Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
Moderator: Alina Czekai
April 21, 2020
5:00 p.m. ET

OPERATOR: This is Conference #3963515

Alina Czekai: Good afternoon. Thank you for joining our April 21st CMS COVID-19 office hours. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the office of CMS administrator Seema Verma.

Office hours provides an opportunity for providers on the front line to ask questions of agency officials regarding CMS's temporary actions that empower local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote telehealth and Medicare.

And while members of the press are always welcome to attend these calls, we ask that they please refrain from asking questions. All press and media questions can be submitted using our media inquiries form, which can be found at cms.gov/newsroom/media-inquiries, and any non-COVID-19 related questions for – from not the media can be directed to covid-19@cms.hhs.gov.

And with that, we will take our first question. Operator, can you please open up the lines to take questions from the audience? Thank you.

Operator: Ladies and gentlemen, participants over the phone, if you would like to ask a question, please press "star" and the number 1 on your telephone keypad. Again, to ask your question, please press "star" then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q and A roster.

Once again, to ask a question, please "star" then the number 1 on your telephone keypad. One moment for your first question. Your first question

comes from the line of (Brenda Schulz). Your line is now open. You may ask your question.

(Brenda Schulz): Hi, good afternoon. Thank you so much for taking my call, I really appreciate it and I find these very valuable. I have a question in regards to CMS, if CMS has given any consideration for delaying the implementation of the PAMA appropriate use criteria requirements. This is supposed to be the teaching year, I believe, and the effects to the payments are going to be going live 1/1/2020.

But given the current pandemic and – the individuals who are helping implement and/or training and/or helping with these projects are on the front lines for caring for COVID patients.

My question is, is CMS delaying – is CMS considering delaying the effective date or offer a hardship exemption to the sites that will not be able to make it due to the COVID pandemic? Any help or clarification would be greatly appreciated.

Demetrios Kouzoukas: Just to be clear, are you referring to the – to the usual – the data collection for the next cycle of the PAMA payment rates?

(Brenda Schulz): No. This is actually appropriate use criteria, which is required. It's going to be required – that will affect radiology in particular is what I'm thinking of. 1/1/2020 …

Demetrios Kouzoukas: Yes.

(Brenda Schulz): … it's going to affect whether or not they get paid, if that makes sense.

Demetrios Kouzoukas: It does. I think one of our CCSQ folks are – do we have any of them on that could speak to that? I can tell you that we are giving consideration to what – how to deal with appropriate use criteria. It's been a law that we've been implementing, as you know, over time and …

(Brenda Schulz): For …

Demetrios Kouzoukas: … given thought to the (inaudible)

(Brenda Schulz): For quite a long time.

Demetrios Kouzoukas: In each – in each – in each year after the next and so …

(Brenda Schulz): Yeah, totally.

Demetrios Kouzoukas: … this is one we're also kind of giving thought to so not …

(Brenda Schulz): OK.

Demetrios Kouzoukas: Not off our radar at all.

(Brenda Schulz): OK, fantastic, I appreciate it. I'm assuming no one else answered so therefore no one else is on the phone to be able to respond to that. So, thank you for taking my call.

Demetrios Kouzoukas: You're welcome.

Operator: Your next question comes from the line of (Rebecca Moore). You may now ask your question.

(Rebecca Moore): Hi, thank you. My first question has to do with the direction where we can bill office visits being performed via telehealth with the visit codes 99201 to 99215 and receive full reimbursement. Are we also able to report the facility component, the G0463?

Male: So, at present, only the professional service can be reported under current telehealth rules …

(Rebecca Moore): OK.

Male: … in circumstances where the patient is at home, yes, and we're still looking into various options otherwise.

(Rebecca Moore): OK, thank you. My second question is in regards to the CS modifier. And we're reporting the modifier under visit services described by the categories listed when there's a COVID test performed, the lab test, they use 001, 002 or the 87635 are ordered.

If the visit results not in that lab test but a test for the antibody test, which I believe is 862 – 32886769, would those also qualify so the E&M service, the office visit, would be reported with the CS modifier?

Tiffany Swygert: Hi, this is Tiffany Swygert. We may have to get back to you. The requirement and the law talks about the requirement of resulting in an order for administration of the clinical diagnostic lab test and it gives the specific section of the statute. I think we'd have to look up the code, unless there's someone else on the call who happens to know whether it falls under that specific authority listed in the law.

(Rebecca Moore): OK.

Male: I think …

(Rebecca Moore): And then – I'm sorry.

Male: I think we haven't issued – I'm sorry, I think we haven't issued guidance yet, but we'll get – we'll take that question into account and do so as soon as we can.

(Rebecca Moore): Great. And then there was some follow up on whether or not the other related services that were listed in some publications, the chest X-rays and ECGs – I just wondered if there was any follow up yet on whether those would also have the CS modifier applied.

Tiffany Swygert: Yes. Thanks for that question. We haven't issued any updated guidance at this point and we are still actively considering that request. I just want to …

(Rebecca Moore): OK.

Female: … remind everyone, since that was a very popular question on the last call, I think now is a good time to just spend a couple of seconds reminding folks of what the – what the law says and what our guidance says. And so, in order to bill with the CS modifier, which will waive cost sharing, the statute does go into defining what a testing-related service is. And so, it says that it's a

medical visit that has to be listed in one of those categories, the evaluation management categories that you were talking about …

(Rebecca Moore): Yes.

