

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

The FAQs in this document supplement the previously released FAQs: 1135 Waiver FAQs, available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf>.

We note that in many instances, the general statements of the FAQs referenced above have been superseded by COVID-19-specific legislation, emergency rules, and waivers granted under section 1135 of the Act specifically to address the COVID-19 public health emergency (PHE). The policies set out in this FAQ are effective for the duration of the PHE unless superseded by future legislation.

A few answers in this document explain provisions from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 (March 27, 2020). CMS is thoroughly assessing this new legislation and new and revised FAQs will be released as implementation plans are announced.

The interim final rule with comment period (IFC), CMS-1744-IFC, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, is available at the following link: <https://www.cms.gov/files/document/covid-final-ifc.pdf>

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A. Payment for Specimen Collection for Purposes of COVID-19 Testing

1. **Question:** What changes did CMS announce regarding specimen collection fees for COVID-19 testing?

Answer: As part of the Public Health Emergency (PHE) for the COVID-19 pandemic and in an effort to be as expansive as possible within the current authorities to have diagnostic testing available to Medicare beneficiaries who need it, in the interim final rule with comment period, we are changing the Medicare payment rules during the PHE for the COVID-19 pandemic to provide payment to independent laboratories for specimen collection from beneficiaries who are homebound or inpatients not in a hospital for COVID-19 testing under certain circumstances.

New: 4/9/20

2. **Question:** What has been the Medicare payment policy for specimen collection for laboratory testing and for transportation and personnel expenses for trained personnel to collect specimens from homebound patients and inpatients (not in a hospital)?

Answer: In general, the Social Security Act (the Act) requires that the Secretary establish a nominal fee for specimen collection for laboratory testing and a fee to cover transportation and personnel expenses (generally referred to as a travel allowance) for trained personnel to collect specimens from homebound patients and inpatients (not in a hospital). The travel allowance is paid only when the nominal specimen collection is also payable. Refer to IOM, Pub. 100-04, Chapter 16, Section 60 for more information. For beneficiaries, neither the annual cash deductible nor the 20 percent coinsurance apply to the specimen collection fees or travel allowance for laboratory tests.

New: 4/9/20

3. **Question:** How is the IFC changing the Medicare specimen collection and travel allowance policy?

Answer: This IFC is providing a specimen collection fee and fees for transportation and personnel expenses known as a travel allowance for COVID-19 testing under certain circumstances for the duration of the PHE for the COVID-19 pandemic. The IFC also describes the definition of “homebound” for purposes of our specimen collection policy and allowing for electronic records of mileage for the travel allowance for the duration of the PHE for the COVID-19 pandemic.

New: 4/9/20

4. **Question:** Who can bill for the Medicare specimen collection fee?

Answer: Independent laboratories can bill Medicare through their MAC for the specimen collection fee. The specimen collection fee applies if the specimen is collected by trained laboratory personnel from a homebound or non-hospital inpatient and the specimen is a type that would not require only the services of a messenger pick up service. However, the specimen collection fee is not available for tests where a patient collects his or her own specimen.

New: 4/9/20

- 5. Question:** What is the nominal fee for specimen collection for COVID-19 testing for homebound and non-hospital inpatients during the PHE?

Answer: The nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally is \$23.46 and for individuals in a non-covered stay in a SNF or whose samples are collected by a laboratory on behalf of an HHA is \$25.46.

Updated: 4/17/20

- 6. Question:** What are the new level II HCPCS codes for specimen collection for COVID-19 testing?

Answer: To identify specimen collection for COVID-19 testing, we established two new level II HCPCS codes effective March 1, 2020. Independent laboratories must use one of these HCPCS codes when billing Medicare for the nominal specimen collection fee for COVID-19 testing for the duration of the PHE for the COVID-19 pandemic. These HCPCS codes are:

- G2023, specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024, specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source

We note that G2024 is applicable to patients in a non-covered stay in a SNF and not to those residents in Medicare-covered stays (whose bundled lab tests would be covered instead under Part A's SNF benefit at §1861(h) of the Act).

Updated: 4/17/20

- 7. Question:** How should a laboratory document the miles traveled to collect a specimen?

Answer: An independent laboratory billing Medicare for the travel allowance is required to log the miles traveled. CMS will not require paper documentation logs that some MACs may have otherwise required; electronic logs can be maintained instead. However, laboratories will need to be able to produce these electronic logs in a form and manner that can be shared with MACs.

New: 4/9/20

- 8. Question:** What is the definition of homebound for purposes of our specimen collection policy?

Answer: Medicare beneficiaries are considered “confined to the home” (that is, “homebound”) if it is medically contraindicated for the patient to leave the home. When it is medically contraindicated for a patient to leave the home, there exists a normal inability for an individual to leave home and leaving home safely would require a considerable and taxing effort.

As an example for the PHE for COVID-19 pandemic, this would apply for those patients: (1)

where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or (2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

A patient who is exercising “self-quarantine” for his or her own safety during a pandemic outbreak of an infectious disease, such as COVID-19, would not be considered “confined to the home” or “homebound” unless it is also medically contraindicated for the patient to leave the home. If a patient does not have a confirmed or suspected diagnosis of an infectious, pandemic disease such as COVID-19, but the patient’s physician states that it is medically contraindicated for the patient to leave the home because the patient’s condition may make the patient more susceptible to contracting an infectious, pandemic disease, the patient would be considered “confined to the home” or “homebound” for purposes of our specimen collection policy.

New: 4/9/20

B. Diagnostic Laboratory Services

1. Question: How does Medicare pay for clinical diagnostic laboratory tests?

Answer: Medicare Part B, which includes a variety of outpatient services, covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. Medically necessary clinical diagnostic laboratory tests are generally not subject to coinsurance or deductible.

Posted: 3/6/20

2. Question: Are there Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes available for COVID-19 laboratory testing?

Answer: Yes, CMS has created two HCPCS codes in response to the urgent need to bill for these services. The codes are:

- U0001, CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel and
- U0002, 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC.

Additionally, the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel has created CPT code 87635 (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) Please visit <https://www.ama-assn.org/press-center/press-releases/new-cpt-code-announced-report-novel-coronavirus-test>

Laboratories can begin billing for the performance of these tests using these codes immediately via standard Fee-for-service billing practices.

Revised: 4/10/20

- 3. Question:** Are all of these codes available for laboratories to use to bill Medicare?
Answer: Yes. The CMS HCPCS codes will be available on the HCPCS and Clinical Laboratory Fee Schedule (CLFS) file beginning April 1, 2020, for dates of service on or after February 4, 2020. The AMA CPT code, 87635 will also be available on the HCPCS and CLFS file beginning April 1, 2020, for dates of service on or after March 13, 2020.
Posted: 3/21/20
- 4. Question:** My laboratory uses the CDC test kit; what code should we use to bill Medicare?
Answer: The appropriate code to use would be HCPCS Code U0001 (CDC 2019-nCoV Real-Time RT-PCR) Diagnostic Panel).
Posted: 3/21/20
- 5. Question:** My laboratory does not use the CDC test kit; what code should we use to bill Medicare?
Answer: If your laboratory uses the method specified by CPT 87635, the appropriate code to use would be CPT 87635. If your laboratory has a test that uses a method not described by CPT 87635, the appropriate code to use would be HCPCS Code U0002.
Posted: 3/21/20
- 6. Question:** What code should we use to bill Medicare if new types of COVID-19 tests are created in the future?
Answer: The appropriate code to use would be HCPCS Code U0002 for COVID-19 test methods that are not specified by either U0001 or 87635. CMS will continue to monitor the types of COVID-19 testing methods and adjust coding as necessary depending on the methodology.
Posted: 3/21/20
- 7. Question:** How will Medicare pay for COVID-19 testing on the CLFS?
Answer: Local MACs are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes and the CPT code in their respective jurisdictions until Medicare establishes national payment rates on the CLFS. Please see <https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf> for more information on current MAC payment rates. If there are questions or concerns about payments, laboratories should contact their MAC with additional information.
For more information on CMS's procedures for public consultation on payment for new clinical diagnostic laboratory tests on the CLFS, please see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory_Public_Meetings.
Revised 4/1/20
- 8. Question:** My laboratory does not use the CDC test kit and will have a delay in implementing the CPT code 87635 in our billing system. May we bill Medicare using U0002?

Answer: Yes. For the time being laboratories may continue to use U0002 to bill Medicare for tests described by the CPT code. We will provide advance notice if this changes.

Posted: 3/21/20

C. Diagnostic Laboratory Services - Serology Testing

1. Question: Are there new Current Procedural Terminology (CPT) codes for COVID-19 testing?

Answer: On April 10, 2020, the American Medical Association (AMA) CPT Committee announced two new CPT codes to report when patients receive blood tests that can detect antibodies for COVID-19. These two codes are:

- 86328: Immunoassay for infectious agent antibody(ies), qualitative or semi-quantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
- 86769: Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

New: 5/1/20

2. Question: When will I be able to bill Medicare for these new test codes?

Answer: Medicare has updated its billing systems to accept these new test codes.

New: 5/1/20

3. Question: My laboratory has a serology test for COVID-19; which CPT code should I use to bill Medicare?

Answer: Both new test codes can be used to bill Medicare for COVID-19 serology testing that can detect antibodies. If your COVID-19 test can be done in a single step, the most appropriate code to use is 86328. Multi-step antibody testing for COVID-19 can be billed using 86769.

New: 5/1/20

4. Question: What is the difference between single-step and multi-step antibody test for COVID-19?

Answer: According to the AMA, CPT code 86328 was established for antibody tests using a single-step method immunoassay. This testing method typically includes a strip with all of the critical components for the assay and is appropriate for a point of care platform. CPT code 86769 was established for COVID-19 antibody tests using a multiple step method. This testing method often involves several steps where a diluted sample is incubated in a sample plate.

New: 5/1/20

5. Question: How is the Medicare payment amount determined for the new COVID-19 CPT codes?

Answer: Local MACs are responsible for developing the payment amount for claims they receive for these newly created CPT codes in their respective jurisdictions until Medicare

establishes national payment rates on the CLFS. Please see <https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf> for more information on current MAC payment rates. If there are questions or concerns about payments, laboratories should contact their MAC for additional information. For more information on CMS's procedures for public consultation on payment for new clinical diagnostic laboratory tests on the CLFS, please see https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ClinicalLabFeeSched/Laboratory_Public_Meetings.

New: 5/1/20

- 6. Question:** Can I continue to use HCPCS code U0002 to bill Medicare for COVID-19 testing?
Answer: Yes, HCPCS code U0002 is still available for billing Medicare if your test does not fit any of the other existing code descriptors for COVID-19 testing.

New: 5/1/20

D. High Throughput COVID-19 Testing

- 1. Question:** Why did CMS create HCPCS codes U0003 and U0004?

Answer: CMS created two new HCPCS codes, effective for dates of service on or after April 14, 2020, specifically for Clinical Diagnostic Laboratory Tests (CDLTs) making use of high throughput technologies, that is, technologies that use a platform that employs automatically processing of more than 200 specimens a day, as described in CMS Ruling No. CMS-2020-1-R, available at <https://www.cms.gov/files/document/cms-2020-01-r.pdf>.

These new HCPCS codes are:

- 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
- U0004: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R

New: 5/1/20

- 2. Question:** What will Medicare FFS pay for HCPCS codes U0003 and U0004?

Answer: Both codes will be paid at rate of \$100.

New: 5/1/20

- 3. Question:** Starting when can HCPCS codes U0003 and U0004 be billed to Medicare?

Answer: The effective date of CMS Ruling 2020-01-R is April 14, 2020, and the \$100 Medicare payment rates for U0003 and U0004 went into effect as of that date.

New: 5/1/20

- 4. Question:** My laboratory testing platform is not specifically listed in CMS Ruling CMS-2020-01-R. Can my laboratory bill Medicare for tests run on my platform using U0003 and U0004?

Answer: Laboratories may bill Medicare using HCPCS codes U0003 and U0004 when the tests described in those codes make “use of high throughput technologies as described by CMS-2020-01-R.” The Ruling includes a list of examples of high throughput technology as of April 14, 2020, and states that high throughput technologies are not limited to technologies listed in the Ruling. The Ruling states: “A high throughput technology uses a platform that employs automated processing of more than two hundred specimens a day.” Laboratories should ensure that the technologies they are using fulfill this definition when they bill Medicare using these codes and maintain supporting documentation as appropriate.

New: 5/1/20

E. Hospital Services

- 1. Question:** During the COVID-19 PHE, can my hospital provide inpatient services at a site (temporary expansion site) that is not currently part of the hospital or even of another type of existing healthcare facility? For example, if local hospitals are almost at capacity during the emergency and the few beds remaining must be reserved for patients needing ventilators and critical care, will Medicare pay for non-critical care inpatient services provided directly by the hospital at a temporary expansion site, such as a repurposed school gymnasium or erected tent?

Answer: During the COVID-19 PHE, CMS is allowing hospitals to provide inpatient hospital services in temporary expansion sites, which may include ambulatory surgical centers (ASCs), repurposed gymnasiums, erected tents, or other sites, to help address the urgent need to expand their care capacity and to develop COVID-19 specific treatment sites. If a hospital meets the CoPs in effect during the COVID-19 PHE while operating one or more temporary expansion sites, Medicare will pay for covered Medicare inpatient services provided at those sites as if they were provided at the permanent inpatient locations of the hospital. If services were provided by the hospital in another Medicare-participating facility, that facility would not bill Medicare for items and services provided by the hospital. The hospital is expected to be operating in a manner not inconsistent with its state’s emergency preparedness or pandemic plan.

New: 5/1/20

- 2. Question:** During the COVID-19 PHE, can my hospital provide outpatient services at a site (temporary expansion site) not considered part of the hospital or even of an existing healthcare facility? For example, if my hospital needs to set up temporary sites for testing or treatment of patients, including those who are COVID-19 positive or suspected to be positive who may need to be isolated, can my hospital provide outpatient services at such a temporary site?

Answer: Similar to what CMS is allowing for hospital inpatient services (described above), during the COVID-19 PHE, CMS is allowing hospitals to provide hospital outpatient services in temporary expansion sites, which may include ASCs, gymnasiums or other sites, to help address the urgent need to expand their care capacity. If a hospital meets the CoPs in effect during the COVID-19 PHE while operating one or more temporary expansion sites, Medicare

will pay for covered Medicare outpatient services provided at those sites as if they were provided at the permanent outpatient locations of the hospital. The hospital is expected to be operating in a manner not inconsistent with its state's emergency preparedness or pandemic plan.

Additionally, due to the PHE, CMS is prioritizing and suspending certain Federal and State Survey Agency surveys pursuant to Federal requirements for a period of time. For more information on survey activity see: <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf>

Revised: 4/17/20

- 3. Question:** Can an acute care hospital repurpose areas of the hospital that are not currently used for patient care (e.g., a cafeteria) as patient care areas, or existing areas that are used for patient care (e.g., outpatient beds) as higher level care areas (e.g., inpatient acute care beds) during the Public Health Emergency?

Answer: CMS is providing needed flexibility to hospitals to ensure they have the ability to expand capacity and to treat patients during the COVID-19 PHE. As part of the *CMS Hospital Without Walls* initiative, for the duration of the COVID-19 PHE, hospitals can repurpose existing clinical (e.g., outpatient beds) and non-clinical space (e.g., cafeterias) for use as acute inpatient patient care areas to help address the urgent need to increase capacity.

New: 4/9/20

- 4. Question:** How can Ambulatory Surgical Centers (ASCs) address the needs of patients who may need hospital or ambulatory care during the COVID-19 Pandemic Public Health Emergency?

Answer: During the PHE, ASCs may help address the needs in surge areas in several ways. An ASC may furnish inpatient services under arrangement for a hospital, or become provider-based to a hospital, or choose to enroll as a hospital themselves. If an ASC enrolls as a hospital, they must meet the hospital Conditions of Participation, to the extent not waived, and may provide any hospital inpatient or outpatient service provided that it operates in a manner not inconsistent with the State's emergency preparedness or pandemic plan (for example: COVID-19 treatment site). The ASC would be, functioning as a full hospital, not solely as a hospital outpatient surgical department. Under any of these scenarios, these entities may provide any hospital service as they would be functioning as a hospital rather than an ASC. ASCs that do not provide hospital services under arrangements to an existing hospital or that do not enroll as a hospital themselves may furnish only those services on the ASC Covered Procedures List, and consider the recommendations to delay all elective surgeries as noted in the QSO-20-22 memo:

<https://www.cms.gov/files/document/qso-20-22-asc-corf-cmhc-opt-rhc-fqhcs.pdf>.

