Billing for Telehealth Services During COVID-19 Public Health Emergency

May 13, 2020
Webinar FAQ Document

1. **Question** – Can you bill a facility fee for telehealth services?

   Answer – As discussed in the webinar, services provided via audio/video communications to a patient at home are not considered to be telehealth services during the current public health emergency. Instead, the patient's home is considered to be a temporarily relocated off-campus provider-based department. Therefore, the facility may bill for services provided to patients at home via audio/video communication as though the patient was located in the hospital outpatient department, with the addition of an appropriate modifier depending upon the facility's particular circumstances. Modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be assigned when items and services are provided to registered patients of a hospital on-campus department or to registered patients of an excepted hospital off-campus provider-based department that has temporarily relocated under the extraordinary circumstance policy outlined in the interim final rule. Modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be assigned when items and services are provided to registered patients of a hospital non-excepted off-campus provider-based department or when the hospital chooses not to pursue temporary relocation of the hospital department under the extraordinary circumstance policy.[1]

   Additionally, if the provider is at an approved distant site and the patient is physically located at your facility, then it would be allowable to report Healthcare Common Procedure Coding System (HCPCS) code Q3014, *Telehealth originating site facility fee*.

2. **Question** – Is there a reference link you can provide that can help delineate when a provider would bill for the E/M visit with HCPCS code G0463 versus HCPCS code Q3014?

   Answer – CMS stated during the CMS Office Hours call of May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing. In other words, if the hospital is using facility resources above and beyond the costs associated with the telecommunications technology, including using hospital auxiliary staff to obtain patient history, record available vital signs, coordinate the discharge instructions, provide patient education, or similar tasks, then it may be appropriate to report an E/M visit charge. If, however, the hospital is not expending facility resources outside of the resources utilized to initiate the telehealth visit, it is likely more appropriate to report HCPCS code Q3014, *Telehealth originating site facility fee*, to cover the costs associated with providing the visit utilizing telecommunications technology.[2] A

[1] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 37-46, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)
[2] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

transcript of the call is available in the Special Open Door Forums section of CMS and is titled "Thursday, May 7, 2020, CMS Office Hours"

3. **Question** – Many of our staff and providers are located at home, and providing services to patients who are also at home. Can we bill the same when the staff or provider are located in their home?

   Answer – There are several items that factor into determining the logistics for billing for services. Services that are provided in a temporarily relocated off-campus provider-based department (that may include the patient's home) by the hospital's clinical staff using telecommunications technology would be billed as though the services were provided face-to-face. Note that services must be provided in accordance with the appropriate level of supervision and the hospital must ensure the location(s) meet all of the conditions of participation, except for the conditions of participation that have temporarily been waived during the public health emergency. If the hospital plans to seek an exception under the extraordinary circumstance relocation policy for their on-campus or excepted off-campus departments, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be appended to the Current Procedural Terminology (CPT®)[3] or HCPCS procedure code(s) that describes the service(s) provided. If the hospital chooses not to seek an exception under the extraordinary circumstance relocation policy or if the services are provided to registered outpatients of a non-excepted off-campus provider-based department, modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be assigned.[4]

   The physician/non-physician practitioner (NPP) would submit their charges on the CMS-1500 using the place of service code that would have been assigned if the service had been provided outside of the current public health emergency with modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*, appended to identify the professional services provided via telehealth.

4. **Question** – Our facility is considered to be provider based. The hospital outpatient physician does an audio/video visit and is on-site at the facility, while the patient is at home. The hospital staff schedule and register the patient for the visit, then the staff open the visit with the check-in and turn the visit over to the physician. Would this qualify as HCPCS code Q3014, *Telehealth originating site facility fee*?

   Answer – The facility service described appears to be primarily supportive in nature and may be reported with HCPCS code Q3014, *Telehealth originating site facility fee*. CMS stated during the CMS Office Hours call of May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[5] In other words, if the hospital is using facility resources above and beyond the costs associated with the telecommunications technology, including using hospital auxiliary staff to obtain patient history, record available vital signs, coordinate the discharge instructions, provide patient education, or similar tasks, then it may be appropriate to report an E/M visit charge. If, however, the hospital is not expending facility

[3] CPT® is a registered trademark of the American Medical Association. All rights reserved.
[4] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 37-46, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)
[5] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

resources outside of the resources utilized to initiate the telehealth visit, it is likely more appropriate to report HCPCS code Q3014, *Telehealth originating site facility fee*, to cover the costs associated with providing the visit utilizing telecommunications technology.

