Sweeping COVID-19 Changes and Regulatory Waivers Announced: Emergency Webinar

May 5, 2020
Webinar FAQ Document

1. **Question** – Do we assign modifier PO or PN when billing for provider-based departments that are performing telehealth services?

   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 exception outlined in the interim final rule, CMS-5531-IFC. 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 exception.[1] Under the temporary relocation provision, 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 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.

2. **Question** – Can hospital labs bill for specimen collection using C9803 when lab personnel are collecting specimens and then performing the test?

   Answer – Yes. HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, is a conditionally packaged service under the Outpatient Prospective Payment System (OPPS), meaning that C9803 will receive separate payment when it is billed without another primary covered hospital outpatient service. The OPPS will make separate payment for HCPCS code C9803 when it is billed with a clinical diagnostic laboratory test with a status indicator of "A" in the Addendum B file, which includes the lab tests for COVID-19 detection.[2]

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[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-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

3. **Question** – Do you recommend using revenue code 0780 for telehealth or revenue code 0510 for clinic visits when performing telehealth services in a patient's home that has been classified as a relocated off-campus provider-based department?

   Answer – The revenue code selected should be the same as the revenue code that would be used if the patient was receiving services in the outpatient department of the hospital. The Centers for Medicare & Medicaid Services (CMS) has stated that items and services provided via telecommunications technology to a patient in a temporarily relocated off-campus provider-based department of the hospital, which may be the patient's home, in accordance with the extraordinary circumstances policy are considered to be face-to-face visits and should be coded and billed as though the service was occurring in person in the outpatient department of the hospital.

4. **Question** – Can HCPCS codes C9803 and U0003 both be billed on a UB-04 form, and will both be reimbursed?

   Answer – Yes. HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, is a conditionally packaged service under the OPPS, meaning that C9803 will receive separate payment when it is billed without another primary covered hospital outpatient service. The OPPS will make separate payment for HCPCS code C9803 when it is billed with a clinical diagnostic laboratory test with a status indicator of "A" in the Addendum B file, which includes HCPCS code U0003, *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.*[3]

5. **Question** – What is the effective date for HCPCS code C9803? Can it be reported prior to the effective date for any specimens collected prior to the effective date?

   Answer – HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, has been given a retroactive effective date of March 1, 2020. It can be reported for any procedures performed on or after that date which meet the code definition but cannot be reported prior to that date of service.

6. **Question** – Can pharmacists provide both telehealth services and telephone services under the incident-to guidelines?

   Answer – Pharmacists are not eligible to bill Medicare directly for their professional services on a CMS-1500 form. However, pharmacists may provide services under the "incident to" provisions, in which case the physician or NPP would be able to bill for the professional services provided by the pharmacist or on the CMS-1500 form.

Requirements for the Skilled Nursing Facility Quality Reporting Program", page 190, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[3] 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 190, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

When pharmacists are functioning as auxiliary staff of a hospital, CMS is deferring to the state scope-of-practice regulations. If the pharmacist is functioning within state scope-of-practice regulations, does not contradict your state emergency or pandemic plans, is providing services incident to a physician/non-physician practitioner (NPP) order, and the service is not is covered under Medicare Part D, then the facility may bill for services that are provided by auxiliary staff on the UB-04 billing form. These must also meet other requirements, such as medical necessity and documentation.[4]

7. **Question** – Can we report specimen collection using HCPCS code C9803 when an E/M service is also provided?

   Answer – Yes. Specimen collection is not included in the lab test and can therefore be separately reported. However, HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, is a conditionally packaged service under the OPPS, meaning that C9803 will not receive separate payment when billed with an Evaluation & Management (E/M) service; rather the payment will be packaged into the E/M service.[5]

8. **Question** – Are we allowed to partially relocate our provider-based departments? We have patients that still physically presenting to our clinics in addition to patients we see via telehealth.