Any Medicare-certified ASC wishing to enroll as a hospital during the COVID-19 PHE should notify the Medicare Administrative Contractor (MAC) that serves their jurisdiction of its intent

by calling the MAC's provider enrollment hotline and following the instructions noted in the [2019-Novel Coronavirus \(COVID-19\) Medicare Provider Enrollment Relief Frequently Asked Questions \(FAQs\)](#) document. Refer to the QSO-20-24-ASC memo for additional information: <https://www.cms.gov/files/document/qso-20-24-asc.pdf>.

Revised: 4/17/20

- 5. Question:** Do hospitals need to report to CMS or the Medicare Administrative Contractor that they have repurposed an existing area, or worked with an off-site location to create new outpatient or inpatient space?

Answer: No. If the Medicare-approved hospital intends to bill Medicare for the services provided under arrangement, no additional enrollment actions are required. Hospitals may begin billing for care in their surge locations or expansion site for inpatient or outpatient services under their existing CMS Certification Number (CCN) for care furnished during the PHE. CMS will also be exercising our enforcement discretion and will not be conducting the onsite survey for hospital surge locations during the PHE.

New: 4/9/20

- 6. Question:** Where can I find the specific waivers to the Medicare Conditions of Participation for acute care and critical access hospitals as well as waivers to the provider-based billing rules?

Answer: <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

New: 4/9/20

- 7. Question:** Will an ASC that chooses to convert its enrollment to a hospital during the PHE be required to file a Medicare cost report?

Answer: For the duration of the PHE, ASCs which rely on blanket waivers issued by CMS to enroll as hospitals during the time period of the PHE will be deemed to have low Medicare program utilization under 42 CFR 413.24(h) and will not be required to submit a full Medicare cost report. These providers will be deemed to satisfy the Medicare cost report submission requirements under 42 CFR 413.24(h) by submitting reduced cost report to their contractors consisting only of a completed and signed certification page from the hospital cost report (Form CMS-2552-10, Worksheet S), signed by the Chief Financial Officer or Administrator.

Payments such hospitals receive from the Medicare Inpatient Prospective Payment System or Outpatient Prospective Payment System will be considered as payment in full. Their cost reports will not be used for reconciliation for any additional payments such as disproportionate share, uncompensated care, direct graduate medical education, or Medicare bad debt. Additionally, the cost report data will not be collected and included in the wage index calculations. The Surge Capacity Hospitals' Medicare cost reports will be due on or before the last day of the fifth month following the close of their fiscal year end,

pursuant to § 413.24(f)(2), and electronic filing requirements are waived.

New: 4/9/20

- 8. Question:** My ASC participates in Medicare through one of the four CMS-approved ASC accrediting organizations (AO). Do I need to notify the AO of my desire to enroll as a hospital during the COVID-19 PHE?

Answer: Notifying your AO is recommended. However, during this PHE and while temporarily operating as a hospital, the facility will fall under the jurisdiction of the State Survey Agency which will coordinate the change in certification to a hospital. As this situation is temporary, nothing will change with your current AO ASC accreditation.

New: 4/9/20

- 9. Question:** How do I make the change from Medicare-certified ASC to enrolling as a hospital?

Answer: Interested Medicare-certified ASCs can use the provider enrollment hotline to contact the Medicare Administrative Contractor serving their jurisdiction (information located at: <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf>) to enroll as a hospital pursuant to a streamlined enrollment and survey and certification process as long as no Immediate Jeopardy (IJ)-level deficiencies were found within the previous three years for the ASC, or if IJ-level deficiencies were found, they were subsequently removed through the normal survey process, and the relevant location meets the conditions of participation and other requirements not waived by CMS.

New: 4/9/20

- 10. Question:** Can an acute care hospital work with another entity to do patient testing offsite, such as in a parking lot?

Answer: Yes. Under existing law and regulations, a hospital may elect to furnish hospital outpatient diagnostic tests under arrangements with another entity. The hospital bills Medicare for these services under this scenario. In addition, as mentioned above, the hospital itself may repurpose clinical or non-clinical sites for hospital outpatient or inpatient care under the flexibilities adopted for the duration of the PHE.

New: 4/9/20

- 11. Question:** The state government, U.S. Army Corps of Engineers, or other governmental entity established a new care location in our area by repurposing and retrofitting a convention center, gymnasium, tent or other site for patient care. Following its development, our hospital has been brought in to operate and staff this site with our clinicians. Can we bill Medicare for the facility and professional services our organization provides there? If so are there reporting or billing rules that determine how this is done?

Answer: Medicare enrolled hospitals that assume the majority operations of a temporary expansion site – including gymnasiums, tents, convention centers, and others – that was built or retrofitted by a public entity can bill Medicare for covered inpatient and outpatient hospital services provided to Medicare beneficiaries at those temporary expansion sites.

These temporary expansion sites need to meet the refined hospital conditions of participation. Hospitals would need to follow existing rules to bill under the applicable Medicare payment system depending on whether they provided outpatient care or inpatient care. Hospitals should add the “DR” condition code to inpatient and outpatient claims for patients treated in temporary expansion site during the Public Health Emergency.

Similarly, practitioners that furnish covered professional services to Medicare beneficiaries in these temporary expansion sites can bill Medicare for these hospital services. Practitioners should use the applicable place of service code depending on whether the temporary expansion site is being used to furnish outpatient or inpatient care. Also, practitioners should add the modifier “CR” to professional claims for patients treated in temporary expansion site during the Public Health Emergency.

New: 4/9/20

12. Question: Will Medicare provide additional payment if a patient needs to be isolated or quarantined in a private room?

Answer: If a Medicare beneficiary is a hospital inpatient for medically necessary care and needs to be isolated or quarantined in a private room, Medicare will pay the Diagnostic Related Group (DRG) rate and any outlier costs for the entire stay until the Medicare patient is discharged. The DRG rate (and outlier payments as applicable) includes payment for when a patient needs to be isolated or quarantined in a private room.

There also may be times when beneficiaries may need to be isolated or quarantined in a hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer, but may remain in the hospital for public health reasons.

Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary. Patients who would have been otherwise discharged from the hospital after an inpatient stay, but are instead remaining in the hospital under quarantine, would not have to pay an additional deductible for quarantine in a hospital.

New: 4/9/20

13. Question: Can a provider that has both private and semiprivate accommodations charge the patient a differential for a private room where isolation of a beneficiary is required?

Answer: A provider with both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary.

Posted: 3/6/20

14. Question: Will a hospital be eligible for additional payment for rendering services to patients that remain in the hospital in the case where they continue to need medical care

but at less than an acute level and those services are unavailable at any area skilled nursing facilities (SNFs) because of an emergency, including the COVID-19 infection?

Answer: A physician may certify or recertify the need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF, but no bed is available in a participating SNF. Assuming the original inpatient admission was appropriate for Part A payment, Medicare will pay the DRG rate and any outlier costs for the entire stay until the Medicare patient can be moved to an appropriate facility.

Posted: 3/6/20

15. Question: Are hospitals that are paid by Medicare through the Inpatient Prospective Payment System (IPPS) going to be paid using a special payment method during the COVID-19 emergency? Is there a special DRG rate at which IPPS hospitals will be reimbursed for this situation?

Answer: There is no special DRG for COVID-19. Recent legislation in the CARES Act provides for increased IPPS payments during the emergency period for Medicare inpatients diagnosed with COVID-19. Further guidance on the implementation of this increased IPPS payment is forthcoming. Otherwise, normal prospective payment methodologies apply to hospitals' discharges paid under the IPPS rate.

Posted: 3/6/20

16. Question: We have a Medicare psychiatric patient requiring inpatient psychiatric care who can't be placed in the excluded distinct part psychiatric unit because of the COVID-19 emergency. Can we place the psychiatric patient in an acute care hospital bed?

Answer: Yes, an acute care hospital with an excluded distinct part psychiatric unit that, as a result of a disaster or emergency, needs to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed can relocate patients. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the emergency. This may occur where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Revised: 3/26/20

17. Question: Can acute care hospitals use inpatient rehabilitation unit beds to increase bed capacity as a result of the COVID-19 emergency?

Answer: Yes, CMS has issued a blanket waiver (<https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>) to allow acute care hospitals to house inpatients in their excluded distinct part inpatient rehabilitation facility (IRF) units, where the IRF unit's beds are appropriate for

acute care. The acute care hospital bills for the care under the Inpatient Prospective Payment System and annotates the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit related to the disaster or emergency. Since these patients would be acute care patients housed in the IRF solely to meet the demands of an emergency, they would not be required to meet the Medicare coverage requirements for IRFs found in 42 CFR 412.622(a)(3), (4), and (5), and guidance in Chapter 1, Section 110 of the Medicare Benefit Policy Manual (Pub. 100-02) and would be excluded from the requirements specified in 42 CFR 412.29(b), which is the regulation commonly referred to as the "60 percent rule."

New: 3/26/20

18. Question: Are there any special waivers or exemptions that only apply to hospitals paid under TEFRA (e.g., IPPS-excluded cancer hospitals or children's hospitals)?

Answer: At this time there are no waivers or exemptions that only apply to hospitals paid under TEFRA. However, waivers that are generally applicable to hospitals regardless of hospital type are applicable to hospitals paid under TEFRA.

New: 5.27.20

19. Question: My hospital needs to transfer a patient to a temporary acute care location operated by the state, military or other public entity during the COVID-19 PHE. What are Medicare's billing and claim processing rules associated with these transfers?

Answer: Hospitals should refer to Medicare's claims processing manual for instructions on Medicare inpatient hospital billing: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf>. A patient status code should be included on every Inpatient Prospective Payment System (IPPS) claim, which indicates the location where the patient was discharged or transferred. For example, code "01" indicates that the patient was discharged to home or self-care, and code "02" indicates that the patient was discharged or transferred to another acute care hospital.

When patients have a short length of stay and are transferred to another acute care hospital, or in other certain circumstances, CMS may adjust payments to IPPS hospitals under the IPPS transfer policy. (See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctst.pdf> for more information on the IPPS Transfer Policy and other adjustments to payments.)

In March 2020, the National Uniform Billing Committee (NUBC), which maintains data elements and codes for Medicare's inpatient billing requirements, reminded stakeholders that patient status code "69 - Discharged/transferred to a designated disaster alternative care site" is applicable in these situations (see

https://www.nubc.org/system/files/media/file/2020/03/ACS%20Announcement_v2.pdf).

Medicare-enrolled hospitals that transfer a patient to a temporary care site operated by a

public entity (e.g., the military) should use patient status code “69” on the Medicare inpatient claim. When a claim with patient status code “69” is processed, a transfer adjustment is not calculated.

New: 5.27.20

F. Hospital Inpatient Prospective Payment Systems (IPPS) Payments under the CARES Act

1. Question: What are the provisions of section 3710 of the CARES Act?

Answer: Section 3710 of the CARES Act directs the Secretary to increase the IPPS weighting factor of the assigned diagnosis-related group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 public health emergency period.

New: 5.27.20

2. Question: How will discharges for individuals diagnosed with COVID-19 be identified?

Answer: A discharge of an individual diagnosed with COVID-19 will be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period.

(For additional information on diagnosis coding related to COVID-19, refer to the FAQs for *Diagnosis Coding under International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* found above.)

New: 5.27.20

3. Question: How did CMS implement the increased payment under the IPPS for COVID-19 patients under the provisions of section 3710 of the CARES Act?

Answer: To implement this temporary statutory adjustment, the IPPS Pricer will apply an adjustment factor to increase the Medicare Severity-Diagnosis Related Group (MS-DRG) relative weight that would otherwise apply by 20 percent when determining IPPS operating payments (including the calculation of payments such as for disproportionate share hospitals (DSHs), indirect medical education (IME), outliers, new technologies, and low-volume hospitals and the hospital specific rates for sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs)) for discharges of patients with a principal or secondary diagnosis of COVID-19.

New: 5.27.20

4. Question: Is the DR condition code required on the claim to receive the increased payment for IPPS discharges of patients diagnosed with COVID-19 provided by section 3710 of the CARES Act?

Answer: No. The DR condition code is not required since this is a legislative change in IPPS

payments.

New: 5.27.20

5. **Question:** Did CMS create new MS-DRG weights under the IPPS to implement section 3710 of the CARES Act?

Answer: No, CMS did not create new MS-DRG weights to implement the 20 percent increase in the MS-DRG weight provided by the CARES Act. Rather, in accordance with section 3710 of the Cares Act, for discharges during the emergency period of patients diagnosed with COVID-19, CMS will multiply the current MS-DRG relative weight for the discharge by a factor of 1.20 when calculating a hospital's operating IPPS payment.

New: 5.27.20

6. **Question:** What are the estimated MS-DRG payments under the IPPS, including the adjustment provided by section 3710 of the CARES Act, for patients diagnosed with COVID-19 and discharged on and after January 27, 2020, and on or before March 31, 2020?

Answer: The following table provides examples to illustrate the increase in IPPS operating MS-DRG payments provided by the CARES Act for patients diagnosed with COVID-19 (identified by the presence of ICD-10-CM diagnosis code B97.29) for discharges occurring on and after January 27, 2020, and on or before March 31, 2020.

Discharges on and after January 27, 2020, and on or before March 31, 2020	MS-DRG Assignment	FY 2020 Relative Weight ¹	Estimated MS-DRG Payment under the CARES Act ²
Principal Diagnosis <ul style="list-style-type: none"> • J12.89 - Other viral pneumonia Secondary Diagnosis <ul style="list-style-type: none"> • B97.29 - Other coronavirus as the cause of diseases classified elsewhere • J96.01 - Acute respiratory failure with hypoxia (MCC) 	MS-DRG 193 Simple Pneumonia and Pleurisy with MCC	1.3335	\$9,275.77
Principal Diagnosis <ul style="list-style-type: none"> • J20.8 - Acute bronchitis due to other specified organisms Secondary Diagnosis <ul style="list-style-type: none"> • B97.29 - Other coronavirus as the cause of diseases classified elsewhere 	MS-DRG 203 Bronchitis and Asthma without CC/MCC	0.6938	\$4,826.04
Principal Diagnosis <ul style="list-style-type: none"> • J22 - Unspecified acute lower respiratory infection Secondary Diagnosis <ul style="list-style-type: none"> • B97.29 - Other coronavirus as the cause of diseases classified elsewhere 	MS-DRG 206 Other Respiratory System Diagnoses without MCC	0.8725	\$6,069.07
Principal Diagnosis <ul style="list-style-type: none"> • J80 - Acute respiratory distress syndrome Secondary Diagnosis <ul style="list-style-type: none"> • B97.29 - Other coronavirus as the cause of diseases classified elsewhere Procedures <ul style="list-style-type: none"> • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours 	MS-DRG 207 Respiratory System Diagnosis with Ventilator Support >96 Hours	5.7356	\$39,896.58

<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • O98.513 - Other viral diseases complicating pregnancy, third trimester <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • J20.8 - Acute bronchitis due to other specified organisms • B97.29 - Other coronavirus as the cause of diseases classified elsewhere 	<p>MS-DRG 833 Other Antepartum Diagnoses without O.R. Procedure without CC/MCC</p>	<p>0.5321</p>	<p>\$3,701.26</p>
<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • A41.89 - Other specified sepsis <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • B20 - Human immunodeficiency virus [HIV] disease (CC) • J12.89 - Other viral pneumonia (MCC) • B97.29 - Other coronavirus as the cause of diseases classified elsewhere <p>Procedures</p> <ul style="list-style-type: none"> • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours 	<p>MS-DRG 974 HIV with Major Related Condition with MCC</p>	<p>2.6739</p>	<p>\$18,599.53</p>

¹ See FY 2020 IPPS Final Rule and Correction Notice Table 5 (tab 'FY 2020 Table 5 CN') found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables>.

² Estimated Operating MS-DRG Payment under the CARES Act based on FY 2020 Standardized amount with a wage index of 1.0 of \$5,796.63 (see FY 2020 IPPS Final Rule and Correction Notice Tables 1A-1E (tab 'FY 2020 CN Table 1A-1E') found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables>) for hospitals that submitted quality data and are meaningful EHR users. Note this estimated operating IPPS payment does not include any other payment adjustments, such as payments for Disproportionate Share Hospitals (DSHs), Indirect Medical Education (IME), outliers, and the hospital specific rates for Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs).

New: 5.27.20

7. Question: What would the estimated MS-DRG payments under the IPPS, including the adjustment provided by section 3710 of the CARES Act, for patients diagnosed with COVID-19 and discharged on or after April 1, 2020, through the duration of the COVID-19 public health emergency period?

