COVID-19 Interim Final Rule FAQs

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

CMS is thoroughly assessing the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136, and new and revised FAQs will be released as implementation plans are announced.

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 SNF or whose samples are collected by a laboratory on behalf of an HHA is $25.46.
   New: 4/9/20

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

   New: 4/9/20

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

Hospital Services

1. **Question**: During the COVID-19 Public Health Emergency, 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 patients who are not critically ill? For example, if my hospital needs to set up temporary sites for testing or treatment of patients, including those who are COVID positive or suspected to be positive who may need to be isolated.
   Answer:
   Similar to the response for hospital inpatient services, during the COVID-19 Public Health Emergency, CMS is allowing hospitals to provide hospital outpatient services in temporary expansion sites, which may include ambulatory surgical centers, gymnasiums or other sites, by making such sites provider-based to the hospital. CMS has waived the provider-based requirements at 413.65 to facilitate seamless expansion, as may be needed to address the clinical needs that arise as result of the PHE. There are no additional enrollment actions required for hospitals intending to bill Medicare for the services provided at the temporary expansion sites under arrangement. Hospitals and any of its provider-based departments, including the temporary expansion provider-based departments, must meet the hospital

Conditions of Participation that have not been waived. The hospital is expected to be operating under their State's emergency preparedness or pandemic plan and also to control and oversee any services provided at temporary expansion sites.

Excepted provider-based departments, including those that temporarily relocate solely for the purpose of addressing clinical needs related to the COVID-19 pandemic, may continue billing with modifier "PO" while non-excepted PBDs should bill with modifier "PN." 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.
New: 4/9/20

2. **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

3. **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 operating under their State's emergency preparedness or pandemic plan may help address the needs in surge areas in several ways. The 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 would be providing hospital inpatient (and outpatient, as necessary) services pursuant to the State's emergency preparedness or pandemic plan (for example: COVID-19 treatment site), not functioning solely as an 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 in accordance with 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.
New: 4/9/20

4. **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

5. **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

6. **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

7. **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

8. **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

   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

9. **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

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, professional 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

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

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

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

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

HCPCS	Descriptor	Office-based Payment Rate to the Professional	Facility-based Payment Rate to the Professional
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 hours or soonest available appointment; 5-10 minutes of medical discussion	$14.80	$13.35

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 Covid19, 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 suspended, under present circumstances, the requirement that there be an established relationship between the health care provider and the patient because it could impede access to the RPM services.
New: 4/9/20

21. **Question:** May clinical staff provide Remote Physiologic Monitoring (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

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

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

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

COVID-19 Medicare FFS FAQs

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.

2. **Question:** Has CMS created any Healthcare Common Procedure Coding System (HCPCS) codes for COVID-19 laboratory testing?
   Answer: Yes, CMS has created two 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. Both codes are effective 2/4/2020 and will be available in the Medicare claims processing system on 4/1/2020. Please visit https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests

3. **Question:** Are there other CPT codes available to bill for COVID-19 laboratory testing?
Answer: Yes. 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

4. **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.

5. **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).

6. **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.

7. **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.

8. **Question:** How will Medicare pay for COVID-19 testing on the CLFS?
Answer: Local Medicare Administrative Contractors (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. 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

9. **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.

Physicians' Services

1. **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 furnished in a beneficiary's home by a physician or NPP. 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 include: care management services, remote patient monitoring services, and communication technology based services.

2. **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. Individual providers may use their MAC hotline number to verbally update their practice location over the phone and would be effective immediately so practitioners could continue providing care without a disruption.

   Please see the FAQs regarding the 1135 telehealth waiver at: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

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

Hospital Services

1. **Question:** During an emergency, will Medicare allow payment for care provided at a site not considered part of a healthcare facility (which are informally termed "alternative care sites" (ACSs)) for patients who are not critically ill? For example, if local hospitals are almost at capacity during an emergency and the few beds remaining must be reserved for patients needing ventilators and critical care, will Medicare pay for non-critical care provided at an ACS, such as a school gymnasium?
   Answer: Even in the absence of an 1135 waiver, a hospital may add a remote location that provides inpatient services, provided that the remote location satisfies the requirements to be provider-based to the hospital's main campus. The remote location must satisfy all provider based requirements at 42 CFR 413.65, including the location requirements at 42 CFR 413.65(e)(3), in addition to the Hospital Conditions of Participation (CoPs). As soon as it adds an additional location, the hospital would be expected to file an amended Form CMS 855A with its Medicare Administrative Contractor. CMS generally requires a survey of compliance with all CoPs at all new inpatient locations, but also has discretion to waive the onsite survey in this area. An onsite survey is not required for the provider-based designation. Once approved, subsequent surveys of the hospital will include any provider based locations.

2. **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 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. Medicare will pay the DRG rate and any cost outliers for the entire stay until the Medicare patient can be moved to an appropriate facility.

3. **Question:** Are hospitals that are paid by Medicare through the Inpatient Prospective Payment System (IPPS) going to be paid using a special payment method? If not, is there a special Diagnostic Related Group (DRG) that IPPS hospitals will be reimbursed for this situation?
   Answer: Normal prospective payment procedures apply to those hospitals reimbursed under the IPPS. There is no special DRG for COVID-19.

4. **Question:** We have a Medicare psychiatric patient that can't be placed in the distinct part

inpatient psychiatric facility (IPF) unit because all patients are quarantined due to COVID-19. Can we still bill under the IPF unit provider number even though they are in a hospital acute care unit bed?
Answer: If the patient is not in the IPPS excluded IPF unit, even if the patient is a psychiatric patient, and as long as the placement of the patient in the hospital's acute care bed is not inappropriate to his/her condition, the hospital will receive IPPS payment for that patient's care. Billing under the IPF unit's provider number is not allowed.