   Answer – Yes. CMS has stated that hospitals may relocate part of their excepted provider-based departments to a new-off campus location while maintaining the original location.[6]

9. **Question** – Can we bill for therapy services provided via telehealth prior to receiving approval to temporarily relocate our provider-based departments?

   Answer – Yes. CMS is allowing both excepted off-campus and on-campus provider-based departments to provide services at temporarily relocated off-campus locations in accordance with the extraordinary circumstance exception outlined in the interim final rule, CMS-5531-IFC, to begin furnishing and billing for services in the new location(s) prior to submitting documentation to the CMS Regional Office in support of the extraordinary circumstances relocation request. Note that the request must be submitted to the Regional Office within 120 days of beginning to provide services at the relocated off-campus location(s).[7]

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[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", page 25, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[5] 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 190, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[6] 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)

[7] 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

10. **Question** – Are pharmacists allowed to provide and bill for E/M services under the incident-to provision with a higher level than the 99211 restriction?

    Answer – Yes, as long as the service is allowed by your state law. Like other auxiliary personnel, the pharmacist may provide services incident to a physician's or non-physician practitioner's (NPP's) services as long as the pharmacist is following the state's scope-of-practice laws, is under the appropriate level of supervision, and payment for the service is not covered under the Medicare Part D benefit.[8]

11. **Question** – Are we required to submit every patient's home address that we wish to classify as a temporarily relocated off-campus provider-based department?

    Answer – Yes. All hospitals that are applying for an extraordinary circumstance relocation exception in response to the COVID-19 public health emergency should notify 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.[9] 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.

12. **Question** – What diagnosis code should be used to bill for COVID-19 testing when there is no order from the provider?

    Answer – Per the ICD-10-CM Official Coding and Reporting Guidelines, asymptomatic patients who are being screened for COVID-19 and have no known exposure to the virus, may be assigned a diagnosis code of Z11.59, *Encounter for screening for other viral diseases.* These same guidelines also advise the assignment of diagnosis code Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases,* for patients who have actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19. If the lab test is subsequently found to be positive for COVID-19 infection, diagnosis code U07.1, *COVID-19,* should be assigned, even if the patient was asymptomatic.[10]

Requirements for the Skilled Nursing Facility Quality Reporting Program", page 40, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[8] 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)

[9] 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)

[10] ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020, Chapter 1, Section g, Subsections 1.d., 1.e., 1.f. and 1.g., https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

13. **Question** – Is the hospital allowed to bill for the facility component of the ER E/M when our ER physicians provide telehealth services?

    Answer – CMS stated during the CMS Office Hours calls of May 5, 2020 and May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[11] 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.

14. **Question** – Can HCPCS code C9803 be reported when collecting specimens for tests other than the PCR COVID-19 test? For instance, can we report C9803 when collecting blood for the COVID-19 antibody test?

    Answer – Although this question has not officially been addressed by CMS, HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, specifies in the description that it should be used to report specimen collection for SARS-CoV-2, which does not include antibody testing. Vitalware would therefore recommend reporting an alternate code, such as 36415, *Collection of venous blood by venipuncture*, when collecting blood for a COVID-19 antibody test.

15. **Question** –If approved for temporary relocation, can we now use modifier PO when services are provided via telehealth from our non-excepted off-campus provider-based departments that are currently billing for services using modifier PN?

    Answer – No. Non-excepted off-campus departments will continue to be non-excepted during the COVID-19 public health emergency even if they relocate and will continue to be paid at the PFS-equivalent rate.[12] These non-excepted off-campus provider-based departments will therefore continue to bill for their services using modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, when services are provided in temporarily relocated departments of the hospital, which may include the patient's home.

16. **Question** – Should we be billing HCPCS code Q3014 when our therapists are providing services via telehealth?

    Answer – No. 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

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

[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)

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 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 Current Procedural Terminology (CPT®)[13] 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.[14]

17. **Question** – Is there a revenue code recommendation for rural health clinics (RHCs) billing for telehealth and telephone services using HCPCS code G2025?