Answer: The following table provides examples to illustrate the increase in IPPS operating MS-DRG payments provided by the CARES Act for patients diagnosed with COVID-19 (identified by the presence of ICD-10-CM diagnosis code U07.1) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 PHE period.

<p style="text-align: center;">Discharges on or after April 1, 2020, through the duration of the COVID- 19 public health emergency period</p>	<p style="text-align: center;">MS-DRG Assignment</p>	<p style="text-align: center;">FY 2020 Relative Weight¹</p>	<p style="text-align: center;">Estimated MS-DRG Payment under the CARES Act²</p>
<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • U07.1 - COVID-19 <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • J12.89 - Other viral pneumonia (MCC) • J96.01 - Acute respiratory failure with hypoxia (MCC) 	<p style="text-align: center;">MS-DRG 177 Respiratory Infections and Inflammations with MCC</p>	<p style="text-align: center;">1.8912</p>	<p style="text-align: center;">\$13,155.10</p>
<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • U07.1 - COVID-19 <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • J22 - Unspecified acute lower respiratory infection • N17.9 - Acute kidney failure, unspecified (CC) 	<p style="text-align: center;">MS-DRG 178 Respiratory Infections and Inflammations with CC</p>	<p style="text-align: center;">1.2433</p>	<p style="text-align: center;">\$8,648.34</p>
<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • U07.1 - COVID-19 <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • J20.8 - Acute bronchitis due to other specified organisms 	<p style="text-align: center;">MS-DRG 179 Respiratory Infections and Inflammations without CC/MCC</p>	<p style="text-align: center;">0.8661</p>	<p style="text-align: center;">\$6,024.55</p>
<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • U07.1 - COVID-19 <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • J80 - Acute respiratory distress syndrome (MCC) <p>Procedures</p> <ul style="list-style-type: none"> • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours 	<p style="text-align: center;">MS-DRG 207 Respiratory System Diagnosis with Ventilator Support >96 Hours</p>	<p style="text-align: center;">5.7356</p>	<p style="text-align: center;">\$39,896.58</p>
<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • O98.513 - Other viral diseases complicating pregnancy, third trimester <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • U07.1 - COVID-19 (MCC) • J20.8 - Acute bronchitis due to other specified organisms 	<p style="text-align: center;">MS-DRG 831 Other Antepartum Diagnoses without O.R. Procedure with MCC</p>	<p style="text-align: center;">1.0785</p>	<p style="text-align: center;">\$7,502.00</p>

<p>Principal Diagnosis</p> <ul style="list-style-type: none"> • A41.89 <p>Secondary Diagnosis</p> <ul style="list-style-type: none"> • B20 - Human immunodeficiency virus [HIV] disease (CC) • U07.1 - COVID-19 (MCC) • J12.89 - Other viral pneumonia (MCC) <p>Procedures</p> <ul style="list-style-type: none"> • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours 	<p>MS-DRG 974 HIV with Major Related Condition with MCC</p>	<p>2.6739</p>	<p>\$18,599.53</p>
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¹ See FY 2020 IPPS Final Rule and Correction Notice Table 5 (tab 'FY 2020 Table 5 CN') found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables>, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables>.

² Estimated Operating MS-DRG Payment under the CARES Act based on FY 2020 Standardized amount with a wage index of 1.0 of \$5,796.63 (see FY 2020 IPPS Final Rule and Correction Notice Tables 1A-1E (tab 'FY 2020 CN Table 1A-1E') found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables>) for hospitals that submitted quality data and are meaningful EHR users. Note this estimated operating IPPS payment does not include any other payment adjustments, such as payments for Disproportionate Share Hospitals (DSHs), Indirect Medical Education (IME), outliers, and the hospital specific rates for Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs).
New: 5.27.20

8. Question: Does the increased IPPS payment under section 3710 of the CARES Act apply to a hospital's capital IPPS payments?

Answer: No. Section 3710 of the CARES Act amended Section 1886(d)(4)(C) of the Social Security Act which generally governs IPPS operating payments. Therefore, in calculating a hospital's capital IPPS payment the MS-DRG weights are not adjusted for a patient diagnosed with COVID-19 and discharged during the emergency period.

New: 5.27.20

9. Question: How does the increased payment under section 3710 of the CARES Act affect a hospital's IPPS high cost outlier payment?

Answer: The FY 2020 fixed-loss amount of \$26,552 was not adjusted by the CARES Act. High cost outlier payments for IPPS discharges during the emergency period with a COVID-19 diagnosis code are determined after applying the increased payment under section 3710 of the CARES Act.

New: 5.27.20

10. Question: Does the increased payment under section 3710 of the CARES Act apply to hospital-specific rate payment for sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs)?

Answer: Yes, for IPPS discharges during the emergency period that have a principal or secondary COVID-19 diagnosis code, CMS will multiply the current MS-DRG relative weight

for the discharge by a factor of 1.20 when calculating the hospital-specific rate payment for SCHs and MDHs.

New: 5.27.20

11. Question: Will cases subject to the IPPS transfer policies receive the 20 percent increase for patients diagnosed with COVID-19 under the CARES Act?

Answer: Yes. For IPPS discharges of patients diagnosed with COVID-19 that are subject to the transfer policy, the MS-DRG relative weight is increased by 20 percent when calculating the hospital's operating IPPS payment.

New: 5.27.20

12. Question: How will claims processed before implementation of the provisions of section 3710 of the CARES Act be handled? Will the claims need to be resubmitted to receive the increased IPPS payment for discharges of patients diagnosed with COVID-19?

Answer: MACs will automatically initiate the reprocessing of affected claims by June 1, 2020. Affected claims are identified by the presence of ICD-10-CM diagnosis code B97.29 (for discharges occurring on and after January 27, 2020, and on or before March 31, 2020) and diagnosis code U07.1 (for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 PHE period).

New: 5.27.20

G. Ambulance Services

1. Question: Can ground ambulance providers and suppliers transport beneficiaries with COVID-19 symptoms, or those who are confirmed to have COVID-19, to destination sites that are not a hospital, critical access hospital (CAH) or skilled nursing facility (SNF)?

Answer: To provide ground ambulance providers and suppliers the flexibility to furnish medically necessary emergency and non-emergency ambulance transports for beneficiaries during the PHE for the COVID-19 pandemic, we are temporarily expanding the list of allowable destinations for ground ambulance transports. During the COVID-19 PHE, a covered destination for a ground ambulance transport may include any destination that is equipped to treat the condition of the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF; community mental health centers; federally qualified health centers; rural health clinics; physician's offices; urgent care facilities; ambulatory surgical centers; any location furnishing dialysis services outside of the ESRD facility when an ESRD facility is not available; and the beneficiary's home. There must be a medically necessary ground ambulance transport of a patient in order for the ambulance service to be covered.

New: 4/9/20

2. Question: How are Advanced Life Support (ALS) assessment, intervention, and ambulance

transport defined?

Answer: Definitions for Ambulance Services are in 42 CFR §414.605. ALS assessment, intervention, and ambulance transport are defined as follows:

- Advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. ALS intervention means a procedure that is, in accordance with State and local laws, required to be furnished by ALS personnel. Advanced life support, level 1 (ALS1) means transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.
- Advanced life support, level 2 (ALS2) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures: (1) Manual defibrillation/cardioversion, (2) Endotracheal intubation, (3) Central venous line, (4) Cardiac pacing, (5) Chest decompression, (6) Surgical airway, and (7) Intraosseous line.

New: 4/9/20

3. Question: How is an ALS assessment determined?

Answer: Medicare ambulance coverage policy provides that an ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS emergency service if the ALS crew completes an ALS assessment, the services provided by the ambulance transportation service provider or supplier is covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary and all other coverage requirements are met (see Medicare Benefit Policy Manual, Chapter 10, Section 30.1.1.).

New: 4/9/20

4. Question: Will all transports of COVID-19 patients or patients suspected to have COVID-19 be designated as Advanced Life Support (ALS) transports?

Answer: No. Payment for an ambulance transport is based on the level of service provided.

New: 4/9/20

5. **Question:** Will CMS allow ground ambulance providers and suppliers to treat COVID-19 patients in their home or designated residence and allow for reimbursement at the ALS reimbursement base rate?

Answer: Section 1861(s)(7) of the Act describes the ambulance services benefit under Medicare as a transportation benefit, and thus an ambulance transport of a beneficiary is required in order for the ambulance to be paid under Medicare.

New: 4/9/20

6. **Question:** Should HCPCS code A0998 (ambulance response and no transport) be reported for treatment in place?

Answer: No, HCPCS code A0998 (ambulance response and no transport) is not covered under the ambulance services benefit (defined in section 1861(s)(7) of the Act), and thus is not payable under Medicare's Ambulance Fee Schedule.

New: 4/9/20

7. **Question:** Will CMS allow all responses, including Basic Life Support (BLS), related to COVID-19 to be billed at the ALS rate, regardless if ALS interventions were performed?

Answer: We recognize that COVID-19 transports require following infectious disease protocols, such as decontamination procedures, personal protective equipment (PPE), and the required engagement of paramedics which may increase the cost of transports involving suspected or diagnosed COVID-19 patients. However, ground ambulance transports must be billed according to the level of service furnished. Only transports that meet the requirements for billing at the ALS level of service can be billed at the ALS rate.

New: 4/9/20

8. **Question:** Can ground ambulance providers and suppliers report other services they provide to PUI or COVID-19 patients?

Answer: Under § 414.610(d), payment under the ambulance fee schedule represents payment in full (subject to applicable Medicare Part B deductible and coinsurance requirements) for all services, supplies, and other costs for an ambulance transport service furnished to a Medicare beneficiary.

New: 4/9/20

9. **Question:** Can I consider any COVID-19 positive patient to meet the medical necessity requirements for ambulance transport?

Answer: The medical necessity requirements for coverage of ambulance services have not been changed. For both emergency and non-emergency ambulance transportation, Medicare pays for ground (land and water) and air ambulance transport services only if they are furnished to a Medicare beneficiary whose medical condition is such that other forms of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided for the billed services to

be considered medically necessary.

New: 4/9/20

10. Question: If the ambulance crew provides treatment but does not transport anyone, can the company bill Medicare for the services provided?

Answer: No. Medicare law prohibits payment for an ambulance service unless a medically necessary transport of a Medicare beneficiary has taken place. However, when an enrolled physician or other qualified health professional furnishes services from an ambulance, he or she may bill for those services under the Medicare Physician Fee Schedule, assuming that the services furnished were in accordance with applicable state law and services are within his or her scope of practice requirements.

Revised: 3/26/20

11. Question: How will ambulance services be paid when patients are moved from hospital to hospital or other approved locations?

Answer: Medicare will pay for ambulance transportation according to the usual payment guidelines. Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals should be included on the inpatient claims submitted by the originating hospitals. Payment will be included in the diagnostic related group (DRG) payment amounts made to hospitals paid under the prospective payment system.

Revised: 3/26/20

12. Question: If a beneficiary who is living at home and using a stationary oxygen unit, has to be transported to another location by ambulance (because other means of transportation are contraindicated), can Medicare pay for any portable oxygen necessary to transport the beneficiary?

Answer: Medicare's standard payment to ambulance providers and suppliers under the Ambulance Fee Schedule for ambulance transports already includes payment for all necessary supplies, including oxygen, provided during the transport. Thus, if the transport is a Medicare-covered service (e.g., the beneficiary must be transported by ambulance to a covered destination because other means of transportation are contraindicated), then no separate payment for furnishing oxygen would be made.

However, if the transport does not qualify as a Medicare-covered service, then payment under Part B may be made to a Durable Medical Equipment supplier for furnishing portable oxygen when supplemental oxygen is needed for the beneficiary during the transport.

Revised: 3/26/20

13. Question: In emergency/disaster situations, how does CMS define an "approved destination" for ambulance transports and would it include alternate care centers, field hospitals and other facilities set up to provide patient care in response to the emergency/disaster?

Answer: CMS defines “approved destination” at 42 CFR 410.40(f), Origin and destination requirements. Medicare can only pay for ambulance transportation when it meets the origin and destination requirements and all other coverage requirements.

42 CFR 410.40(f) allows Medicare to pay for an ambulance transport (provided that transportation by any other means is contraindicated by the patient’s condition and all other Medicare requirements are met) to the following destinations:

- From any point of origin to the nearest hospital, Critical Access Hospital (CAH), or SNF that is capable of furnishing the required level and type of care for the beneficiary’s illness or injury and the return trip to the beneficiary’s home. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary’s condition.
- For beneficiaries residing in a SNF who are receiving Part B benefits only, ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip. For SNF residents receiving Medicare Part A benefits, this type of ambulance service is subject to SNF consolidated billing.
- For a beneficiary who is receiving renal dialysis for treatment of ESRD, from a beneficiary’s home to the nearest facility that furnishes renal dialysis, including the return trip.

A physician’s office normally is not a covered destination under Medicare Part B. However, under certain circumstances an ambulance transport may temporarily stop at a physician’s office without affecting the coverage status of the transport. Note that there is an exception to this rule during the COVID-19 PHE, as explained further below.

Should a facility that would normally be the nearest appropriate facility be unavailable during an emergency/disaster, Medicare may pay for transportation to another facility so long as that facility meets all Medicare requirements and is still the nearest facility that is available and equipped to provide the needed care for the illness or injury involved.

Medicare payment for an ambulance transport to a temporary expansion site may be available if the site is determined to be part of a hospital, CAH or SNF that is an approved destination for an ambulance transport under 42 CFR 410.40(f). If the temporary expansion site is part of a hospital, CAH or SNF that is an approved destination under 42 CFR 410.40(f) for an ambulance transport, Medicare will pay for the transport on the same basis as it would to any other approved destination.

In addition, to provide ground ambulance providers and suppliers the flexibility to furnish medically necessary emergency and non-emergency ambulance transports for beneficiaries

during the PHE for the COVID-19 pandemic, we are temporarily expanding the list of allowable destinations for ground ambulance transports. During the COVID-19 PHE, a covered destination for a ground ambulance transport may include any destination that is equipped to treat the condition of the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services will be furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF; community mental health centers; federally qualified health centers; rural health clinics, physician's offices; urgent care facilities; ambulatory surgical centers; any location furnishing dialysis services outside of the ESRD facility when an ESRD facility is not available; and the beneficiary's home. There must be a medically necessary ground ambulance transport of a patient in order for the ambulance service to be covered.

Physicians, non-physician practitioners, and suppliers should contact their Part B MAC or DME MAC with questions about SNF consolidated billing. There is also additional information about SNF consolidated billing on the CMS Medicare Learning Network (MLN) Publications webpage.

Institutional providers should contact their Part A MAC with questions about SNF consolidated billing. There is also additional information about SNF consolidated billing on the CMS MLN Publications webpage.

Revised: 4/10/20

14. Question: Our ambulance uses an electronic patient care reporting device to record beneficiary signatures that authorize submission of claims to Medicare. We are concerned that a known or suspected COVID-19 patient using a touch screen to sign or holding an electronic pen or stylus could contaminate these devices for future patients and for ambulance personnel. Are we permitted to sign on behalf of a patient with known or suspected COVID-19?

Answer: Yes, but only under specific, limited circumstances. CMS will accept the signature of the ambulance provider's or supplier's transport staff if that beneficiary or an authorized representative gives verbal consent. CMS has determined that there is good cause to accept transport staff signatures under these circumstances. See 42 CFR 424.36(e). CMS recommends that ambulance providers and suppliers follow the Centers for Disease Control's Interim Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPs) for COVID-19 in the United States, which can be found at the following link: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>. This guidance includes general guidelines for cleaning or maintaining EMS transport vehicles and equipment after transporting a patient with known or suspected COVID-19. However, in cases where it would not be possible or practical (such as a difficult to clean surface) to disinfect the electronic device after being touched by a beneficiary with known or suspected COVID-19, documentation should note the verbal consent.

New: 4/10/20

H. Ambulance Services- Vehicle and Staffing Requirements for Ambulance Providers and Suppliers

- 1. Question:** Would a ground ambulance vehicle operating without a renewed license nevertheless satisfy the Medicare requirements at 42 CFR § 410.41 if, during the PHE for the COVID-19 pandemic, a state or locality issues a law or regulation, or a legally adequate waiver, that permits ground ambulance vehicles to operate without a renewed license?