5. **Question:** Will Medicare provide additional payment if a patient needs to be isolated or quarantined in a private room?
Answer: There may be times when beneficiaries with the virus need to be 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.

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

6. **Question:** Can a provider having both private and semiprivate accommodations charge the patient a differential for a private room where isolation of a beneficiary is required?
Answer: A provider having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary.

Drugs & Vaccines Under Part B

1. **Question:** Will Medicare Part B pay for vaccinations of Medicare beneficiaries?
Answer: Medicare Part B pays for preventive Hepatitis B vaccinations for high-and intermediate-risk beneficiaries and also for influenza and pneumococcal vaccinations for all Medicare beneficiaries. Medicare Part B will also pay for medically reasonable and necessary vaccinations of beneficiaries against a microbial agent or its derivatives (e.g., tetanus toxin, Hepatitis A) following likely exposure in accordance with normal Medicare coverage rules.

   Under current law, once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine.

2. **Question:** If new drugs are created 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 until they receive a code and are on the pricing files. New drugs that are covered under Medicare Part D can be billed to the beneficiary's Part D plan.

3. **Question:** If a State distributes CDC's Strategic National Stockpile (SNS) drugs 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?
   Answer: For services rendered to Medicare beneficiaries, standard Medicare billing rules apply. Based on existing policy, providers may not seek reimbursement for no cost items such as SNS drugs. Specifically, the policy is described in the CMS Internet Only Manual Pub. 100-04, Chapter 32, Section 67 which states that provider may not seek reimbursement for no cost items as noted in Section 1862(a)(2) of the Social Security Act.

4. **Question:** Will Medicare Part B cover a 90-day supply of drugs in the event that a pandemic occurs, when such drugs are needed for a patient's chronic condition?
   Answer: With respect to drugs covered under Part B, with the exception of immunosuppressive drugs -- which are generally limited to a 30-day supply – but including drugs that need to be administered through Durable Medical Equipment, local MACs have discretion to pay for a greater-than-30-day supply of drugs. When considering whether to pay for a greater-than-30- day supply of drugs, MACs will take into account the nature of the particular drug, 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 local determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.

   With respect to immunosuppressive drugs, although Medicare would customarily not pay for more than a 30-day supply because dosage frequently diminishes over a period of time and it is not uncommon for the physician to change the prescription from one drug to another. In the event of an emergency, local MACs may consider allowing payment for a medically necessary, greater-than-30-day supply of Medicare-covered, immunosuppressive drugs on a case-by-case basis taking local considerations into account.

5. **Question:** Can a Medicare beneficiary receive more than a 30-day supply of Medicare Part B covered drugs during an emergency?
   Answer: In most situations where there are specific limits on coverage of additional quantities or time limited coverage periods that are 30 days or less, Medicare Part B does not pay for additional quantities. For example, oral anti-emetic drugs are covered only when they are used immediately before, at, or within 48 hours after administration of an anticancer chemotherapeutic agent. For immunosuppressive drugs, claims processing

contractors will generally not consider a supply of immunosuppressive drugs in excess of 30 days to be reasonable and necessary and will deny payment, unless there are special circumstances. Information on exceptions for special circumstances would be made available by the local MAC that processes a provider or supplier's immunosuppressive drug claims.

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf
See section 80.3.3, Special Requirements for Immunosuppressive Drugs)

Ambulance Services

1. **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 the transport of a Medicare beneficiary has taken place. However, when a physician or NPP 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.

2. **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.

3. **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 payment to ambulance suppliers and providers for ambulance transports 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 available.
   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.

4. **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. These requirements specify that an appropriate destination is one of the following:
   - Hospital;
   - Critical Access Hospital (CAH);
   - Skilled Nursing Facility (SNF);
   - Beneficiary's home;
   - Dialysis facility for ESRD patient who requires dialysis.

   Beneficiaries residing in a SNF, who are receiving Part B benefits only, are eligible for ambulance transport to one additional "approved destination," that is, from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident. For SNF residents receiving Medicare Part A benefits, this type of ambulance service is subject to SNF consolidated billing.[1]

   A physician's office is not a covered destination. However, under certain circumstances an

[1]In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF 1 In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF stay which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not.

The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception: There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.

For Medicare beneficiaries in a covered Part A stay, these separately payable services include:
•physician's professional services;
•certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
•certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
•erythropoietin for certain dialysis patients;
•certain chemotherapy drugs;
•certain chemotherapy administration services;
•radioisotope services; and
•customized prosthetic devices.

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services for these beneficiaries can be separately billed to and paid by the Medicare contractor.

ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

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.

42 CFR 410.40 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) from any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.

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

Physicians, non-physician practitioners, and suppliers should contact their Part B MAC or Durable Medical Equipment (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 Medicare Learning Network (MLN) Publications webpage.

Medicare Payment to Facilities Accepting Government Resources

1. **Question:** Can a skilled nursing facility 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: 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)).

2. **Question:** Does Medicare pay health care providers such as hospices, hospitals and skilled nursing facilities separately for personal protective equipment and supplies necessary to

prevent the spread of infectious disease?

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

Oxygen

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

   Answer: Yes, we are exercising enforcement discretion to cover medically necessary home use of oxygen for patients diagnosed with COVID-19 during the emergency. CMS is currently reviewing NCDs and LCDs to identify and remove barriers to beneficiaries with COVID-19 receiving home oxygen and we hope to have more information on this process soon.