    Answer – CMS has not provided specific guidance on revenue codes that must be billed with HCPCS code G2025, *Distant site telehealth services provided by an RHC/FQHC*. CMS' only guidance regarding revenue codes for services provided in an RHC is that an appropriate four-digit revenue code should be entered for each type of service provided to explain each charge. It should be noted that telehealth distant site services furnished between January 27, 2020 and June 30, 2020 are to be reported using modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*. For telehealth distant site services furnished between July 1, 2020 and the end of the public health emergency, RHCs will use HCPCS code G2025 to identify services that were furnished via telehealth.[15]

18. **Question** – Can physicians bill for any service listed in the telehealth fee schedule when the service is provided via audio only, or do we need to report telephone services if we don't have the video component?

    Answer – If the service provided is an E/M service, then telephone CPT® codes 99441-99443 may be used. The Relative Value Units (RVUs) have been significantly increased for these services. With the increase, the telephone CPT® codes will crosswalk to CPT® codes 99212-99214.[16] Additionally, CMS updated the list of

[13] CPT® is a registered trademark of the American Medical Association. All rights reserved.
[14] 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)
[15] MLN Matters SE20016, "New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)", page 2, https://www.cms.gov/files/document/se20016.pdf (April 30, 2020)
[16] 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)

approved telehealth services to provide examples of CPT® codes that may be furnished using audio-only communication.[17]

19. **Question** – Can you provide clarification as to when we should report modifier PO versus modifier PN for telehealth services?

    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.[18] 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 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.

20. **Question** – Can physical therapists now bill for their professional services provided via telehealth on a CMS-1500 form?

    Answer – Yes. CMS has waived the requirements which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of healthcare professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This includes physical therapists, occupational therapists, and speech language pathologists.[19]

21. **Question** – What is the process for requesting to temporarily relocate our provider-based departments?

    Answer – All hospitals that are applying for an extraordinary circumstance relocation exception in response to the COVID-19 public health emergency should notify their CMS Regional Office by email within 120 days of

[17] 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)
[18] 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)
[19] "Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19", pages 1-2, https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf (April 30, 2020)

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.[20]

22. **Question** – Can facilities bill for rehabilitation services provided via audio only, or is a video component required?

    Answer – CMS has not addressed this particular circumstance, although they do note in the final rule that therapy services can effectively be furnished using telecommunications technology. They do, however, address the use of audio only to provide partial hospitalization program (PHP) services remotely. Specifically, they state that their expectation is that PHP services would be provided using telecommunications technology that includes both audio and video but that these services may be provided using audio only in cases where both audio and video are not accessible.[21] They further note that audio-only services should not be provided in cases where the provider feels that the services cannot adequately be performed using audio-only communication.

23. **Question** – Can you clarify when it would be appropriate to report the originating site fee and when it would be appropriate to report the service provided, such as clinic visits, therapy, or education services?

    Answer – CMS stated during the CMS Office Hours calls of May 5, 2020 and May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[22] 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.[23]

24. **Question** – Can facilities bill for telehealth services using modifier PN without submitting a request to temporarily relocate their departments?

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[20] 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)

[21] 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 47-50, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

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

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

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.

25. **Question** – Can HCPCS code C9803 be reported by respiratory therapists who collect a specimen for COVID-19 testing, or is this code limited to laboratory personnel?

    Answer – HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, is intended to be reported when hospital staff perform specimen collection for COVID-19 testing. There is no requirement that it be collected specifically by laboratory personnel.

26. **Question** – Can hospitals bill for therapies provided by clinical staff such as registered dietitians? Can you provide guidance on which CPT® codes and revenue codes to use?