Answer: Yes, depending on state or local law. 42 CFR § 410.41 specifies Medicare's requirements for ambulance vehicles, and § 410.41(a)(1) states that a vehicle used as an ambulance must be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle. Key to this is that § 410.41(a) requires compliance with state and local laws. During the PHE for the COVID-19 pandemic, should a state or locality enact or promulgate a law, regulation, or legally adequate waiver permitting an ambulance vehicle to operate without a renewed license, such an ambulance would be in compliance with Medicare's requirements at § 410.41(a). We also note that the staffing requirements at § 410.41(b) must be met in order for the ambulance transport to meet the § 410.41 requirements (see discussion in the FAQs below regarding waivers of these provisions).

New: 5/1/20

- 2. Question:** During the PHE for the COVID-19 pandemic, if a state law or local law permits ambulance staffing by personnel licensed/certified below the levels of certification required under 42 CFR § 410.41(b), would an ambulance so staffed be considered to meet the Medicare requirements of § 410.41(b)? For example, CMS has heard that, during the course of the PHE for the COVID-19 pandemic, and pursuant to state waiver, one or more states may permit an Emergency Medical Responder (EMR), which is a certification status below the scope of practice of an Emergency Medical Technician (EMT) to staff a Basic Life Support (BLS) vehicle, or a Registered Nurse (RN), which is a health care professional status different than an EMT-paramedic, to staff an Advanced Life Support (ALS) vehicle.

Answer: Yes, depending on state or local law. During the PHE for the COVID-19 pandemic, and pursuant to 42 U.S.C. 1320b-5(b)(1)(B), Medicare is waiving the specified ambulance staffing certification requirements of 42 CFR § 410.41(b) such that, if a state and/or local law, or regulation, or a waiver issued by the applicable state or local authority permits a BLS or ALS ambulance to be alternatively staffed, such staffing arrangement would satisfy Medicare requirements. For example, should it be permitted by a state or local law, or regulation, or a waiver issued by the applicable state or local authority, for purposes of meeting Medicare's staffing requirements for a covered transport, a BLS vehicle could be staffed with an EMR instead of an EMT-basic or an ALS vehicle could be staffed with an RN instead of a EMT or paramedic. Note that the onus is on an ambulance provider or supplier

to ensure that it otherwise continues to meet all applicable Medicare enrollment, coverage, and other requirements.

New: 5/1/20

- 3. Question:** During the PHE for the COVID-19 pandemic, if an ambulance provides services across state lines and the vehicle staff are not licensed or certified to provide services in the state in which the ambulance services are provided, will the ambulance be considered to meet the vehicle staff certification requirements under 42 CFR § 410.41(b) while providing services in that state?

Answer: During the PHE for the COVID-19 pandemic, pursuant to 42 U.S.C. 1320b-5(b)(2), Medicare is waiving the requirement at 42 CFR § 410.41(b) that vehicle personnel be licensed or certified in the State in which they are furnishing services if they have equivalent licensing or certification in another State and are not affirmatively excluded from practice in that State or in any other State. Where the terms of this waiver are met, the ambulance staff certification requirements of § 410.41(b) could be met when ambulances provide services across state lines. Note, however, that this does not waive state or local laws (only Medicare’s own certification requirements in § 410.41(b) for purposes of Medicare payment and coverage) such that, should a state not permit out of state ambulances to provide services, Medicare’s waiver would not affect a state’s potential enforcement of its provisions.

New: 5/1/20

I. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- 1. Question:** Has CMS implemented any changes to help RHCs and FQHCs respond to the to the serious public health threats posed by the spread of the 2019 novel coronavirus (COVID-19)?

Answer: Yes. CMS has removed some regulatory requirements and added additional flexibilities to assist RHCs and FQHCs in furnishing services during the COVID-19 Public Health Emergency (PHE). These include:

- a) Expansion of Virtual Communication Services for RHCs and FQHCs to include online digital evaluation and management services using patient portals; and
- b) Revision of Home Health Agency Shortage Area Requirement for Visiting Nursing Services Furnished by RHCs and FQHCs

New: 4/9/20

- 2. Question:** When do these changes go into effect?

Answer: These changes are in effect for the duration of the COVID-19 PHE and are not permanent.

New: 4/9/20

- 3. Question:** Are these changes permanent?

Answer: These changes are in effect for the duration of the PHE for the COVID-19 pandemic and are not permanent.

New: 4/9/20

4. Question: Do these changes apply to all RHCs and FQHCs?

Answer: Yes. They apply to all RHCs (independent/freestanding and provider-based) and all FQHCs (including grandfathered tribal FQHCs).

New: 4/9/20

J. Expansion of Virtual Communication Services for FQHCs/RHCs

1. Question: What are “online digital evaluation and management services” in RHCs and FQHCs?

Answer: Online digital evaluation and management services are non-face-to face, patient-initiated, digital communications using a patient portal, that require a clinical decision that otherwise typically would have been provided in the office. CMS has been paying separately under the physician fee schedule for these services since before the PHE and is expanding the same flexibilities to RHCs and FQHCs.

New: 4/9/20

2. Question: Are there specific codes that describe these services?

Answer: Yes. The codes that have been added for RHCs and FQHCs are:

- 99421 - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- 99422 - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- 99423 - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

New: 4/9/20

3. Question: What is an online patient portal?

Answer: An online patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an Internet connection by using a secure username and password.

New: 4/9/20

4. Questions: Does the RHC or FQHC practitioner have to be physically in the RHC or FQHC, or can they respond from another location such as their home?

Answer: The RHC or FQHC practitioner can respond from any location during a time that they are scheduled to work for the RHC or FQHC.

New: 4/9/20

5. Question: How will Medicare pay RHCs and FQHCs for performing online digital evaluation and management services?

Answer: The online digital assessment codes are being added to the codes that are billed using HCPCS code G0071, the RHC/FQHC specific code for Virtual Communication Services.

New: 4/9/20

- 6. Question:** How can RHCs and FQHCs bill for online digital evaluation and management services?

Answer: RHCs and FQHCs can bill for online digital evaluation and management services using the RHC/FQHC HCPCS code G0071. The payment for G0071 will be the PFS national non-facility payment rate for HCPCS code G2012 (communication technology-based services), HCPCS code G2010 (remote evaluation services), CPT 99421, CPT 99422, and CPT 99423. The new payment rate is \$24.76.

New: 4/9/20

- 7. Question:** When will the new payment rate for G0071 be effective?

Answer: The new payment rate is effective for services provided on or after March 1, 2020. However, claims submitted with this code before the claims processing system is updated will be reprocessed.

New: 4/9/20

- 8. Question:** How frequently can G0071 be billed by RHCs and FQHCs?

Answer: Because these codes are for a minimum 7-day period of time, they cannot be billed more than once every 7 days.

New: 4/9/20

- 9. Question:** Can virtual communication services be furnished to both new and established patients?

Answer: Yes. Virtual communication services may be furnished to both new and established patients during the COVID-19 PHE.

New: 4/9/20

- 10. Question:** Is beneficiary consent required?

Answer: Yes, but during the PHE, it may be obtained at the same time the services are furnished.

New: 4/9/20

- 11. Question:** Will RHCs be held to the RHC productivity requirements during the COVID-19 PHE?

Answer: Many RHCs have had to change the way they staff their clinics and bill for RHC services as a result of the COVID-19 PHE and may have difficulty in meeting the productivity standards. Under existing policy in Chapter 13 of the Medicare Benefit Policy Manual, A/B MACs can provide an exception to any RHC that has had difficulty in meeting the productivity standards as a result of the COVID-19 PHE; A/B MACs may choose to proactively grant productivity exceptions to RHCs who have experienced disruptions in

staffing and services as a result of the COVID-19 PHE.

New: 5/27/2020

12. Question: What telehealth services can be furnished and billed by RHCs and FQHCs?

Answer: RHCs and FQHCs can serve as the distant site to furnish and bill for any telehealth services that are included on the list of Medicare telehealth services under the Physician Fee Schedule (PFS) for the duration of the COVID-19 PHE. A list of this services can be found here: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

New: 5/27/2020

13. Question: How should distant site telehealth services be reported on the cost report?

Answer: RHCs and FQHCs should report distant site telehealth service costs on their cost report along with costs for furnishing originating site telehealth services. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled “Cost Other Than RHC Services.” FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled “Other FQHC Services”.

New: 5/27/2020

14. Question: Do distant site telehealth services have to be related to COVID-19?

Answer: No. Distant site telehealth services do not have to be related to COVID-19.

New: 5/27/2020

15. Question: Do telehealth services have to be initiated by the patient?

Answer: No. Telehealth services do not have to be initiated by the patient. However, the patient should be made aware of any cost-sharing for which he or she is liable.

New: 5/27/2020

16. Question: Who can furnish distant site telehealth services?

Answer: Distant site telehealth services can be furnished by the RHC or FQHC practitioner or any health care practitioner working within their state scope of practice. They have to be working for the RHC/FQHC, as an employee or under direct contract.

New: 5/27/2020

17. Question: Where can RHC or FQHC practitioners be located when furnishing distant site telehealth services?

Answer: For the duration of the COVID-19 PHE, RHC or FQHC practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC.

New: 5/27/2020

18. Question: Can the patient's home serve as an originating site?

Answer: Yes. Effective March 6, 2020, the patient's home can serve an originating site for the duration of the COVID-19 PHE. For treatment of substance use disorder and related conditions, the patient's home was eligible before the PHE.

New: 5/27/2020

19. Question: Will coinsurance apply to distant site telehealth services?

Answer: During the COVID-19 PHE, coinsurance and deductible (if applicable) does not apply for certain evaluation and management services when they are related to COVID-19 testing, whether they are furnished in person or via telehealth. A list of these services can be found at https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mInc-se#_Toc37139913. Additional information regarding coinsurance and deductibles can be found at <https://www.cms.gov/files/document/se20011.pdf>.

New: 5/27/2020

20. Question: Are modifiers required to identify services to which coinsurance and deductibles do not apply?

Answer: RHCs and FQHCs must use the "CS" modifier on the claim to identify the COVID-19 testing-related services to which the coinsurance and deductible do not apply. Coinsurance and deductible amounts should not be collected from beneficiaries for these services.

New: 5/27/2020

21. Question: Will coinsurance and deductibles apply for telehealth services that are not related to COVID-19 testing?

Answer: Yes. Coinsurance and deductible (if applicable) is only removed for specified COVID-19 testing-related services, whether they are furnished in person or via telehealth, as described at <https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mInc-se>.

New: 5/27/2020

22. Question: Can FQHC lookalikes also bill for distant site telehealth services during the COVID-19 PHE?

Answer: Yes, FQHC lookalikes can also bill for distant site telehealth services for the duration of the COVID-19 PHE.

New: 5/27/2020

23. Question: When did the changes for services furnished by RHCs and FQHCs during the COVID-19 PHE go into effect?

Answer: The effective dates for these changes are as follows:

Distant Site Telehealth Services by RHCs and FQHCs - January 27, 2020

Telehealth Services Furnished when the patient is at home - March 6, 2020 (For treatment

of substance use disorder and related conditions, the patient's home was eligible before the PHE).

Expanded Virtual Communication Services - March 1, 2020

Revision of HHA Shortage Area Requirement for Visiting Nursing Services - March 1, 2020

Audio-only Telehealth Services - March 1, 2020

New: 5/27/2020

K. Revision of the Home Health Agency Shortage Area Requirement for Visiting Nursing Services Furnished by RHCs and FQHCs

1. **Question:** Can RHCs and FQHCs bill for visiting nursing services?

Answer: Yes. In an area in which there exists a shortage of home health agencies (HHAs), visiting nursing services can be furnished to a homebound individual by an RN or a LPN under a written plan of treatment.

New: 4/9/20

2. **Question:** How are we changing the HHA shortage area requirement for visiting nursing services and what additional flexibilities does this provide for RHCs and FQHCs?

Answer: During the COVID-19 PHE, we will assume that the area typically served by the RHC, and the area that is included in the FQHC's service area plan, has a shortage of home health agencies, and no request for this determination is required. The RHC or FQHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care. No visits will be payable to the RHC/FQHC if such patient is already being treated under a home health plan of care.

New: 4/9/20

3. **Question:** Is there a change in how "homebound" is determined?

Answer: No. During the PHE, as previously, a patient would be considered "homebound" if it is medically contraindicated for the patient to leave the home. The patient's medical records must document leaving the home is medically contraindicated. For example, a beneficiary could be considered "homebound" if: (1) a physician has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or (2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

New: 4/9/20

4. **Question:** Can a visiting nurse service be billed if the nurse goes to the patient's home to collect a lab specimen for coronavirus testing?

Answer: Not if it is the only service provided. Visiting nurse services are only billable as an RHC/FQHC visit when they require skilled nursing services. If the RN or LPN collects a specimen for testing and does not provide skilled nursing services under a written plan of

treatment, then it would not be a RHC or FQHC billable visit.

New: 4/9/20

5. **Question:** How does this change affect how RHCs and FQHCs bill for visiting nursing services?

Answer: There are no billing changes for visiting nursing services. Qualified visiting nursing services are billed as an RHC or FQHC visit using revenue code 0527.

New: 4/9/20

L. Medicare Telehealth (Please note that these FAQs do not include flexibilities that might be exercised under the CARES act)

1. **Question:** What services can be provided by telehealth during a waiver for the public health emergency (PHE) declared by the Secretary under the section 1135 waiver authority?

Answer: Medicare telehealth services include many services that are normally furnished in-person. CMS maintains a list of services that may be furnished via Medicare telehealth. This list is available here: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Under the emergency declaration and waivers, these services may be provided to patients by physicians and certain non-physician practitioners regardless of the patient's location. Medicare also pays for certain other services that are commonly furnished remotely using telecommunications technology, but are not considered Medicare telehealth services. These services can always be provided to patients wherever they are located, and include physician interpretation of diagnostic tests, care management services, and virtual check-ins.

New: 4/9/20

2. **Question:** Who are the Qualified Providers who are permitted to furnish telehealth services under the PHE waiver?

Answer: The same health care providers are still permitted to furnish Medicare telehealth services under the waiver authority during the Public Health Emergency, including physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish telehealth services within their scope of practice and consistent with Medicare benefit rules that apply to all services.

New: 4/9/20

3. **Question:** Is any specialized equipment needed to furnish Medicare telehealth services?

Answer: Currently, CMS allows telehealth services to be furnished using telecommunications technology that has audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many

mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication, they qualify as acceptable technology. For more information: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html>.

New: 4/9/20

- 4. Question:** Can practitioners provide Medicare telehealth services using their phones?
Answer: Yes, for use of certain phones. Section 1135(b)(8) of the Social Security Act allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. Additionally, CMS amended its regulations through the IFC to remove the potential perception of restrictions on technology that practitioners can use to provide telehealth services. The Office of Civil Rights has also issued guidance allowing covered health care providers to use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk of penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. For more information: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html>.

New: 4/9/20

- 5. Question:** How does a health care provider bill for telehealth services?
Answer: The IFC directs physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. We believe this interim change will maintain overall relativity under the PFS for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth. During the PHE, the CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. Practitioners should continue to bill these services using the CMS-1500/837P.

New: 4/9/20

- 6. Question:** How much does Medicare pay for telehealth services?
Answer: Medicare pays the same amount for telehealth services as it would if the service were furnished in person.

New: 4/9/20

- 7. Question:** How long will practitioners be able to bill using these new flexibilities?
Answer: The telehealth waiver will be effective until the end of the PHE declared by the

Secretary of HHS on January 31, 2020. Billing for the expanded Medicare telehealth services, as well as for the telephone assessment and management, telephone, evaluation and management services, and additional flexibilities for communications technology-based services (CTBS) are effective beginning March 1, 2020, and through the end of the PHE.

New: 4/9/20

- 8. Question:** Can physicians and practitioners let their patients know that Medicare covers telehealth in new locations during the PHE?

Answer: Yes. Physicians and practitioners should inform their patients that services are available via telehealth in new locations, including their homes, during the PHE and educate them on any applicable cost sharing.

New: 4/9/20

- 9. Question:** Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?

Answer: Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary. If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a “distant site”), they should report those services as telehealth services. If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished.

New: 4/9/20

- 10. Question:** How are telehealth services different from virtual check-ins and e-visits? How much does Medicare pay for these services?

Answer: Medicare telehealth services are services that would normally occur in person but are instead conducted via telecommunications technology and are paid at the full in-person rate. Service such as the virtual check-in, eVisits, remote evaluation, and telephone visits are not services that would normally occur in person, and are not paid as though the service occurred in person. A virtual check-in lets professionals bill for brief (5-10 min) communications that mitigate the need for an in-person visit and can be furnished via any synchronous telecommunications technology visit that would be furnished along with an e-visit is similar to a virtual check-in, but should be reported when a beneficiary communicates with their health care provider through an online patient portal. Telephone visits may be furnished via audio-only telephone whereas the remote evaluation describes the evaluation of a prerecorded video or image provided by the patient. Table 1 illustrates the respective payment rates to the physician or other practitioner; they vary based on the

practice setting.