5. **Question** – If we typically charge and bill for both the facility and professional charges in the Emergency Department, what would be appropriate to charge if the patient is present in the ED, but the provider is performing audio/video services from another facility that is owned by the same organization?

   Answer – When services are provided via audio/video communications and the patient and provider are both located somewhere on the campus of the same facility, CMS has stated that the services would be reported as face-to-face services.[6] Note that the definition of "same facility" generally applies to entities that are billing under the same Medicare Provider Number (MPN).

6. **Question** – If our registered nurse and nurse practitioner are doing a telehealth check-in with our obstetric/gynecologic patients, would these be reported using HCPCS code Q3014?

   Answer –If the registered nurse and nurse practitioner are providing an evaluation and management service using audio/video communications that meets your facility's internal criteria for E/M assignment, then it may be appropriate to report HCPCS code G0463, *Hospital outpatient clinic visit for assessment and management of a patient*. CMS stated during the CMS Office Hours call of May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[7] In other words, if the hospital is using facility resources above and beyond the costs associated with the telecommunications technology, including using hospital auxiliary staff to obtain patient history, record available vital signs, coordinate the discharge instructions, provide patient education, or similar tasks, then it may be appropriate to report an E/M visit charge. If, however, the hospital is not expending facility resources outside of the resources utilized to initiate the telehealth visit, it is likely more appropriate to report HCPCS code Q3014, *Telehealth originating site facility fee*, to cover the costs associated with providing the visit utilizing telecommunications technology.

7. **Question** – Is it correct that HCPCS code Q3014 is only to be reported with video visits and not telephone visits?

   Answer – Yes. By definition, telehealth services are services provided using audio/video communications and are not audio-only in nature.[8] There are some outpatient therapy and education services that may be provided as audio-only services when provided by auxiliary staff of the hospital when audio and video communication is not possible; however, those services would be reported using the appropriate code for the actual services that are provided, rather than the the originating site fee.[9] Other telephone services, including CPT® codes 98966-98968, are not considered telehealth services, and should not be reported with HCPCS Q3014, *Telehealth originating site facility fee*.

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[6] Hospitals: CMS Flexibilities to Fight COVID-19, "CMS Hospital Without Walls (Temporary Expansion Sites)," page 4, https://www.cms.gov/files/document/covid-hospitals.pdf, (April 29, 2020)

[7] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[8] "Medicare Telehealth Frequently Asked Questions, Question #8, https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf (March 17, 2020)

[9] Hospitals: CMS Flexibilities to Fight COVID-19, "CMS Hospital Without Walls (Temporary Expansion Sites)", page 4, https://www.cms.gov/files/document/covid-hospitals.pdf (April 29, 2020)

8. **Question** – Are we able to bill HCPCS code G0463 for telehealth services if the patient self-reports vitals?

   Answer – Yes; it may be appropriate to report HCPCS code G0463, *Hospital outpatient clinic visit for assessment and management of a patient,* if a patient self-reports their vital signs.[10] Use of HCPCS code G0463 is based upon your facility's internal criteria for E/M assignment and whether or not the patient's home has been designated as a relocated off-campus provider-based department under the extraordinary circumstance policy outlined in the interim final rule published on April 30, 2020.[11]

9. **Question** – How do I get the patient's home designated as a relocated PBD?

   Answer – Hospitals may apply for an extraordinary circumstance relocation exception in response to the COVID-19 public health emergency by notifying their CMS Regional Office by email within 120 days of beginning to provide services in the new off-campus location(s) and include the following information: 1) The hospital's CMS Certification Number (CCN); 2) the address of the current provider-based department (PBD); 3) the address(es) of the relocated PBD(s); 4) the date which they began furnishing services at the new PBD(s); 5) a brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19; and 6) an attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan.[12] Additionally, CMS reiterated during the CMS Office Hours call on May 7, 2020 that addresses must be provided for each of the locations to which the hospital outpatient department is temporarily relocating. The email may contain multiple addresses or may be in the form of a spreadsheet, but hospitals are reminded that the information must be encrypted and should not include unnecessary protected health information (PHI), such as patient names.

