipment.

So, did I understand you correctly that for those situations and nothing has changed that we still expand our wall, we notify the regional office, we use the PO or PN modifier depending on if we chose to notify the regional office, and the reporting of modifier 95 with a therapist clinical services would apply, as you said earlier addressing this question, would apply to those types of hospitals who can't expand their walls if the waiver does not apply to it at all. Is that a true distinction between the two things?

Male: So, first of all, thank you for articulating root of the confusion, and we'll continue to try to be as clear as possible. And I think it's absolutely right to note that using the same technologies but using different legal terms for purposes of billing is obviously a pretty confusing scenario. But in the attempt to allow (for them) to maintain the maximum flexibility, I think some of that confusion comes with that.

That said, to answer your question, so your analysis is completely correct except that for purposes of outpatient therapy services because the hospital, at that point, is billing for those therapy services not – and not pay them to the OPPS but they're paid under the hospital outpatient – under the outpatient therapy benefit, they actually can be reported as telehealth services even for hospital outpatient department.

In other words, for those outpatient therapy services alone, not for the full range of services that can be furnished and reported by a hospital but for outpatient therapy service, the hospital really would have the option of doing either the designation of the patient's home as part of the hospital or alternatively, reporting those services as telehealth services under outpatient therapy.

(Becky Kadis): And when you started your statement, you said those hospitals not under OPPS. So, you're referring to hospitals that are paid by some other method than OPPS can have that choice.

Male: No, even those hospitals that are paid for their services generally under OPPS, the outpatient therapy services, while they're not legally from a legal perspective, their outpatient therapy services that are billed by the hospital.

And so actually, they can be reported under telehealth, but they could also be reported under hospital without walls construct.

So, even for hospitals that are paid under the OPPS for the specific outpatient therapy services, they could, in the alternative even for those hospitals, be reported as telehealth services.

(Becky Kadis): So, that would be the list of therapy services that is currently on the list of eligible telehealth services, only those physical medicine codes would be eligible…

Male: Right, just for – right.

(Becky Kadis): …for being reported with modifier 95 on a UB04 and not go through the hassle of submitting all of the addresses and keeping up with that…

Male: That's correct.

(Becky Kadis): …choosing not to use the expansion waiver.

Male: That is correct, but just for the services that are described as outpatient therapy.

(Becky Kadis): And (inaudible) all on the telehealth list.

Male: Correct.

(Becky Kadis): OK. Because that's a big departure from what we've heard before and that's why there's so much confusion around that. And even in your earlier question, you said that there are two methods for a hospital to be paid and again said for hospital that aren't eligible for the expansion waiver. So, this time you said it much more clearly. So, thank you for that.

Male: Good. I appreciate the question and all the more for the opportunity to clarify.

(Becky Kadis): OK. Thank you so much.

Alina Czekai: Great. Thank you for your question and thank you everyone for joining our Office Hours today. We hope these calls continue to be helpful and we appreciate all that you're doing as our nation addresses COVID-19.

Our next Office Hours will take place next Tuesday, June 9th at 5 p.m. Eastern. Have a great rest of your evening. Stay safe and healthy.

End