New: 4/9/20

Table 1: Payment rates for the virtual check in and the e-Visit

HCPCS	Descriptor	Office-based Payment Rate to the Professional	Facility-based Payment Rate to the Professional
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	\$15.52	\$13.35
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	\$31.04	\$27.43
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	\$50.16	\$43.67
G2061	Qualified non-physician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes	\$12.27	\$12.27
G2062	Qualified non-physician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes	\$21.65	\$21.65
G2063	Qualified non-physician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes	\$33.92	\$33.56
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24	\$14.80	\$13.35

HCPCS	Descriptor	Office-based Payment Rate to the Professional	Facility-based Payment Rate to the Professional
	hours or soonest available appointment; 5-10 minutes of medical discussion		

11. Question: What has changed for communication technology-based services (e.g. remote evaluation of patient images/video and virtual check-in) for practitioners who bill for E/M codes?

Answer: During the PHE for COVID-19, HCPCS codes G2010 and G2012, which may only be reported when they do not result in an in-person or telehealth visit, can be furnished to both new and established patients. During the PHE, the required annual beneficiary consent to receive these services may be obtained at the same time that the services are furnished either by the billing practitioner or by staff under general supervision. If the brief communication technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional the service would be considered bundled into the previous E/M service and would not be separately billable.

New: 4/9/20

12. Question: Can other practitioners who do not bill for E/M codes provide communication technology-based services (e.g. remote evaluation of patient images/video and virtual check-in) or telephone assessment and management services during the PHE?

Answer: Yes. During the PHE, the availability of HCPCS codes G2010 and G2012 is broadened to allow certain practitioners, such as physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists, who do not report E/M codes to bill for these services. CMS has also activated CPT codes 98966, 98967, and 98968, which describe assessment and management services conducted over the phone.

New: 4/9/20

13. Question: Will CMS require specific modifiers to be applied to the existing codes?

Answer: For telehealth services furnished during the PHE, CMS is allowing practitioners to use the POS code that they would have otherwise reported had the service been furnished in person. To identify these services as Medicare telehealth, CMS is requiring that modifier 95 be appended to the claim.

There are also three additional scenarios where modifiers are ordinarily required on Medicare telehealth claims. When a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska

and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

New: 4/9/20

14. Question: Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

Answer: There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the public health emergency. The practitioner should report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person.

New: 4/9/20

15. Question: What about beneficiaries who do not have access to smart phones or other technology that supports two-way, audio and video telecommunications technology?

Answer: The IFC allows physicians and other practitioners to bill for certain telephone assessment, evaluation and management services during the PHE. These services were previously not separately billable. These services may be billed for both new and established patients.

New: 4/9/20

16. Question: What has changed for communication technology-based services (CTBS) (HCPCS codes G2010 and G2012 - e.g. remote evaluation of patient images/video and virtual check-ins) for practitioners who bill for Evaluation and Management (E/M) services?

Answer: As stated in the CY 2019 PFS final rule, we finalized that if the communications technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, the CTBS would be considered bundled into that previous E/M service and would not be separately billable. Under the policy in the CY 2019 PFS final rule, in instances when the CTBS leads to an E/M service with the same physician or other qualified health care professional, the CTBS is considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable. However, when the CTBS leads to an E/M visit with a different physician or other qualified health care professional, the CTBS would not be considered bundled into that visit (83 FR 59486) and the CTBS is separately billable. This has not changed during the PHE.

New: 4/9/20

17. Question: Can consent for multiple CTBS or interprofessional consultations services be obtained at one time?

Answer: Yes. Beneficiary consent may be obtained annually for all CTBS (e.g. remote evaluation of patient images/video and virtual check-ins) or interprofessional consultation services occurring within the year (84 FR 62699).

New: 4/9/20

18. Question: What does it mean for CTBS (HCPCS codes G2010 and G2012, (e.g. remote evaluation of patient images/video and virtual check-ins)) to be initiated by the patient?

Answer: On page 59484 of the CY 2019 PFS final rule, we stated that, for G2012, “We expect that these services will be initiated by the patient, especially since many beneficiaries would be financially liable for sharing in the cost of these services.” For G2010, we noted that this service is initiated by the patient (83 FR 59487). This means that the patient must consent to the service before or at the same it takes place and does not prohibit practitioners from educating, on their own initiative, beneficiaries on the availability of the service prior to, or at the same time it takes place.

New: 4/9/20

19. Question: Can the CTBS (HCPCS codes G2010 and G2012, (e.g. remote evaluation of patient images/video and virtual check-ins)) be billed on the same day, by the same practitioner, for the same patient?

Answer: As long as all requirements for billing both codes are met, and time and effort are not being counted twice, HCPCS codes G2010 and G2012 may be billed by the same practitioner, for the same patient, on the same day.

New: 4/9/20

20. Question: Can Remote Physiologic Monitoring (RPM) services be furnished to new patients as well as established patients?

Answer: Starting March 1 and for the duration of the PHE, RPM services can be furnished to both new and established patients. We ordinarily require an initiating visit for RPM services, similar to other care management services, but this requirement may be satisfied via a telehealth visit. Regardless, for the duration of the PHE, we are not requiring patients to be established patients in order to receive RPM services. Patients that receive RPM services can be established or new.

Revised: 4/23/20

21. Question: May clinical staff provide RPM services under general supervision?

Answer: Yes. We finalized in the CY 2020 PFS final rule (84 FR 62698) that RPM services, including but not limited to HCPCS codes 99453, 99454, 99457, 99458, may be provided under the general supervision of the billing practitioner. We note that, beneficiary consent to receive these services may also be obtained by auxiliary personnel under general supervision of the billing practitioner. Further, we note that, as specified in the IFC (85 FR 19245-19246), during the PHE when physicians and other health care professionals are faced with challenges regarding potential exposure risks for themselves and their patients,

the direct supervision requirement that applies for most other services that are furnished incident to a physician or other practitioner's services may be met virtually through audio/video real-time communications technology.

We also note that clinical staff are "auxiliary personnel." According to the 2019 CPT Codebook (p. xii), "A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service."

New: 4/9/20

22. Question: The prefatory language for the Remote Physiologic Monitoring (RPM) CPT codes 99453, 99454, and 99457 requires that the device used to capture a patient's physiologic data must be a medical device as defined by the FDA. Can we assume that any device used to capture a patient's physiologic data whether Class I, Class II, Class III would meet this requirement?

Answer: The device used to capture a patient's physiologic data must meet the FDA definition of being a medical device. The CPT code descriptor does not indicate that the device must be an FDA approved device. Medical devices are defined on the FDA website as follows:

"Medical devices range from simple tongue depressors and bedpans to complex programmable pacemakers with micro-chip technology and laser surgical devices. In addition, medical devices include in vitro diagnostic products, such as general purpose lab equipment, reagents, and test kits, which may include monoclonal antibody technology. Certain electronic radiation emitting products with medical application and claims meet the definition of medical device. Examples include diagnostic ultrasound products, x-ray machines, and medical lasers." For more information, see the FDA link at:

<https://www.fda.gov/medical-devices>.

New: 4/9/20

23. Question: Are beneficiary-provided vital signs sufficient to satisfy that portion of the annual wellness visit (AWV) when conducted via telehealth?

Answer: If the beneficiary is at home and has access to the types of equipment they would need to self-report vital signs (e.g., weight, blood pressure), and if the visit meets all other requirements of the code, this scenario would satisfy the requirements for purposes of billing the AWV code.

CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth during the PHE. This list is available here:

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

New: 5/27/2020

24. Question: What telephone-only service codes were finalized as telehealth services for the duration of the PHE?

Answer: For purposes of the PHE for the COVID-19 pandemic, Medicare has added several codes that describe telephone-only services to the list of Medicare telehealth services. These include CPT codes 99441–99443, which describe audio-only telephone evaluation and management (E/M) phone visits with practitioners who can independently bill for E/M services. While these codes are ordinarily limited to established patients, during the PHE, Medicare will make payment for them for both new and established patients. These services are noted on the list of telehealth services at

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

Please report the POS that would have used had the service occurred in person for these telephone-only service codes and all other telehealth services during the PHE.

In addition, while not currently on the Medicare telehealth services list, during the PHE for COVID-19, CMS pays CPT codes 98966–98968, which describe audio-only telephone assessment and management visits for practitioners who cannot independently bill for E/M phone visits, for example certain therapists, social workers, and clinical psychologists.

New: 5/27/2020

25. Question: If the video connection is disconnected during an audio-video Medicare telehealth visit due to technological issues, can the visit still be billed as Medicare telehealth?

Answer: Practitioners should report the code that best describes the service. If the service was furnished primarily through an audio-only connection, practitioners should consider whether the telephone evaluation and management or assessment and management codes best describe the service, or whether the service is best described by one of the behavioral health and education codes for which we have waived the video requirement during the PHE for the COVID-19 pandemic. If the service was furnished primarily using audio-video technology, then the practitioner should bill the appropriate code from the Medicare telehealth list that describes the service. Note that CPT codes 99441–99443, which describe audio-only telephone E/M phone visits with practitioners who can independently bill for E/M services, have been added to the Medicare telehealth list for the purposes of the PHE for the COVID-19 pandemic, and payment rates for these codes are set to be the same as the analogous in-person E/M visits.

New: 5/27/2020

1. Question: How should the CS modifier, which removes application of beneficiary cost-sharing (deductible and co-payment), be applied to telehealth services and/or E/M visits?

Answer: The CS modifier should be applied for certain evaluation and management services related to COVID-19 testing, whether they are furnished in person or via telehealth. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635. Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020, and the end of the PHE; result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

For services furnished on or after March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

Additionally, the CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. And the billing practitioner should report the POS code that reflects the place the service would have been furnished if furnished in-person.

New: 5/27/2020

26. Question: Do Medicare telehealth services require CR (“catastrophe/disaster related”) modifier and/or DR (“disaster related”) condition code?

Answer: No, the CR and DR modifiers are not necessary for Medicare telehealth services.

New: 5/27/2020

27. Question: What codes can emergency physicians use if they want to perform telehealth services?

Answer: ED physicians can perform telehealth services from any location. CMS has temporarily added the ED E/M codes (CPT codes 99281–99285), the critical care codes (CPT codes 99291 and 99292), and the observation codes (CPT codes 99217–99220, 99224–99226, and 99234–99236) to the list of Medicare telehealth services for the duration of the COVID-19 PHE. When delivering emergency telehealth services, ED physicians should use the code that most accurately reflects that service and use the same place of service code that they would have used if that service was delivered in-person. The CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. For example, regardless of location, ED physicians who are delivering emergency services can use the ED E/M codes with place of service 23 (ED) and apply modifier 95.

When a practitioner furnishes services to a patient who is at the same location, such as when the practitioner and patient are in different areas of the same hospital, the services are not considered telehealth services. Instead, the services should be reported as in-person services.

New: 5/27/2020

28. Question: How should telehealth services be documented in the medical record (e.g., face-to-face time, preparation time)?

Answer: We expect the same level of documentation that would ordinarily be provided if the services furnished via telehealth were conducted in person.

New: 5/27/2020

29. Question: Can Physician Assistants (PAs) provide and bill for Interprofessional Telephone/Internet/Electronic Health Record Consultations (codes 99446–99449 and 99451)?

Answer: Yes, a PA can furnish these interprofessional consultation services, and the usual billing rules for PA services apply.

New: 5/27/2020

30. Question: How should practitioners bill for audio-only services that last longer than 30 minutes?

Answer: During the PHE for the COVID-19 pandemic, Medicare has added to the list of telehealth services CPT codes 99441–99443, which describe audio-only phone visits with

practitioners who can independently bill for E/M services, and CPT codes 98966–98968, which describe audio-only phone visits with practitioners who cannot independently bill for E/M services (for example certain therapists, social workers, and clinical psychologists). CPT codes 99443 and 98968 describe 21–30 minutes of medical discussion, respectively for each practitioner type; but there are no CPT codes available to describe medical discussions lasting longer than 30 minutes.

New: 5/27/2020

31. Question: Is beneficiary consent required for virtual check-ins, e-visits, audio-video telehealth visits, and/or telephone-only E/M telehealth visits?

Answer: Beneficiary consent to receive virtual check-ins and e-visits is required although it may be obtained once annually and, during the PHE for the COVID-19 pandemic, consent may be obtained at the same time the service is furnished. Similar to services furnished in person, the patient’s consent is not required to be noted on the medical record for telehealth services furnished using interactive audio-video technology. The audio-only phone visits also do not require the patient’s consent to be noted in the medical record.

New: 5/27/2020

32. Question: Should practitioners use the same telehealth billing codes if the audio-video or audio-only appointment includes Teletype (TTY), relay services, accessible software, interpreter services support, or other means of effective communication?

Answer: Yes, if a practitioner receives TTY, relay services, accessible software, interpreter services support, or other means of effective communication, then they would use the same billing codes for when they don’t need TTY, relay services, accessible software interpreter services, or other means of effective communication. Practitioners cannot charge patients more for a telehealth visits if the patient requires TTY relay services, accessible software, interpreter services or other means of effective communication.

New: 5/27/2020

33. Question: Are services designated on the telehealth list as non-covered by Medicare eligible for payment during the PHE?

Answer: No. Services that are currently non-covered remain so unless subsequent rulemaking is undertaken to make them covered services. These services were added to the telehealth list for informational purposes only, to reflect stakeholder requests.

New: 5/27/2020

M. Physician Services

1. Question: What does the IFC change for physician and practitioner billing?

Answer: We are revising certain Medicare regulations to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the Medicare program during the public health emergency (PHE) resulting from the COVID-19 pandemic.

To that end, the IFC makes temporary changes to certain policies regarding:

- Supervision by a physician or non-physician practitioner
- Payment for certain services furnished by teaching physicians and moonlighting residents
- Telehealth and other communication technology-based services
- Services furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Payment to laboratories for specimen collection

New: 4/9/20

2. Question: What are the changes to supervision?

Answer: In general, we are revising the definition of direct supervision to include, during the PHE, a virtual presence through the use of interactive telecommunications technology, for services paid under the Physician Fee Schedule as well as for hospital outpatient services. The revised definition of direct supervision also applies to pulmonary, cardiac, and intensive cardiac rehabilitation services during the PHE. Additionally, we changed the supervision requirements from direct supervision to general supervision, and to allow general supervision throughout hospital outpatient non-surgical extended duration therapeutic services. Most other therapeutic hospital outpatient services have been subject to general, rather than direct, supervision requirements since January 1, 2020. General supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. General supervision may also include a virtual presence through the use of telecommunications technology but we would note that even in the absence of the PHE general supervision could be conducted virtually, such as by audio-only telephone or text messaging.

New: 4/9/20

3. Question: When do the changes on supervision take effect and for how long?

Answer: The changes to supervision rules are effective for services beginning March 1, 2020, and last for the duration of the COVID-19 Public Health Emergency.

New: 4/9/20

4. Question: Are there any changes in how hospitals account for resident time at alternate locations?

Answer: Existing regulations have specific rules on when a hospital may count a resident for purposes of Medicare graduate medical education payments. Currently, if the resident is performing activities within the scope of his/her approved program in his/her own home, or a patient's home, the hospital may not claim the resident. We are changing the regulations so if the resident is at home or in a patient's home, but performing duties within the scope of the approved residency program and meets appropriate physician supervision

requirements, a hospital that is paying that resident's salary and fringe benefits can claim that resident for IME and DGME purposes. This allows residents to perform their duties in alternate locations, including their home or a patient's home, so long as it meets appropriate physician supervision requirements.

New: 4/9/20

5. Question: Can residents furnish telehealth services?

Answer: Through this interim final rule, for the duration of the PHE for the COVID-19 pandemic, we are allowing Medicare payment for services billed by teaching physicians when residents furnish telehealth services to beneficiaries under direct supervision of the teaching physician which is provided by interactive telecommunications technology. Medicare may also make payment for services billed by the teaching physician under the so-called primary care exception under our regulation at section 415.174 when a resident furnishes telehealth services to beneficiaries under the direct supervision of the teaching physician by interactive telecommunications technology.