10. **Question** – Where do I need to send the list of patient addresses?

    Answer – An email may be sent to your CMS Regional Office, within 120 days of beginning to furnish and bill for services at the relocated off-campus provider-based departments (which may be the patient's home).[13]

    For Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island or Vermont, the email may be sent to robosfm@cms.hhs.gov.

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[10] CMS Outreach and Education, "Tuesday, May 5, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[11] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 41, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[12] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 41, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[13] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 41, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

For New Jersey, New York, Puerto Rico, or Virgin Islands, the email may be sent to RONYcfm@cms.hhs.

For Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia, the email may be sent to ROPHICFM@cms.hhs.gov.

For Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina or Tennessee, the email may be sent to ROATLfm@cms.hhs.gov.

For Illinois, Indiana, Michigan, Minnesota, Ohio, or Wisconsin, the email may be sent to ROCHIfm@cms.hhs.gov.

For Arkansas, Louisiana, New Mexico, Oklahoma, or Texas, the email may be sent to RODALFM@cms.hhs.gov.

For Iowa, Kansas, Missouri, or Nebraska, the email may be sent to rokcmmfm@cms.hhs.gov.

For Colorado, Montana, North Dakota, South Dakota, Utah, or Wyoming, the email may be sent to rodenmmfm@cms.hhs.gov.

For Arizona, California, Hawaii, Nevada, or the Pacific Territories, the email may be sent to ROSFOFM@cms.hhs.gov.

For Alaska, Idaho, Oregon or Washington, the email may be sent to ROSEA_DFMFFSO2@cms.hhs.gov. [14]

11. **Question** – If billing on a facility claim with HCPCS code G0463 when the patient's home has been designated as a provider-based department, which modifier would it appropriate to report? Is the patient's address required to be on the claim in the facility location?

    Answer – Modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be assigned when items and services are provided to registered patients of a hospital on-campus department or to registered patients of an excepted hospital off-campus provider-based department that has temporarily relocated under the extraordinary circumstances policy outlined in the interim final rule. Modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be assigned when items and services are provided to registered patients of a hospital non-excepted off-campus provider-based department or when the hospital chooses not to pursue temporary relocation of the hospital department under the extraordinary circumstances policy.[15] Under the temporary relocation exception, hospitals may temporarily relocate a portion of each of their outpatient departments to multiple off-campus locations; these locations may include the patients' homes. Hospitals that opt to temporarily relocate their outpatient departments, or a portion of each department, under this provision must submit a request to their CMS Regional Office no later than 120 days following the date they begin providing services at one or more of these off-campus locations. The temporary relocation sites will be

[14] CMS Regional Offices, available at: https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices

[15] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 37-46, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

considered excepted off-campus provider-based departments of the hospital for the duration of the public health emergency and will be reimbursed for services provided using telecommunications technology at a rate which is equivalent to the rate that would be received if the services were provided during a face-to-face visit in the hospital outpatient department.

During the CMS Office Hours call on Thursday, May 14, the CMS Subject Matter Expert stated that the address of the main campus of the hospital should be listed on the claim. The patient's home address would not be reported on the claim.[16]

12. **Question** – If we file for the relocation expansion to make the patient's home a provider-based department, can we charge for HCPCS code G0463 with modifier PO instead of HCPCS code Q3014?

    Answer – Code selection is determined on the amount of work completed by the facility staff, and not solely based upon the designation the patient's home as a temporarily relocated off-campus provider-based department. CMS stated during the CMS Office Hours call of May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[17] In other words, if the hospital is using facility resources above and beyond the costs associated with the telecommunications technology, including using hospital auxiliary staff to obtain patient history, record available vital signs, coordinate the discharge instructions, provide patient education, or similar tasks, then it may be appropriate to report an E/M visit charge. If, however, the hospital is not expending facility resources outside of the resources utilized to initiate the telehealth visit, it is likely more appropriate to report HCPCS code Q3014, *Telehealth originating site facility fee*, to cover the costs associated with providing the visit utilizing telecommunications technology.

13. **Question** – Can you clarify if we can charge for HCPCS code G0463 using modifier PN if the hospital does not send the information to the CMS Regional Office to make the patient's home a provider-based department?