    Answer – Auxiliary staff of the hospital, which includes registered dietitians, may provide services incident to a physician's or NPP's services, as long as they are operating under their state scope-of-practice laws and under the appropriate level of supervision. State regulations may dictate what particular services may be provided. For a registered dietician, these services may include medical nutrition therapy, CPT® codes 97802-97804 or HCPCS codes G0270-G0271, or diabetes self-management training services, HCPCS codes G0108-G0109.[24]

    CMS instructions for DSMT services indicates that revenue code 0942 - *OTHER THERAPEUTIC SERVICES (ALSO SEE 095X, AN EXTENSION OF 094X) - EDUCATION/TRAINING* should be used when reporting these services.[25]

27. **Question** – Should we use HCPCS code C9803 for Medicare patients and HCPCS code G2023 for commercial payors when billing for specimen collection in a hospital outpatient department?

    Answer – CMS requires that HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, be reported when specimen collection for COVID-19 testing is performed in a hospital outpatient department. Each commercial payor will have their own guidelines and reimbursement policies related to specimen collection. It will likely be necessary to check with each regarding their specific policies to ensure accurate reimbursement for these services.

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[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", pages 46-47, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[25] Publication 100-02 Medicare Benefit Policy Manual, "Chapter 15 Covered Medical and Other Health Services, Subsection 300.5.1 Payment for DSMT, Special Claims Processing Instructions", pages 272-273, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf (July 2, 2007)

28. **Question** – Can HCPCS code C9803 be reported for specimen collection on an inpatient basis?

    Answer – CPT® and HCPCS codes are not reported on inpatient claims. Inpatient claims for Medicare beneficiaries are assigned a single MS-DRG based upon the ICD-10-CM and ICD-10-PCS codes reported for that encounter. All provided items and services, with some minor exceptions, are packaged into the MS-DRG reimbursement that is received. Even though HCPCS codes are not reported, it is important that hospitals accurately report their costs for all services that are provided during an inpatient encounter. Ultimately, it will be up to each individual hospital to determine which services are included in the typical inpatient room and board charge and which services should be separately billed on the inpatient claim.

29. **Question** – Is modifier CR required when billing for COVID-19 lab tests?

    Answer – CMS has requested that modifier CR, *Catastrophe/disaster related*, be assigned to identify Part B line item services/items that are related to a COVID-19 waiver for both institutional and non-institutional providers. Note that Medicare also stated that they will not deny claims due to the presence of this modifier for items or services that are not related to a COVID-19 waiver.[26]

30. **Question** – Can pharmacists bill Medicare directly for their professional service under the "incident to" guidelines?

    Answer – No. Pharmacists are not eligible to bill Medicare directly for their professional services on a CMS-1500 form. However, pharmacists may provide services under the "incident to" provisions, in which case the physician or NPP would be able to bill for the professional services provided by the pharmacist or on the CMS-1500 form.

    When pharmacists are functioning as auxiliary staff of a hospital, CMS is deferring to the state scope-of-practice regulations. If the pharmacist is functioning within state scope-of-practice regulations, does not contradict your state emergency or pandemic plans, is providing services incident to a physician/non-physician practitioner (NPP) order, and the service is not is covered under Medicare Part D, then the facility may bill for services that are provided by auxiliary staff on the UB-04 billing form. These must also meet other requirements, such as medical necessity and documentation.[27]

31. **Question** – Are modifiers GT and 95 required in addition to modifiers PO and PN?

    Answer - There are no circumstances in which modifiers GT and 95 would be used with modifiers PO or PN. Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* is appended to CPT® and HCPCS codes for professional services provided via telehealth, and reported on the CMS-1500 professional claim form. Modifier GT, *Via interactive audio and video telecommunication systems,* is only allowed on institutional claims billed under Critical Access Hospital

[26] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, page 41, https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (May 1, 2020)
[27] 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 25, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

Method II, as of October 1, 2018. The current public health emergency has not changed the use of modifier GT[28]. Modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, and modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, may only be reported by OPPS hospitals.

[28] Transmittal R2095OTN, "Revisions to the Telehealth Billing Requirements for Distant Site Services", https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2095OTN.pdf (June 20, 2018)