New: 4/9/20

6. Question: Does Medicare pay for a doctor or non-physician practitioner (NPP) to furnish care in a beneficiary's home?

Answer: Medicare pays for evaluation and management (E/M) and other services (e.g., injections, venipunctures.) furnished in a beneficiary's home by a physician or NPP. Medicare pays for Medicare telehealth services, which include many services that are normally furnished in-person. Under the emergency declaration and waivers, these services may be provided to patients by physicians and certain non-physician practitioners regardless of the patient's location. Additionally, Medicare makes payment for a number of non-face-to-face services that can be used to assess and manage a beneficiary's conditions. These services include: care management, remote patient monitoring, and communication technology based services, e.g., remote evaluation of patient images/video and virtual check-ins. Importantly, Medicare will also pay physicians for care furnished in the patient's home by auxiliary personnel as long as those services are furnished incident to a physician's service and as long as the practitioner is providing appropriate supervision through audio/video communication when needed. In addition to personnel employed by the physician, this could potentially also include clinicians leased from other entities (e.g., a home health agency, home infusion provider, or ambulance provider). In these circumstances, payment for such services would be made to the billing practitioner who would then make the appropriate payment to the contracted entity (for example, the home infusion provider).

Revised: 4/10/20

7. Question: Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

Answer: There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the public health emergency. The practitioner should report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment

for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person.

New: 4/10/20

- 8. Question:** The ambulatory surgical center (ASC) in my community has recently converted to a hospital under unique provisions available during the PHE and my medical group has been contracted to provide care there. If clinicians from our medical group furnish covered professional services to Medicare beneficiaries at the ASC-turned-Hospital, can we bill Medicare for non-surgical services?

Answer: Yes. Physicians and other practitioners who are permitted to bill under Medicare can bill Medicare for covered professional hospital services that are furnished to Medicare beneficiaries at an ASC that temporary enrolls as a hospital during the PHE. Practitioners would bill under the Medicare Physician Fee Schedule and follow existing billing rules for care furnished in a hospital. Practitioners should use the applicable place of service code depending on whether the ASC-turned-hospital is furnishing outpatient or inpatient care. Also, practitioners should add the modifier “CR” to professional claims for patients treated in temporary expansion sites during the Public Health Emergency.

New: 4/10/20

- 9. Question:** My medical group is contracted to provide care at a local hospital. The hospital has built a tent, transitioned a gymnasium, or converted another non-clinical location into a space to provide patient care. If clinicians from our medical group furnish covered professional services to Medicare beneficiaries at those new patient care locations, can we bill Medicare?

Answer: Yes. Physicians and other practitioners who are permitted to bill under Medicare can bill Medicare for covered professional services that are furnished to Medicare beneficiaries at temporary expansion sites, including gymnasiums, or other non-clinical locations. Practitioners would bill under the Medicare Physician Fee Schedule and following existing billing rules for services furnished in the hospital. Practitioners should use the applicable place of service code depending on whether the temporary expansion site is furnishing outpatient or inpatient care. Also, practitioners should add the modifier “CR” to professional claims for patients treated in temporary expansion site during the PHE.

New: 4/10/20

- 10. Question:** The state or the Army Corps of Engineers, or other governmental entity established a new care location in our area by repurposing and retrofitting a convention center, gymnasium, or other site for patient care. My medical group has been asked to provide patient care in one of these locations. Can we bill Medicare for covered professional services furnished in these locations? If so are there reporting or billing rules that determine how this is done?

Answer: Yes. Physicians and other practitioners who are permitted to bill under Medicare

can bill Medicare for covered professional services that are furnished to Medicare beneficiaries at temporary expansion sites, including those established by the state, the Army Corps of Engineers or other governmental entities. Practitioners would bill under the Medicare Physician Fee Schedule and following existing billing rules for services furnished in the hospital. Practitioners should use the applicable place of service code depending on whether the temporary expansion site is furnishing outpatient or inpatient care. Also, practitioners should add the modifier “CR” to professional claims for patients treated in temporary expansion site during the PHE.

New: 4/10/20

N. Home Infusion Services

- 1. Question:** How can beneficiaries who are not leaving their home get infusion therapy? Can physician practices provide medically necessary drugs in the beneficiaries’ home?

Answer: Under existing policy eligible home infusion therapy suppliers (i.e., durable medical equipment (DME) suppliers enrolled in Medicare as pharmacies that provide external infusion pumps and supplies, who comply with Medicare’s DME Supplier and Quality Standards, and maintain all pharmacy licensure requirements in the State in which the applicable infusion drugs are administered) can furnish medically necessary infusion therapy in the patient’s home. See the following list of Frequently Asked Questions (FAQs) for more information on the home infusion therapy benefit, including a list of covered infusion drugs: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Downloads/Home-Infusion-Therapy-Services-Temp-Transitional-Payment-FAQs.pdf>

Under existing policy, home health agencies also may administer medically necessary injected or infused drugs in the patient’s home, if the patient or caregiver cannot self-administer, when part of the plan of care. CMS considers beneficiaries to be “confined to the home” (that is, “homebound”) if it is medically contraindicated for the patient to leave the home. For example, a beneficiary could be considered “homebound” if: (1) a physician has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or (2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

Physicians (including those practicing in free-standing infusion centers) can furnish physicians’ services, including medically necessary injected or infused drugs, in the patient’s home. Through this interim final rule, physicians can also do this incident to their professional services, for example, under contract with auxiliary personnel, as defined in our regulation at §410.26(a)(1), to leverage additional staff and technology necessary to provide care outside their office setting under direct supervision using interactive audio-

video technology. For example, physicians may enter into contractual arrangements with a home health agency (defined under section 1861(o) of the Act), a qualified infusion therapy supplier (defined under section 1861(iii)(3)(D) of the Act), or entities that furnish ambulance services in order to utilize their nurses or other clinical staff as auxiliary personnel under leased employment (§ 410.26(a)(5)). In such instances, Medicare payment for the physicians' direct and "incident-to" services would be made to the billing practitioner who would then make the appropriate payment to the contracted entity (for example, the HHA). Payments would be made in accordance with the PFS and would not be considered a home health service under the Medicare home health benefit or a service under the home infusion therapy services benefit. Rather, the entity with which the physician contracts would seek payment for any services they provided from the billing practitioner and would not submit claims to Medicare for such services.

New: 4/9/20

- 2. Question:** For physicians that are providing needed drugs in the patient's home incident to their professional services using auxiliary personnel, are there changes to physician supervision requirements?

Answer: Through this interim final rule, CMS is altering supervision requirements for physicians and other practitioners. For the duration of the PHE for the COVID-19 pandemic, CMS is altering the definition of direct supervision at § 410.32(b)(3)(ii), to provide that the necessary presence of the physician or other practitioner for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We also note that this new flexibility would apply where the physician practice contracts with an entity for auxiliary personnel as defined in our regulation at §410.26(a)(1), including a home health agency, or a qualified home infusion therapy supplier, to provide incident-to services in the patient's home.

New: 4/9/20

O. Accountable Care Organizations (ACO)

- 1. Question:** What happens if an Accountable Care Organization (ACO) or its participants do not report the Quality or Promoting Interoperability categories to the Merit-based Incentive Payment System (MIPS), and what happens if they do?

Answer: For MIPS eligible clinicians (ECs) who participate in Shared Savings Program ACOs, if the ACO does not completely report quality AND no ACO participant or MIPS EC in the ACO reports promoting interoperability (PI) due to extreme and uncontrollable circumstances, then the ACO will be eligible to have those two categories reweighted to zero percent, and the cost performance category will continue to be weighted at zero percent under the Alternative Payment Model (APM) scoring standard. Although MIPS ECs participating in Shared Savings Program ACOs will continue to receive full credit for Improvement Activities under the APM scoring standard, because it would be the only

performance category that would be scored, the MIPS ECs participating in the ACO would instead receive a neutral payment adjustment under MIPS.

In contrast, however, if the ACO completely reports quality and/or any ACO participant or MIPS EC in the ACO reports Promoting Interoperability, then all MIPS ECs that bill through the tax identification number (TIN) of an ACO participant in the ACO would receive a MIPS score (based on ACO quality data and/or available Promoting Interoperability data, added to full credit for Improvement Activities, while the cost performance category would continue to be weighted at zero percent). The resultant MIPS payment adjustment could be upward, downward, or neutral.

New: 4/9/20

- 2. Question:** MIPS ECs who have not submitted any MIPS data by April 30, 2020, will qualify for the automatic extreme and uncontrollable circumstances policy and will receive a neutral payment adjustment for the 2021 MIPS payment year, but for MIPS ECs who participate in Medicare Shared Savings Program (Shared Savings Program) ACOs, what happens if some but not all MIPS ECs or groups participating in the ACO report data for the PI performance category?

Answer: If the ACO completely reports data for the Quality performance category and/or any ACO participant TIN or MIPS EC in the ACO reports data for the PI performance category, then all MIPS ECs that bill through the TIN of an ACO participant in the ACO would receive a MIPS score. Under the APM scoring standard, that score would be based on ACO quality data and/or available PI data, added to full credit for the Improvement Activities performance category, while the Cost performance category would continue to be weighted at zero percent. If some PI data is reported and quality data is not reported, the quality performance category would be re-weighted to zero percent in calculating the score. The resultant MIPS payment adjustment could be upward, downward, or neutral.

With regard to the PI performance category, it is important to note that an ACO's PI score is the average of the scores for the MIPS ECs in the ACO. If a MIPS EC qualifies for a significant hardship or other type of exception for the PI performance category (as all MIPS ECs, including those who participate in APMs, do for performance year 2019 as a result of the current PHE), but chooses to submit data for the category as an individual or group, their data will be scored and will contribute to the ACO's PI score. If a MIPS EC *does not* report PI, they will be excluded from the calculation and will not negatively impact the ACO's overall PI performance category score.

New: 4/29/20

- 3. Question:** Our organization is preparing the beneficiary notification for our Medicare FFS beneficiaries. In an effort to focus operational resources on the prevention and treatment of COVID-19 for our Medicare beneficiaries, can we delay proactive beneficiary notifications?

Answer: CMS is aware that the COVID-19 PHE may impact an ACO's ability to furnish the standardized written notice to beneficiaries prior to or at the first primary care visit, as required by § 425.312(a)(2). CMS is sensitive to the challenges caused by the pandemic and will consider the impact that these circumstances have on an ACO's ability to carry out the required beneficiary notifications in a timely manner. Accordingly, due to the PHE posed by COVID-19 and the urgent need for ACOs to focus on responding to the pandemic, CMS is exercising its enforcement discretion to adopt a temporary policy of relaxed enforcement in connection with the deadline for furnishing the standardized written beneficiary notifications required under § 425.312(a) as long it is completed by the end of the current performance year.

New: 5/1/20

4. **Question:** Our organization has experienced a significant reduction in office primary care visits due to the COVID-19 PHE. We would like to know how to provide the standardized written beneficiary notification in instances of e-visit and telehealth services?

Answer: Under § 425.312(a)(2), ACOs are permitted to distribute the annual standardized written notice to beneficiaries in a form and manner specified by CMS. CMS has stated in the Medicare Shared Savings Program Accountable Care Organizations Marketing and Outreach Materials Guidance that the standardized written notifications may be provided through electronic transmission (such as email or secure portal) or mail. These methods can be used in conjunction with e-Visits and Telehealth technology. CMS is sensitive to the challenges caused by the pandemic and will consider the impact that these circumstances have on an ACO's ability to carry out the required beneficiary notifications in a timely manner. Accordingly, due to the PHE posed by COVID-19 and the urgent need for ACOs to focus on responding to the pandemic, CMS is exercising its enforcement discretion to adopt a temporary policy of relaxed enforcement in connection with the deadline for furnishing the standardized written beneficiary notifications required under § 425.312(a) as long it is completed by the end of the current performance year.

New: 5/1/20

5. **Question:** What emergency preparedness and response resources are available for ACOs?

Answer: HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) has developed several [emergency preparedness and response resources](#) for healthcare facilities and emergency medical professionals, including a technical assistance (TA) document specifically addressing [Engagement of ACOs in Medical Surge Activities](#).

New: 5/1/20

6. **Question:** If an ACO terminated its Shared Savings Program agreement effective August 31, 2020, and if the ACO were to incur shared losses for performance year 2020, for how many months would the ACO owe shared losses if the Extreme and Uncontrollable policy was triggered?

Answer: The Secretary’s declaration of the COVID-19 Public Health Emergency (PHE) in January 2020 triggered the Medicare Shared Savings Program’s Extreme and Uncontrollable Circumstances Policy. The extreme and uncontrollable circumstance of the COVID-19 PHE began in January 2020, and will apply nationwide for the duration of the PHE for the COVID-19 pandemic. Shared losses will be mitigated for all ACOs participating in a performance-based risk track, including: Track 2, the ENHANCED track, the BASIC track, levels C through E, and the Track 1+ Model, based on the length of the PHE. For example, if the PHE is in effect for 7 months (January through July 2020) any shared losses an ACO incurs for performance year 2020 will be reduced by at least 58.33% (for 7 of the 12 months). Then, if an ACO terminates on August 31st, the ACO would owe 66.66% (for 8 of the 12 months) of any remaining shared losses for performance year 2020 after adjusting for the extreme and uncontrollable circumstance. If the PHE covers the full year (January through December 2020) any shared losses an ACO incurs for performance year 2020 would be reduced completely, and the ACO would not owe any shared losses.

New: 5/15/20

P. Cost Reporting

- 1. Question:** Will CMS delay the filing deadline for cost reports impacted during the COVID-19 PHE?

Answer: Yes, 42 CFR 413.24 (f)(2)(ii) allows this flexibility. CMS will delay the filing deadline of Fiscal Year End (FYE) 10/31/2019 and FYE 11/30/2019 cost reports until June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports until July 31, 2020.

In summary the extension impacts the following cost reporting fiscal year ends for all provider types (hospitals, SNFs, HHAs, hospices, ESRDs, RHCs, FQHCs, CMHCs, OPOs, histocompatibility labs and home office cost statements):

Cost Reporting Period Ending	Initial Due Date	Extended Due Date
10/31/2019	3/31/2020	6/30/2020
11/30/2019	4/30/2020	6/30/2020
12/31/2019	5/31/2020	7/31/2020

New: 4/10/20

Q. Opioid Treatment Programs (OTPs)

- 1. Question:** How are the add-on codes for take-home supplies of medication provided by opioid treatment programs billed?

Answer: There are two codes that describe take-home dosages of medication:

- HCPCS code G2078 — take-home supplies of methadone — describes up to 7 additional days of medication and is billed along with the respective weekly bundled payment in units of up to 3 (for a total of up to a one month supply). This add-on code is only used with the methadone weekly episode of care code (HCPCS code G2067).
- HCPCS code G2079 — take-home supplies of oral buprenorphine — describes up to 7

additional days of medication and is billed along with the base bundle in units of up to 3 (for a total of up to a 1 month supply). This add-on code is only used with the oral buprenorphine weekly episode of care code (HCPCS code G2068).

New: 4/10/20

- 2. Question:** What is the threshold for billing the weekly bundled payment codes for opioid treatment programs?

Answer: The threshold to bill a full episode is that at least one service is furnished (from either the drug or non-drug component) to the patient during the week that corresponds to the episode of care. If no drug was provided to the patient during that episode, the OTP must bill the G-code describing a weekly bundle not including the drug (HCPCS code G2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

New: 4/10/20

R. Inpatient Rehabilitation Facility Services

- 1. Question:** If an IRF freestanding hospital or unit of a hospital accepts a patient solely in order to meet the demands of an emergency, will the patient be included in the freestanding hospital's or unit's inpatient population for purposes of calculating the applicable compliance thresholds at 42 CFR 412.29(b) ("the 60 percent rule")?

Answer: As a result of the COVID-19 emergency, and when an applicable section 1135 waiver is in effect, CMS will modify enforcement of the requirements specified in 42 CFR 412.29(b), which is the regulation commonly referred to as the "60 percent rule." Additional information regarding these requirements can be found in Chapter 3, Section 140.1.3 of the Medicare Claims Processing Manual (Pub. 100-04). If an IRF freestanding hospital or unit of a hospital admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such, the patient will not be included in the freestanding IRF hospital's or IRF unit's inpatient population for purposes of calculating the applicable compliance thresholds outlined in § 412.29(b). In the case of an admission that is made solely to meet the demands of the emergency, the facility should clearly identify in the inpatient's medical record that the patient is being admitted solely to meet the demands of the emergency. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

New: 4/10/20

S. Skilled Nursing Facility Services

- 1. Question:** Does the section 1812(f) waiver for the 3-day qualifying hospital stay apply only to those beneficiaries who are actually diagnosed with COVID-19, or does the waiver apply to all SNF-level beneficiaries under Medicare Part A?