    Answer – Yes. CMS stated during the CMS Office Hours call of May 7, 2020 that hospitals who do not plan to seek an exception under the extraordinary circumstances relocation policy may bill for services provided to registered patients of the hospital using telecommunications technology by appending modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, to those services. The services will then be reimbursed at the PFS-equivalent rate, which is currently 40% of the OPPS rate.

14. **Question** – If you initially have 100 patient addresses to submit for the relocation exception and those are sent in your initial email, what do you do when you get 50 more patients that you want to serve under the temporary relocation exception?

    Answer – CMS has not yet provided any additional information as to how this could best be accomplished, but they have stated they will provide additional information in future Frequently Asked Question (FAQ)

[16] CMS Outreach and Education, "Thursday, May 14, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[17] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

documents. They also noted that facilities may work with their CMS Regional Office to streamline these processes.[18]

15. **Question** – If we change the site of service to the patient's home, is it for all patients, or can you continue to have a mix of on-site, off-site and at home? Would it be safe to say that the roster of patient addresses would have only the patient addresses for those receiving telehealth (audio/video) services?

    Answer – Yes. CMS stated that hospitals may relocate a portion of their excepted provider-based departments to new-off campus location(s) while maintaining the original on-campus location.[19] CMS is expecting most facilities to provide services in a variety of locations, both on-campus and off-campus. Patient addresses need to be provided for every patient's home that is temporarily being designated as an off-campus provider-based department of the hospital for purposes of receiving services in their home under the extraordinary circumstance relocation exception.

16. **Question** – What if the patient is admitted to Observation or Inpatient status and the physician's services are provided via telephone only? In this instance, both the patient and the provider are in the same facility, but the provider does not see the patient to limit the COVID-19 exposure risk.

    Answer – In the scenario described, the physician's services could be reported using CPT® codes 99441-99443, *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services,* but will be bundled into any E/M service reported within the previous 7 days or within the next 24 hours. When the physician "rounds" the next day and sees the patient, which may be done by audio/video communication, then the telephone service would bundle into CPT® codes 99218-99239. However, if the initial admission service is done via audio/video communications rather than audio only, the corresponding CPT® code for the observation or inpatient visit may be reported.[20]

17. **Question** – Can we append modifier 95 on CPT® codes 99441-99443 for telephone visits? These are audio-only visits and not audio/video (synchronous) visits.

    Answer – Yes. CMS has established a policy that requires modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*, to be appended to CPT® codes 99441-99443, *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services*.[21]

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[18] CMS Outreach and Education, "Thursday, May 14 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[19] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 42, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[20] CMS Outreach and Education, "Thursday, May 14 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[21] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, page 15, https://www.cms.gov/files/document/covid-final-ifc.pdf (March 30, 2020)

18. **Question** – If we bill CPT® codes 99441-99443 and make the patient's home a relocated provider-based department, can we bill a facility component?

    Answer – No, because CPT® codes 99441-99443, *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services,* are professional services only codes and are not appropriate for reporting on a facility claim form.[22]

19. **Question** – Would modifiers CS and 95 be reported on the same CPT® code?

    Answer – Yes, it is possible that multiple modifiers would be necessary to correctly report all circumstances for a single CPT® code. If the service results in an order for the COVID-19 test, then modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test*, should be applied so that patient cost-sharing requirements are appropriately waived. If the service is provided via telehealth, then modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* would be reported on the professional claim form.[23]

20. **Question** – If a COVID phone assessment is performed, would we use the E/M, such as CPT® 99213, with modifier CS?

    Answer – Because the service is audio-only rather than audio/video, CPT® codes 99441-99443, *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient,* would be more appropriate. Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test*, would be appended to the telephone code if the service resulted in an order for or performance of VOCID-19 testing. In the Interim Final Rule published on April 30, 2020, the Relative Value Units (RVUs) for the telephone services were increased to mirror CPT® codes 99212-99214, *Office or other outpatient visit*.[24]

    CMS instructions state that pricing modifiers are sequenced first, followed by informational modifiers. Although there has been no guidance specific to sequencing modifier CS, , best practice is to sequence modifier CS first, as this modifier is used to waive the deductible or coinsurance amounts, and modifier 95 is informational.[25]

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[22] CMS Outreach and Education, "Thursday, May 14, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[23] MLN Matters®, "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)," pages 2-4, https://www.cms.gov/files/document/se20011.pdf (April 10, 2020)

[24] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 139, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[25] CMS-1715-F, "Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for

21. **Question** – What is your suggestion for the use of modifier CS for use on chest x-rays or other labs since there is no clarification regarding its usage?

    Answer – During the May 14 CMS Office Hours call, there was no specific timeframe given for release of additional guidance on modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test*.[26] The Families First Coronavirus Response Act (FFCRA) portion states, "Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product." CMS has interpreted this to mean that modifier CS should be appended to the E/M visit and laboratory test only. Other payers may have a broader interpretation. You may wish to contact your Medicare Administrative Contractor (MAC) and other payers for additional guidance pending clarification from CMS.[27]

22. **Question** – We have a patient that comes through the ED, but the visit is not COVID-19 related. We still did a COVID test. Would we use modifier CS for the E/M level? The patient came through ED and went to surgery. At this time, we are performing the COVID-19 test on every patient prior to surgery.

    Answer – Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* should be used when the E/M service results in the order for or performance of a COVID-19 test.[28] Because the administration of the test is facility protocol prior to surgery, and the E/M visit did not specifically result in an order for the COVID-19 test, modifier CS does not appear to be appropriate in this circumstance. You may wish to contact your MAC for further guidance.

23. **Question** – We perform a telehealth service in our COVID Clinic to determine each patient's need to be tested for COVID-19. Would we be able to report two separate services since the office visit was done through telemedicine and the testing was done in the office?

    Answer – The answer to this question will vary depending upon whether you are reporting facility or professional services. When billing for the facility, specimen collection is not included in the E/M service and therefore may be separately reported using HCPCS code C8903, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*. However, HCPCS code C9803, is a conditionally packaged service under the OPPS, meaning that C9803 will

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Evaluation and Management, Observation and Provision of Self-Administered Esketamine, Interim Final Rule, page 62708, https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other (November 19, 2019)

[26] CMS Outreach and Education, "Thursday, May 14, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[27] Families First Coronavirus Response Act, "Division F Health Provisions, Section 6001 Coverage of Testing for COVID-19," available here: https://www.congress.gov/bill/116th-congress/house-bill/6201/text (March 24, 2020)

[28] Families First Coronavirus Response Act, "Division F Health Provisions, Section 6001 Coverage of Testing for COVID-19," available here: https://www.congress.gov/bill/116th-congress/house-bill/6201/text (March 24, 2020)

not receive separate payment when billed with an Evaluation & Management (E/M) service on the same date of service; rather the payment will be packaged into the E/M service.

When billing for professional services, the specimen collection would be reported using CPT® code 99211, *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services,* and the telemedicine service would be reported using an appropriate E/M code based on the services that are documented in the patient's record with modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*, and a place of service code that reflects the location where the service would have been provided in the absence of the current public health emergency.

24. **Question -** Has CMS released reimbursement information for CPT® code 86769?

    Answer – Unfortunately, the Clinical Laboratory Fee Schedule (CLFS) with reimbursement information has not been updated. During a recent CMS Office Hours call, the subject matter expert from CMS explained that the pricing information was still under discussion.[29]

25. **Question -** Where am I able to register to attend the CMS Office Hours calls?

    Answer – The CMS Office Hours calls are a part of the Open Door Forums, and you may subscribe by selecting the All Open Door Forum Mailing List Sign-Up link, available here: https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums

26. **Question -** How does a facility bill for outpatient speech & physical therapy e-visits?

    Answer – An e-visit (or electronic visit) is not a treatment session, is not considered telehealth, and is patient-initiated contact. HCPCS codes G2061-G2063, *Qualified nonphysician health care professional online assessment and management service,* describe an on-line service that is conducted through an on-line medium, such as a patient portal. These services have now been assigned to status indicator A, *Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS,* and may be submitted on the facility claim form.[30]

27. **Question -** Can a hospital outpatient therapy department be paid for a telehealth visit when provided by a physical therapist, occupational therapist, or a speech language pathologist?