Answer: The qualifying hospital stay waiver applies to all SNF-level beneficiaries under

Medicare Part A, regardless of whether the care the beneficiary requires has a direct relationship to COVID-19. See: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

New: 4/10/20

- 2. Question:** Can a Medicare Part A beneficiary who has exhausted his or her SNF benefits, but continues to need and receive skilled care in the SNF (e.g., for a qualifying feeding tube), renew SNF benefits under the section 1812(f) waiver regardless of whether or not the SNF or hospital was affected by the COVID-19 emergency?

Answer: If the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60 day “wellness period.” (<https://www.cms.gov/files/document/coronavirus-snf-1812f-waiver.pdf>)

New: 4/10/20

- 3. Question:** In order to help minimize unnecessary person-to-person contacts during the current PHE, is it permissible for clinical social workers (CSWs) to conduct their visits to Part A SNF residents remotely? If so, are such services subject to consolidated billing (CB, the SNF “bundling” requirement for services furnished during the course of a Medicare-covered stay)?

Answer: The option to conduct their SNF visits remotely is always open to CSWs, regardless of whether a PHE is in effect. Moreover, the CB rules that apply to bundled services (such as CSW services that are furnished to a SNF’s Part A resident) do not change merely because the services in question happen to be rendered remotely rather than in person; accordingly, such services when conducted remotely would remain subject to CB.

New: 3/26/20

- 4. Question:** Does waiving (pursuant to section 1812(f) of the Act) the requirement for a 3-day prior hospitalization for coverage of a SNF stay apply to swing-bed services furnished by CAHs and rural (non-CAH) swing-bed hospitals?

Answer: Yes, under the section 1812(f) waiver, CAHs and rural (non-CAH) swing-bed hospitals may furnish extended care services to a SNF-level patient even if the patient has not had a 3-day prior hospitalization in that or any other facility. The Social Security Act permits certain CAHs and rural (non-CAH) swing-bed hospitals to enter into a swing-bed agreement, under which the hospital can use its beds, as needed, to provide either acute or SNF care. Rural (non-CAH) hospitals are paid under the SNF PPS for their SNF-level swing-bed services. By contrast, CAH swing-bed services are not subject to the SNF PPS. Instead, Medicare pays CAHs based on 101 percent of reasonable cost for their swing-bed services. For additional information on swing-beds, see: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/SwingBed>.

New: 4/10/20

T. General Billing Requirements

1. **Question:** Regarding the use of the condition code “DR” and modifier “CR”, should these codes be used for all billing situations relating to COVID-19 waivers?

Answer: Yes. With the exception of telehealth services, use of the “DR” condition code and “CR” modifier are mandatory for institutional and non-institutional providers in billing situations related to COVID-19 for any claim for which Medicare payment is conditioned on the presence of a “formal waiver” (as defined in the CMS Internet Only Manual, Publication 100-04, Chapter 38, § 10). The DR condition code is used by institutional providers only, at the claim level, when all of the services/items billed on the claim are related to a COVID-19 waiver. The CR modifier is used by both institutional and non-institutional providers to identify Part B line item services/items that are related to a COVID-19 waiver. Medicare will not deny claims due to the presence of this condition code or modifier for services/items not related to a COVID-19 waiver.

Revised: 4/23/20

2. **Question:** How will Medicare pay for COVID-19 testing administered prior to and in association with a procedure to be performed in a Medicare-enrolled setting, such as ambulatory surgical centers and independent freestanding emergency departments?

Answer: CMS has not established national policy, either through rulemaking or a national coverage determination, regarding coverage of pre-procedure COVID-19 testing. Absent national policy, coverage of these tests are determined by the Medicare Administrative Contractors. Providers are reminded that all services provided must be reasonable and necessary and medical necessity must be documented in the medical record.

New: 5/27/20

3. **Question:** If a beneficiary previously received testing for COVID-19, can the facility/practitioner be paid for retesting the beneficiary prior to the performance of the procedure?

Answer: CMS has not established national policy, either through rulemaking or a national coverage determination, regarding coverage of pre-procedure COVID-19 testing. Absent national policy, coverage of these tests are determined by the Medicare Administrative Contractors. Providers are reminded that all services provided must be reasonable and necessary and medical necessity must be documented in the medical record.

New: 5/27/20

U. Home Health

1. **Question:** For purposes of the statutory requirement that a patient have a face-to-face encounter with a physician or an allowed non-physician practitioner in order to qualify for Medicare home health care, can this encounter occur via telehealth during a pandemic outbreak of an infectious disease?

Answer: The face-to-face encounter, as described at 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, can be performed via telehealth in accordance with the requirements under 1834(m)(4)(C) of the Social Security Act. Under the expansion of telehealth under the 1135 waiver, beneficiaries are able to use telehealth technologies with their doctors and practitioners from home (or other originating site) for the face-to-face encounter to qualify for Medicare home health care.

Please see the FAQs regarding the 1135 telehealth waiver at:

<https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf>

New: 5/1/20

2. **Question:** Can home health agencies furnish services using telecommunications technology during the PHE for the COVID-19 pandemic?

Answer: Yes. Home health agencies are able to furnish services using telecommunications technology during the PHE as long as such services do not substitute for in-person visits ordered on the plan of care. This can include telephone calls (audio only and TTY), two-way audio-video telecommunications that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of the home health agency and patient's physician/practitioner as to whether such technology can meet the patient's need. The use of telecommunications technology in furnishing services under the home health benefit must be included on the plan of care and the plan of care must outline how such technology will assist in achieving the goals outlined on the plan of care.

New: 5/1/20

3. **Question:** Can home health agencies include services furnished using telecommunications technology on the home health claim that it submits to Medicare for payment?

Answer: Only in-person visits are to be reported on the home health claim submitted to Medicare for payment. On an interim basis, HHAs can report the costs of telecommunications technology on the HHA cost report as allowable administrative and general (A&G) costs by identifying the costs using a subscript between line 5.01 through line 5.19.

New: 5/1/20

4. **Question:** Can ordering clinician include "as needed" or "when necessary" (commonly abbreviated as PRN) on the orders for the home health plan of care for telecommunications encounters in the event the patient chooses not to have in-person visits by home care nurse?

Answer: If an HHA anticipates that there may be the need for "PRN" telecommunications encounters (including telephone calls) for the purposes of providing a skilled service, these "PRN" orders can be included on the home health plan of care similar to how "PRN" orders

for in-person visits would be included. That is, orders for services to be provided “as needed” or “PRN” must be accompanied by a description of the beneficiary's medical signs and symptoms that would occasion the visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If a range of visits is ordered, the upper limit of the range is considered the specific frequency under 42 CFR § 409.43(b).

New: 5/1/20

- 5. Question:** Can home health agencies complete the initial assessments virtually or over the phone during the PHE for the COVID-19 pandemic?

Answer: Yes. CMS has waived the requirements at 42 CFR § 484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients’ homebound status remotely, by phone, or by record review. This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long- term care facilities. This will also allow for maximizing coverage by already scarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.

New: 5/1/20

- 6. Question:** Can home health agencies complete the comprehensive assessment and updates to the comprehensive assessment virtually or over the phone during the PHE for the COVID-19 pandemic?

Answer: Utilizing telecommunications technology is an option for the completion of the comprehensive assessment and the update of the comprehensive assessment. HHAs can provide services to beneficiaries using telecommunications technology (which can include audio-only or TTY telephone calls, or two-way audio-video telecommunications technology, like FaceTime or Skype) so long as it’s part of the patient’s plan of care and does not substitute for in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care. The plan of care should be modified to reflect which visits will be made in person, and which visits will be conducted via telecommunications technology.

While we have provided certain flexibilities, the regulations require HHAs to have an infection prevention and control program, and to educate patients about infection prevention and control in the home. As such, we expect HHAs to make every effort to educate patients as to what processes the HHA has in place to protect patients as well as home care staff. While there are some aspects of care that can be done via telecommunications technology, not everything can be accomplished by telecommunications technology when skilled care is required. The HHA will have to work closely with the patient to determine what would help to reassure them that visits from

HHA staff are safe. If the patient continues to refuse any in-person visits as per the plan of care, including assessment or other patient care visits, the HHA will have to determine if the HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence per 42 CFR § 484.60.

New: 5/1/20

V. Drugs & Vaccines under Part B

- 1. Question:** Will Medicare Part B pay for COVID-19 vaccinations of Medicare beneficiaries?
Answer: Yes. The CARES Act includes a provision that establishes Part B coverage for COVID-19 vaccines and their administration without any cost-sharing. Because it will be covered under Part B, the COVID vaccine and its administration will not be covered under Part D.

New: 4/10/20

- 2. Question:** If new drugs are approved to treat COVID-19, can they be billed?
Answer: New drugs that are covered under Medicare Part B, including new antiviral drugs, can be paid by the Medicare Administrative Contractors once they receive a code and are on the pricing files.

Posted: 3/6/20

- 3. Question:** If a State distributes Strategic National Stockpile (SNS) drugs or supplies to hospitals (<https://www.phe.gov/about/sns/Pages/default.aspx>), what are the Medicare billing rules? How should hospitals handle billing for services that involve the use of SNS provided drugs or supplies?
Answer: A hospital's use of medicines and supplies received from the SNS to treat patients with known or suspected COVID-19 would not affect Medicare's payment under the inpatient prospective payment system (IPPS) or outpatient prospective payment system (OPPS). Although Medicare usually doesn't allow payment for services that are paid for by a governmental entity, there is an exception for services furnished as a means of controlling infectious diseases (see 42 CFR 411.8(b)(4)).

New: 3/26/20

- 4. Question:** Will Medicare Part B cover an extended supply of drugs during a pandemic or similar emergency, when such drugs are needed for a patient's chronic condition?
Answer: For Part B drugs, when considering whether to pay for an extended supply of drugs, Medicare and its contractors, known as Medicare Administrative Contractors or MACs, will make decisions locally. In general, local Medicare contractors will take into account the nature of the particular Part B drug (including Part B immunosuppressive drugs), the patient's diagnosis, the extent and likely duration of disruptions to the drug supply chain during an emergency, and other relevant factors that would be applicable when making a determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary. Information on payment for extended supplies of Part B drugs in special circumstances is made available by the local MAC that processes a

provider or supplier's drug claims.

Please see Fact Sheet posted at: <https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf>

New: 3/26/20

W. National Coverage Determinations (NCD)

- 1. Question:** Are all LCD/NCD medical necessity DME criteria waived under CMS-1744-IFC, Section U? Specifically, are the requirements for in person pre-service interactions waived for DME?

Answer: No. While CMS-1744-IFC waived certain coverage criteria and/or in-person encounter requirements (for items other than power mobility devices), the medical record must be sufficient to support payment for the services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary). We remind physicians, practitioners, and suppliers that, unless there is a specific exception, services and equipment furnished to patients must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

CMS-1744-IFC finalized that to the extent an NCD or LCD (including articles) would otherwise require a face-to-face or in-person encounter for other implied face-to-face services, those requirements would not apply during the public health emergency (PHE) for the COVID-19 pandemic. However, some face-to-face encounter requirements for DMEPOS Power Mobility Devices (PMDs) are mandated by statute for program integrity purposes. The IFC does not apply to those statutory requirements.

New: 4/23/20

- 2. Question:** Regarding face-to-face requirements, some drugs require the first few doses to be administered by a healthcare professional before DME coverage begins. Would the infusion nurse/supplier be able to provide first doses at a beneficiary's home as long as the physician is there virtually?

Answer: Physicians (including those practicing in free-standing infusion centers) can furnish physicians' services, including medically necessary injected or infused drugs, in the patient's home. Through flexibility adopted in the March 31st interim final rule, physicians can also furnish services in the patient's home as an incident to their professional services with their auxiliary personnel, as defined in our regulation at §410.26(a)(1), under direct supervision which is provided using interactive audio-video technology. This allows physicians to leverage additional staff and technology necessary to provide care outside their office setting, for example, with contracted auxiliary personnel, under direct supervision using interactive audio-video technology. For example, physicians may enter into contractual arrangements with a home health agency (defined under section 1861(o) of the Act), a qualified infusion therapy supplier (defined under section 1861(iii)(3)(D) of the Act), or

entities that furnish ambulance services in order to utilize their nurses or other clinical staff as auxiliary personnel under leased employment (§ 410.26(a)(5)). In such instances, Medicare payment for the services furnished directly by physicians, and provided by auxiliary personnel incident to their professional services, would be made to the billing practitioner who would then make the appropriate payment to the contracted entity (for example, the HHA). Medicare payments would be made to the physician under the PFS, and services would not be considered a home health service under the Medicare home health benefit or a service under the home infusion therapy services benefit. Rather, the entity with which the physician contracts would seek payment from the billing practitioner for any auxiliary personnel they provided and would not submit claims to Medicare for such services.

The safety of the patient needs to be considered regarding the setting for patient treatment. Accordingly, the healthcare professional will need to use their clinical judgment when considering virtual services. We recommend that the healthcare provider also take into account the reasonable accommodations of the individual and be inclusive of caregivers in the treatment process. We remind physicians, practitioners and suppliers that services and equipment furnished to patients must be reasonable and necessary. Accordingly, the medical record should be sufficient to support payment for the services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary).

New: 4/23/20

- 3. Question:** With the lifting of certain clinical indications in the IFC, does that allow for home oxygen coverage for Medicare/Medicaid beneficiaries for non-respiratory conditions, such as with cluster headache?

Answer: No. During the Public Health Emergency, we will not enforce the clinical indications for coverage across respiratory NCDs and LCDs (including articles) to allow for maximum flexibility for practitioners to care for their patients with respiratory conditions. While respiratory devices for acute respiratory conditions are covered as described in Section U of CMS-1744-IFC, these changes do not apply to non-respiratory conditions like cluster headaches.

New: 4/23/20

- 4. Question:** Are there other NCDs/LCDs whose clinical indications will not be enforced during the PHE?

Answer: Yes, CMS-1744-IFC, Section U includes respiratory, anticoagulation management and infusion pump policies. Some NCDs and LCDs are specifically identified in the IFC. In addition to that list, we have identified LCDs for nebulizers and high frequency chest wall oscillation and will continue to update the list in these FAQs if we identify other NCDs or LCDs that fall within the types established in CMS-1744-IFC. Questions may be directed to

your Medicare Administrative Contractor regarding whether additional NCDs or LCDs should be considered.

- NCD 240.2 Home Oxygen.
- NCD 240.4 Continuous Positive Airway Pressure for Obstructive Sleep Apnea.
- LCD L33800 Respiratory Assist Devices (ventilators for home use).
- NCD 240.5 Intrapulmonary Percussive Ventilator.
- LCD L33797 Oxygen and Oxygen Equipment (for home use).
- NCD 190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR)
- LCD L33785 High frequency chest wall oscillation
- LCD L33370 Nebulizers
- LCD 35434 Oximetry services

New: 4/23/20

5. **Question:** Can an exception be made to allow hyperbaric oxygen (HBO) where we can treat, only when medically necessary, COVID-19 patients specifically where Pulmonary Fibrosis or other related conditions are at play?

Answer: No. The NCD for HBO (20.29) is not one of the types of NCDs under CMS-1744-IFC, Section U. In the Medicare population, HBO is used primarily to treat chronic wounds and not lung disease so it is not included.

New: 4/23/20

6. **Question:** If an LCD or NCD is not specifically listed in CMS-1744-IFC, Section U, are the clinical indications lifted? For example, would the nebulizer LCD/NCD be included in CMS-1744-IFC, Section U?

Answer: As long as the LCD or NCD is respiratory, home anticoagulation management, or infusion pump-related, it would fall under CMS-1744-IFC, Section U. The list of covered NCD and LCDs in CMS-1744-IFC, Section U is not all inclusive. In the example of the nebulizer LCD/NCD, it falls under CMS-1744-IFC, Section U because it is respiratory-related. We remind physicians, practitioners and suppliers that services and equipment furnished to patients must be reasonable and necessary. Accordingly, the medical record should be sufficient to support payment for the services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary).

New: 4/23/20

[X. Medicare Payment to Facilities Accepting Government Resources](#)

1. **Question:** Can a skilled nursing facility (SNF) accept Federal, State, or local government resources (e.g., supplies and staffing assistance) to help with the COVID-19 emergency and still bill Medicare?

Answer: Yes. Although Medicare usually doesn't allow payment for services that are paid for by a governmental entity, there is an exception for services furnished as a means of controlling infectious diseases (see 42 CFR 411.8(b)(4)).