    Answer – When therapy services are provided in a temporarily relocated off-campus provider-based department by the hospital's clinical staff using telecommunications technology, the therapy services would be billed as though they were provided face-to-face. Note that services must be provided in accordance with the appropriate level of supervision and the hospital must ensure the location(s) meet all of the conditions of

[29] CMS Outreach and Education, "Thursday, May 14, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[30] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 119, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

participation, except for the conditions of participation that have temporarily been waived during the public health emergency. Also, if therapy services are not provided by clinical staff of the hospital, the hospital would not bill for these services. If the hospital plans to seek an exception under the extraordinary circumstance relocation policy for their on-campus or excepted off-campus department, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be appended to the CPT® or HCPCS procedure code(s) that describes the service(s) provided. If the therapy services are normally provided in a non-excepted off-campus provider-based department or if the facility does not plan to seek an exception under the extraordinary circumstance relocation policy, modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be appended to the procedure code(s). CMS has published a list of the outpatient therapy, counseling, and educational services that hospital clinical staff may furnish incident to a physician's service during the COVID-19 public health emergency.[31]

28. **Question -** Therapy services are paid under the Medicare Physician Fee Schedule, and the hospital will be paid under the MPFS rate when billing with modifier PN. Would there be any reason to apply for the PBD relocation application, or can we skip that part?

    Answer – You are correct that most therapy services are reimbursed under the Medicare Physician Fee Schedule (MPFS) rather than under the Outpatient Prospective Payment System (OPPS) and therefore will not be subject to a reduction in reimbursement if the facility does not apply for the extraordinary circumstance relocation exception. CMS has stated that it is not mandatory to submit a request for temporary relocation of the hospital outpatient department to the CMS Regional Office in order to report services provided in the patient's home using modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*.[32]

29. **Question -** Can facilities charge for the approved rehabilitation services, diabetes education, etc. on a facility claim when audio/visual communication is used, whether or not they have submitted the patient's address to be designated as a relocated PBD, providing they add modifier PN or modifier PO?

    Answer – This is partially correct. Modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, may be assigned when billing items and services provided to a registered outpatient of the hospital in their home using telecommunications technology when the hospital chooses not to pursue temporary relocation of the hospital department under the extraordinary circumstances policy.[33] Modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, may only be assigned when the hospital has temporarily relocated one or more of their departments under the extraordinary circumstance policy by submitting a request to their CMS Regional Office no later than 120 days following the date they begin providing services at one or more of

[31] List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (April 30, 2020)
[32] CMS Outreach and Education, "Tuesday, May 5, 2020 CMS Office Hours," and "Thursday, May 14 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
[33] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 37-46, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

these off-campus locations. The temporary relocation sites will be considered excepted off-campus provider-based departments of the hospital for the duration of the public health emergency and will be reimbursed for services provided using telecommunications technology at a rate which is equivalent to the rate that would be received if the services were provided during a face-to-face visit in the hospital outpatient department. Because most therapy services are reimbursed under the MPFS, this may be a moot point.

30. **Question -** Can a nurse provide diabetes education via telehealth and bill for the service?

    Answer –When diabetes education is provided in a temporarily relocated off-campus provider-based department by the hospital's auxiliary staff using telecommunications technology, the therapy services would be billed as though they were provided face-to-face. Note that services must be provided in accordance with the appropriate level of supervision and the hospital must ensure the location(s) meet all of the conditions of participation, except for the conditions of participation that have temporarily been waived during the public health emergency. Also, if education services are not provided by clinical staff of the hospital, the hospital would not bill for these services. If the hospital plans to seek an exception under the extraordinary circumstance relocation policy for their on-campus or excepted off-campus department, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be appended to the CPT® or HCPCS procedure code(s) that describes the service(s) provided. If the therapy services are normally provided in a non-excepted off-campus provider-based department or if the facility does not plan to seek an exception under the extraordinary circumstance relocation policy, modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be appended to the procedure code(s). CMS has published a partial list of the outpatient therapy, counseling, and educational services that hospital auxiliary staff may furnish incident to a physician's service during the COVID-19 public health emergency.[34]

31. **Question -** If a physical therapy service is provided via telehealth, is it correct that we would need to append condition code DR and modifier 95? Also, would there be a need to report modifier CR since it is part of telehealth?

    Answer – Condition code DR, *Disaster Related,* is used on both facility and professional claims when all items and services submitted on the claim are related to a COVID-19 waiver. If the patient's visit is impacted by COVID-19, then the condition code is appropriate. Modifier CR, *Catastrophe/disaster related,* is used on both facility and professional claims to identify specific Part B line items that are provided based upon a formal waiver.[35] It would not be necessary to report both modifier CR and condition code DR on the same claim.

    Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* should be applied to line items billed on professional claims that describe services furnished via telehealth with dates of service on or after March 1, 2020 and for the duration of the public health emergency. Modifier 95 would not be used when billing facility claims.

[34] List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (April 30, 2020)

[35] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 3, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

32. **Question -** What is the difference between a virtual check-in code and Q3014?

    Answer – HCPCS code Q3014, *Telehealth originating site facility fee,* may be reported by the facility when the patient presents to the hospital and receives telehealth services provided by a practitioner at a distant site. In this instance, the hospital provides the audio/visual telecommunications equipment and a room for the patient's visit.[36] HCPCS code Q3014 may also be reported when a practitioner is providing services via telecommunications technology to a registered outpatient of the hospital whose home has been temporarily designated as an off-campus provider-based department under the extraordinary circumstance relocation exception to cover the hospital's costs for providing the equipment and space for the practitioner.

    A virtual check-in is a brief check-in with the provider to see if an office visit or other service may be necessary. This is patient initiated, and may be provided either by telephone or using telecommunications technology.[37]

33. **Question -** If we decide to make the patient's home a relocated provider-based department but we've already billed the professional fee as telehealth, are we able to go back and bill the facility component? Would that require an update to the billing for the professional component billing?

    Answer – CMS instructions state that during the COVID-19 pandemic, physicians should report telehealth services as they would if there was no public health emergency. Providers who did not routinely see patients via telehealth prior to the public health emergency are allowed to submit claims with the place of service code that reflects the usual location where patients are seen, rather than submit claims using place of service code '02' and receive the lower facility rate.[38] CMS has requested that modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* be appended for services provided via telehealth in these cases. To ensure that appropriate reimbursement is received for professional services, it may be necessary to resubmit your professional claims in accordance with this guidance.

34. **Question -** Are NPP or "incident to" claims billed on the facility claim (UB-04) or the professional claim (CMS-1500)?

    Answer – The answer is dependent upon your provider contract. Some NPP's have their own National Provider Identifier (NPI) and may submit a professional claim and bill for their services on the CMS-1500. NPPs who are hospital employees usually bill for their services on the facility claim form (UB-04).[39]

35. **Question –** The ability to use time or medical decision making for E/M code selection only applies to audio/visual services and not the audio-only services, correct?

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[36] MLN® Booklet, "Telehealth Services, Originating Sites," https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf, (March 2020)
[37] Medicare Telemedicine Health Care Provider Fact Sheet, https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet (March 17, 2020)
[38] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 21, https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (April 10, 2020)
[39] Pub. 100-04 Medicare Claims Processing Manual, Chapter 3, Section 10.1, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf (September 23, 2014)

Answer – Yes. Using the time or medical decision making as the determining factor for code selection is limited to CPT® codes 99201-99215. In the interim final rule published on April 30, 2020, CMS clarified that using the approximate time within the current descriptions of CPT® codes 99201-99215 is appropriate.[40]

36. **Question -** Is there any rule for using time as the determining factor for E/M office visits, other e-visits, or telephone visits without requiring that at least 50% of the visit was spent providing counseling and coordination of care?

    Answer - For professional services outside of the public health emergency, time could only be used as the determining factor for code selection when 50 percent or more of the time was spent in counseling or coordination of care. During the public health emergency, CMS has relaxed the rules for CPT® codes 99201-99215 and is allowing physicians to use either time or medical decision making as the determining factor for E/M assignment within this code range. Other codes, such as e-visits and telephone visits, do not fall within this range of E/M codes and are not affected.[41]

37. **Question -** Is it only appropriate to charge for partial hospitalization telehealth encounters, when that department is temporarily relocated to the patient's home?

    Answer - Partial hospitalization services may be provided to patients using telecommunications technology when the patient's home is designated as a relocated off-campus provider-based department, under the rules outlined in the extraordinary circumstance relocation exception. CPT® codes 90785, 90832, 90834, 90837 and 90847 are a few of the services that may be provided in this manner, per the List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 interim final rule.[42]

38. **Question -** What is the appropriate code to bill for a 30-minute telephone call for partial hospitalization individual therapy visit in place of the normal group therapy visit for 1 hour?

    Answer – CPT® code 90832, *Psychotherapy, 30 minutes with patient,* may be assigned in this circumstance. While CMS would prefer to have the services provided via the audio/video format, there are instances when this is not achievable for a variety of reasons. Because these services may be provided in an audio-only format and can take the place of a face-to-face encounter, certain services may be reported even though

[40] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 182, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)
[41] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, pages 135-137, https://www.cms.gov/files/document/covid-final-ifc.pdf (March 30, 2020)
[42] List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (April 30, 2020)

they are provided via audio-only communication.[43] Of note, CPT® code 90853 *Group psychotherapy (other than of a multiple-family group)* has been temporarily added to CMS' list of approved telehealth services.[44]

39. **Question -** How can we do facility billing for telehealth genetic counseling?

    Answer – The genetic counselor would be considered ancillary staff, similar to a nurse or registered dietician. The genetic counselor would need to be operating within your state's scope of practice regulations, providing services incidental to a physician/NPP order, within the appropriate level of supervision, and not going against any state pandemic or emergency preparedness regulations.[45]

    Services provided by the genetic counselor in a temporarily relocated off-campus provider-based department (that may include the patient's home) using telecommunications technology would be billed as though they were provided face-to-face. Note that services must be provided in accordance with the appropriate level of supervision and the hospital must ensure the location(s) meet all of the conditions of participation, except for the conditions of participation that have temporarily been waived during the public health emergency. If the hospital plans to seek an exception under the extraordinary circumstance relocation policy for their on-campus or excepted off-campus departments, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be appended to the CPT® or HCPCS procedure code(s) that describe the service(s) provided. If the counseling services are normally provided in a non-excepted off-campus provider-based department or if the facility does not plan to seek an exception under the extraordinary circumstance relocation policy, modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be appended to the procedure code(s). CMS has published a list of the outpatient therapy, counseling, and educational services that hospital clinical staff may furnish incident to a physician's service during the COVID-19 public health emergency.[46]

40. **Question -** If a hospital-based genetic counselor is doing phone calls (audio-only), can these be billed using HCPCS code G0463 if the department temporarily relocates to the patient's home?

    Answer – No, because HCPCS code G0463, *Hospital outpatient clinic visit for assessment and management of a patient,* has not been designated as a code that may be done audio-only in lieu of audio/visual telecommunication.[47]

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[43] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 46-53, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[44] List of Telehealth Services, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes (April 30, 2020)

[45] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 26, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[46] List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (April 30, 2020)

[47] List of Telehealth Services, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes (April 30, 2020)

41. **Question -** There has been an ongoing debate regarding the level of E/M that a pharmacist can perform incident to. Most documentation references a limitation to 99211. Is your presentation indicating that a higher level of E/M can be performed incident to by a pharmacist?

    Answer – No, the low-level E/M visit 99211, *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services,* is what is allowable for a pharmacist to use under incident to guidelines; however, the code is not recognized by Medicare for facility billing. When submitting a charge for the pharmacist's services on a UB-04 claim, facilities would report HCPCS G0463, *Hospital outpatient clinic visit for assessment and management of a patient*, for the low-level clinic visit.[48]

42. **Question -** Can hospital-based rehabilitation facilities bill audio/visual telehealth services? We are hearing conflicting information that this is only for independent rehab facilities. What CPT® codes and modifiers would be used?

    Answer – When reviewing information for outpatient rehabilitation facilities, we were unable to find anything specific. During the CMS Office Hours call on Thursday, May 14, 2020, the question was brought to the attention of the CMS Subject Matter Experts. Their response was that the issue was under consideration and information would be provided soon. Unfortunately, until the further guidance is issued, the usage of CPT® codes and modifiers remains unknown.[49]

43. **Question -** How do we bill a telehealth visit that is falling on an inpatient bill? Should these be split off from the inpatient visit or should we append a modifier?

    Answer – For facility inpatient accounts, the services would not be reported with CPT®/HCPCS codes and modifiers, as those codes are for reporting professional and outpatient hospital services only. On an inpatient account, you would need to determine if telehealth services are included in your facility's daily room and board rate. If this is not part of the established room and board charge, a separate charge for the telehealth visit may be added, although there would be no additional reimbursement for the telehealth service as all items and services provided to inpatients are reimbursed under a single MS-DRG payment.[50]

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[48] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 26, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[49] CMS Outreach and Education, "Thursday, May 14, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[50] Pub. 100-04 Medicare Claims Processing Manual, Chapter 3, Section 40, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf (April 22, 2012)