Revised: 3/26/20

- 2. Question:** Does Medicare pay health care providers such as hospices, hospitals, and skilled nursing facilities (SNFs) separately for personal protective equipment and supplies necessary to prevent the spread of infectious disease?

Answer: Not directly. Medicare payments for health care services include payment for the supplies necessary to appropriately provide the service, including any personal protective equipment and supplies appropriate for the patient's condition and treatment. However, there are not separate payments for those supplies. Additional resources for infection control, such as supplies or staffing assistance, may be made available from other local, state, or federal government agencies.

Revised: 4/10/20

Y. Oxygen

- 1. Question:** Does Medicare cover home use of oxygen for patients diagnosed with COVID-19?

Answer: The current national and local coverage determinations that otherwise restrict coverage of home-use of oxygen will not be enforced during the public health emergency for the COVID-19 pandemic. This change is intended to allow practitioners flexibility to treat their patients with home-use of oxygen during this emergency. This enforcement discretion will only apply during the PHE for the COVID-19 pandemic. At the conclusion of the PHE for the COVID-19 pandemic, we will return to enforcement of these clinical indications for coverage.

Revised: 4/10/20

Z. Temporary Department of Defense Sites

- 1. Question:** Do temporary Department of Defense (DOD) medical treatment sites bill Medicare for emergency inpatient and outpatient hospital services?

Answer: No, military hospital ships docked in a United States port and temporary military field hospitals erected in the United States in response to a mission assignment from the Federal Emergency Management Agency do not bill civilians or the Medicare program for any services rendered.

New: 4/17/20

AA. Military Treatment Facilities (MTFs)

- 1. Question:** Do Department of Defense (DOD) MTFs bill Medicare for emergency inpatient and outpatient hospital services?

Answer: The Medicare statute generally prohibits payment to Federal providers like DOD hospitals, but there is an exception for emergency inpatient and outpatient hospital services. CMS and DOD have worked closely on this so that a substantial number of DOD hospitals within the United States can meet this exception and bill Medicare for covered emergency hospital services related to COVID-19 treatment (as well as for covered emergency hospital services not related to COVID-19). Regulations concerning payments are

set out at 42 C.F.R. Part 424, subpart G.

New: 4/17/20

BB. Hospice

- 1. Question:** Can hospices furnish services using telecommunications technology during the PHE for the COVID-19 pandemic?

Answer: Yes. Hospices are able to furnish services using telecommunications technology during the PHE when a patient is receiving routine home care. This can include telephone calls (audio only or TTY), two-way audio-video telecommunications technology that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of hospice as to whether such technology can meet the patient's/caregiver's/family's needs and the use of technology should be included on the plan of care for the patient and family.

New: 5/1/20

- 2. Question:** Can hospice physicians/hospice nurse practitioners conduct the required face-to-face encounter for re-certifications using telecommunications technology?

Answer: Hospices are allowed to use 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and the clinician (e.g., FaceTime, Skype) to satisfy the face-to-face encounter requirement, which is required for the third benefit period (after the patient has typically been receiving hospice for six months) and each subsequent 60-day benefit period thereafter. An explanation of why the clinical findings from the hospice face-to-face encounter support that the patient still has a life expectancy of six months or less is required as part of the recertification narrative. We do not believe that telephone calls (audio only or TTY) would provide the necessary clinical information for a hospice physician to determine whether the patient continues to have a life expectancy of six months or less. As such, telephone calls (audio only or TTY) cannot be used to satisfy the hospice face-to-face encounter requirement.

New: 5/1/20

- 3. Question:** Can hospices include services furnished using telecommunications technology on the hospice claim that it submits to Medicare for payment?

Answer: Only in-person visits (with the exception of social work telephone calls) are to be reported on the hospice claim submitted to Medicare for payment. For purpose of service-intensity add-on (SIA) payments, only in-person visits performed by registered nurses and social workers provided during routine home care during the last seven days of life are eligible for these add-on payments. As a reminder, the SIA payments are made above and beyond the routine home care per diem payment amount. On the hospice cost report, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as "other patient care services" using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as "PHE

for COVID-19”.

New: 5/1/20

- 4. Question:** Can hospices complete the initial and comprehensive assessments virtually or over the phone during the PHE for the COVID-19 pandemic?

Answer: Assuming that the patient is receiving routine home care during the initial and comprehensive assessment timeframe, furnishing services using telecommunications technology (e.g., using two-way audio-video telecommunications technology that allows for real-time interaction between the clinician and the patient, like FaceTime or Skype, or using audio-only or TTY telephone calls) would be compliant if such technology can be used to the extent that it is capable of resulting in a full assessment of the patient and caregiver’s needs to inform an individualized plan of care. The initial and comprehensive assessment are the foundation of the plan of care, laying out the patient and family needs/goals and outlining the plan for the delivery of these services. An in-person initial and comprehensive assessment is standard practice and crucial to establishing the patient-hospice relationship. During this PHE, we expect in most, but not all, situations that the initial and comprehensive assessment visits would be done in person (especially when assessing skin/wound care; uncontrolled pain/symptoms; effectively teaching patient/caregiver medication administration, etc.). The assessments must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The ultimate goal of these assessments is to fully identifying the needs of the patient and caregivers to establish an individualized patient-centered plan of care.

New: 5/1/20

[CC. Ambulatory Surgical Centers \(ASC\)](#)

- 1. Question:** If ASCs had participated in the Accelerated and Advance Payment (AAP) program and Hospital without Walls, do Medicare payments made when the entity is operating as a hospital count toward the recoupment?

Answer: Yes. Under the COVID-19 Accelerated and Advance Payment (CAAP) program, at this time CMS plans to begin recoupment of the payment 120 days after issuance of the AAP. When the recoupment period begins, all Part A and Part B claim payments for the provider or supplier that received the payment will be applied to the AAP until the end of the recoupment period. For providers covered under the CARES Act (acute inpatient hospitals, children’s hospitals, certain cancer hospitals, and critical access hospitals), CMS will begin to fully recover their AAP beginning one year from the date these providers received AAP payments. CMS will begin to fully recover AAP for Non-CARES Act providers and all Part B suppliers starting 210 days from the date of payment. A demand letter will be issued for any balance that remains at the end of the recoupment period. Once a demand letter is issued and if the entity is not able to repay the AAP in full due to financial hardship, they may work with their Medicare Administrative Contractor (MAC) to establish an

extended repayment schedule (ERS); however, interest will start to accrue on the unpaid balance 31 days after issuance of the demand letter.

We note that on April 26, 2020, CMS issued a notice that it was suspending Advanced Payments for Part B suppliers and would no longer be accepting applications for this program. CMS also announced that it would be reevaluating new and pending applications for its Accelerated Payment Program. These announcements follow the provision of additional funding for healthcare providers under the Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139 (2020), as well as the initial resources provided by Congress under the CARES Act. These funds are being distributed through HHS's CARES Act Provider Relief Fund, and, unlike funds from the Accelerated and Advance Payment Program, they do not need to be repaid. We encourage providers in need of additional liquidity to apply for funding from the Provider Relief fund at

www.hhs.gov/providerrelief

New: 5/1/20

- 2. Question:** If enrolling as a hospital, will the facility be able to bill for services under both Parts A and B?

Answer: Once the ASC is successfully enrolled as a hospital during the PHE, they will be able to bill for all facility and professional services within the scope of their licensure and expertise. These facilities should ensure that they are appropriately resourced for the types of procedures they are performing. They would be able to bill for all services that an acute care hospital is able to bill for, including inpatient and outpatient services under both Parts A and B. We remind ASCs considering converting their enrollment to a hospital during the PHE that they should be performing services in a manner which is not inconsistent with their state's emergency preparedness or pandemic plan.

New: 5/1/20

- 3. Question:** At the end of the PHE, for inpatients that these ASCs are treating, will they have a grace period to allow them to discharge or transfer the patients if stable (but not admit any new ones) without sanction?

Answer: As noted in [QSO memo 20-24-ASC](#), after the PHE is lifted, the CMS RO will terminate the hospital's billing privileges and send a tie-out notice to the MAC. The MAC will deactivate the hospital's billing privileges and reinstate the ASC billing privileges effective on the date the ASC terminates its hospital status. Note that once there is no longer a need for the ASC to be a hospital under their state's emergency preparedness or pandemic plan, the ASC should come back into compliance with all applicable ASC federal participation requirements, including the ASC Conditions for Coverage. During the PHE wind down, CMS will consider any technical violations of its normal rules on a case by case basis.

New: 5/1/20

- 4. Question:** If an ASC enrolls as a hospital and elects to resume its operation as an ASC prior to the end of the PHE, is this resumption of ASC billing privileges effective on the postmarked date of the notification from the ASC, or does the ASC need to receive a form in return from the MAC or the regional office?

Answer: If the temporarily enrolled hospital decides to revert back to an ASC prior to the end of the PHE period, they must notify their MAC in writing. The notification should include the hospital and ASC's Legal Business Name, Tax Identification Number, National Provider Identifier, Provider Transaction Access Number and the requested deactivation date of the hospital's temporary billing privileges. The ASC's billing privileges will be restored as of the date of postmarking, although a lag may be required to process the notification. The MAC will notify the ASC when their billing privileges have been restored. However, the ASC does not need to wait for this notification from the MAC to resume normal operations.

Note that the ASC must be in compliance with all applicable ASC federal participation requirements, including the ASC Conditions for Coverage, before billing privileges can be restored.

New: 5/1/20

- 5. Question:** If CMS deactivates the ASC's billing privileges when it enrolls as a hospital, are private payers, who often use the same Medicare PTAN, able to continue to use the ASC PTAN to process reimbursement, even though Medicare has issued a hospital PTAN for the entity?

Answer: CMS's temporary deactivation of an ASC's PTAN to process payment should have no direct bearing on the ability of private payers to use this number for their own payment processing purposes; however, we cannot speak directly for private payers or to the operations of their payment systems. Facilities should contact payers with whom they have network arrangements or otherwise do business with to verify how conversion to a hospital may impact their ability to receive payment.

New: 5/1/20

- 6. Question:** Is it possible for an ASC to affiliate with multiple hospitals in a market?

Answer: Assuming for the purposes of this response, provided that the ASC that becomes a hospital is in compliance with COPs to the extent not waived, the ASC can provide inpatient and outpatient hospital services under arrangements with multiple hospitals. An ASC furnishing services under arrangements with a hospital is not eligible to directly bill Medicare for those services, and should seek reimbursement from the hospital for which it is performing services under the terms of the arrangement. Medicare is generally not involved with contractual agreements between private entities, including those associated with services furnished "under arrangements."

New: 5/1/20

7. Question: Do ASCs enrolling as a hospital during the PHE only receive hospital rates for cases they were not previously performing?

Answer: No. An ASC which chooses to utilize the waivers provided by CMS to convert into a hospital will be a hospital for the duration of the PHE, and will be paid as a hospital for all covered services furnished. Facilities enrolling as a hospital for the duration of the PHE should ensure that they are operating in a manner which is consistent with the state pandemic preparedness plan, and that they satisfy all COPs not waived.

New: 5/1/20

8. Question: Are only inpatient cases at an ASC-become-hospital now billed/paid as hospital under Part A? Will previously-scheduled outpatient procedures scheduled at ASC also be billed as hospital services? Or can this institution bill as a hospital only if a hospital physician performs a treatment or procedure at our ASC-become-hospital?

Answer:

- ASCs not temporarily recertifying as hospitals, but that are instead operating under arrangements with a hospital, should seek payment from the hospital, if applicable, under the terms of their contract, which may or may not permit them to continue to provide their own ASC services.
- ASCs furnishing services as a temporary provider-based department within a hospital are considered part of the hospital and therefore cannot bill independently as an ASC for other services.
- An ASC which utilizes the waivers provided by CMS to convert to a hospital for the duration of the PHE will be paid as a hospital under the appropriate part of Medicare depending on whether the patient is admitted (i.e., inpatient vs. outpatient) and will be subject to all Medicare payment policies and limitations to the extent not waived (e.g., two midnight rule and MOON).

New: 5/1/20

[DD. Diagnosis Coding under International Classification of Diseases, Tenth Revision, Clinical Modification \(ICD-10-CM\)](#)

1. Question: Where can I find information about coding for the 2019 novel coronavirus disease (COVID-19)?

Answer: You can find information about coding for the 2019 novel coronavirus disease (COVID-19) from the four cooperating parties for the ICD-10-CM. The four cooperating parties are the American Hospital Association, American Health Information Management Association, Centers for Medicare & Medicaid Services, and the Centers for Disease Control and Prevention/National Center for Health Statistics.

Centers for Disease Control and Prevention/National Center for Health Statistics:

- For discharges before April 1, 2020 –
- <https://www.cdc.gov/nchs/data/icd/interim-coding-advice-coronavirus-March-2020-final.pdf>

- For discharges on or after April 1, 2020 -
- <https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf>

Centers for Medicare & Medicaid Services:

- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software>
- <https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM>

A frequently asked questions (FAQ) document, jointly developed and approved by two of the four cooperating parties for ICD-10-CM, the American Hospital Association's Central Office on ICD-10-CM/PCS (the official U.S. Clearinghouse on medical coding) and the American Health Information Management Association is available at:

- <https://www.codingclinicadvisor.com/faqs-icd-10-cm-coding-covid-19>
- <https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/>

New: 5/27/20

EE. Chronic Care Management Services

1. **Question:** When, how and by whom can beneficiary consent for chronic care management (CCM) services be obtained?

Answer: Informed consent to receive CCM services must be obtained prior to the start of CCM services. Consent does not have to be obtained at the required initiating visit for CCM that must be performed by the billing practitioner, but it can be obtained at that time. Since the billing practitioner discusses CCM with the beneficiary during the initiating visit, if consent is separately obtained, it may be obtained under general supervision, and can be verbal as long as it is documented in the medical record and includes notification of the required information. Further, there need not be an employment relationship between the person obtaining the consent and the billing practitioner.

New: 5/27/20

FF. Outpatient Therapy Services

1. **Question:** Can outpatient therapy services that are furnished via telehealth and separately paid under Part B be reported on an institutional claim (e.g., UB-04) during the COVID-19 PHE?

Answer: Yes, outpatient therapy services that are furnished via telehealth, and are separately paid and not included as part of a bundled institutional payment, can be reported on institutional claims with the “-95” modifier applied to the service line. This includes:

- Hospital – 12X or 13X (for hospital outpatient therapy services);
- Skilled Nursing Facility (SNF) – 22X or 23X (SNFs may, in some circumstances, furnish Part B physical therapy (PT)/occupational therapy (OT)/speech-language pathology (SLP) services to their own long-term residents);

- Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type);
- Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services);
- Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT & SLP as well as OT services); and
- Home Health Agency (HHA) – 34X (agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes only if such patients are not under a home health plan of care).

New: 5/27/20

- 2. Question:** Can therapy services furnished using telecommunications technology be paid separately in a Medicare Part A skilled nursing facility (SNF) stay?

Answer: Provision of therapy services using telecommunications technology (consistent with applicable state scope of practice laws) does not change rules regarding SNF consolidated billing or bundling. For example, Medicare payment for therapy services is bundled into the SNF Prospective Payment System (PPS) rate during a SNF covered Part A stay, regardless of whether or not they are furnished using telecommunications technology. Therapy services furnished to a SNF resident, whether in person or as telehealth services, during a non-covered SNF stay (Part A benefits exhausted, SNF level of care requirement not met, etc.) must be billed to Part B by the SNF itself using bill type 22X, regardless of whether or not they are furnished using telecommunications technology.

New: 5/27/20

- 3. Question:** Can outpatient therapy services be furnished and paid separately for patients receiving Medicare home health services?

Answer: No. For patients under a home health plan of care, payment for therapy services (unless provided by physicians/non-physician practitioners) is included or bundled into Medicare's payment to the HHA, and those services must be billed by the HHA under the HHA consolidated billing rules. Patients should first be assessed for whether they are eligible to receive therapy services under the home health benefit prior to initiating outpatient therapy services. Receiving therapy services under the home health benefit may be in the best interest of the patient as there is no applicable coinsurance, copay, or deductible for such services (with the exception of negative pressure wound therapy using a disposable device), and the patient may also have a need for skilled nursing services, home health aide services, or medical social services under the home health benefit. However, if the patient is not eligible for home health care, including when it is not possible to provide in-person therapy services in the patient's home (i.e., the patient is not under a home health plan of care), then outpatient therapy furnished via telehealth under Part B could be an appropriate alternative and separately billed, assuming all applicable requirements are otherwise met.

New: 5/27/20