Tiffany Swygert: … that's furnished during the public health emergency, results in an order for or administration of the lab test for COVID and relates to the furnishing or administration of this test.

But because it does specifically address that the waiver is for the testing-related service that's listed in the statute, I just want to be clear that that is reflected in the current guidance that is out and we're still exploring whether there's an avenue to expand that to other related services that aren't specifically mentioned in the statute. So, we are still exploring that but that is not the current guidance.

(Rebecca Moore): OK, great, thank you. And then just one last question. I think – are you still giving consideration to adding additional providers to the list of qualified providers, in particular PT, OT, Speech, is that still under consideration?

Male: Yes. You're asking about for telehealth?

(Rebecca Moore): For telehealth, yes.

Male: Yes, yes, we are – we are still actively working on considering those things.

(Rebecca Moore): OK, great. Thanks so much for taking my call.

Operator: Your next question comes from the line of Megan Windler. Your line is now open, you may ask a question.

(Megan Windler): Thank you. I wanted to follow up on the code for the serology assay that was released by the AMA on 4th – effective 4/10 and I believe somebody had inquired about it at our last meeting on 4/16, to just get an idea of where we are with reimbursement and any alternate codes that might be relative for billing and charging logic, to just see where that's at.

Demetrios Kouzoukas: You're looking at – for the codes being released in the system or are you looking for the pricing?

(Megan Windler): We're looking for reimbursement information and also, you know, just – I don't know if CMS is thinking about creating any HCPCS or alternate codes for reporting purposes. The codes specifically in question is the 86769, again, and that was made effective on 4/10. We still – I haven't seen any reimbursement information from CMS in the system yet.

Demetrios Kouzoukas: Now, I know that we're working on taking up the AMA codes. I think these are the ones that were released Friday before last if I've got the time right. And we'll – we've been, I think, pretty timely on taking action on the AMA recommendations for codes and we're looking at this one with the same kind of progress.

(Megan Windler): OK. So, for – so it's being looked at currently with CMS? I apologize, I just want to – I'm taking notes to get clarification here.

Demetrios Kouzoukas: Yes. Just if we're talking about the serologic code …

(Megan Windler): Yes.

Demetrios Kouzoukas: Forgive me, I don't remember the number.

(Megan Windler): 86769.

Demetrios Kouzoukas: (Inaudible) yes, and it was released either – I think it was on a Friday night very recently. That was – that's the one that we're currently taking up and working on follow up from. And I would just, you know, in terms of – I know you're going to ask when and exactly how long and I would just point you to how we have handled the – you know, the previous codes that we've been working hard to take those up and we expect that we'll be working on this one on a similar timeframe.

(Megan Windler): OK. So, until then, we're – it's OK for us to hold claims until that's released? So, there's not going to be any kind of impact on delayed claims submissions in this?

(Demetrios): I think our usual criteria would apply there. Diane, I don't know if you can speak to that.

Diane Kovak: Yes, absolutely. It's fine to hold claims until any new codes are implemented in the systems and as Demetrios said, we're working as quickly as we can to implement these codes.

It will not be a long period of time, we're not talking months and months here. We're talking probably weeks even though we don't have the exact date for you right now. So, yes, until they're fully implemented you can hold those claims.

(Megan Windler): OK (inaudible) all right. Well, perfect. Well, thank you very much for taking my call and answering these questions. We look forward to an update. And then one more question. For inpatient, face to face, the critical care and the remote services, is an actual face to face needed for the critical care for inpatient?

Demetrios Kouzoukas : I don't know that we have the right …

(Ron): I …

Male: That we have the inpatient (inaudible) but, (Ron), did I hear you start?

(Ron): No, I was just going to – I think if you could re-ask the question, maybe I'm missing something in the …

(Megan Windler): For remote services that – you know, the telehealth services that are being provided and rolled out, when a patient is inpatient critical care, is there any – do – does the physician need to be face to face with the patient? Or how – how are we getting around the face to face interaction with critical care in inpatient?

(Ron): So – sure, so under many of the professional codes, there's a – there's a face to face requirement as part of the description for the code and when services are on the telehealth list, the audio video interaction can meet the requirements for that face to face. In cases where there isn't a video, then ordinarily we would say that that wouldn't meet the face to face requirements.

(Megan Windler): Perfect. Thank you so much for the clarification.

(Ron): Sure, thank you.

(Megan Windler): Have a good day.

Operator: Your next question comes from the line of Sherri Mahaney. You may now ask your question.

(Sherri Mahaney): Hi, thank you for taking my call. I have a question regarding signatures. I've seen that the order expansion for verbal orders as well as for DME – I didn't know, given that some practitioners may be working offsite and may not be able to provide an electronic signature for diagnostic testing, if there were any expansions on signature requirements normally in place for the PHE. Just want to make sure that I'm not missing any guidance out there.

Connie Leonard: Hi, this is Connie Leonard and CMS is currently reviewing this particular issue. What we've said publicly so far is that if you cannot get a signature, it is appropriate to put, you know, "COVID-19". But we're really more geared towards the orders having at least an electronic signature.

You know, we're hopeful that most physicians are doing, you know, some form of telehealth and can sign electronically. But in the worst case, they could put "COVID-19" when – in the signature requirement and we expect to release some more guidance hopefully in the near future.

(Sherri Mahaney): Great, thanks for that information. Would it be acceptable then to write kind of "COVID-19" and if the practitioner happens to have a stamp signature to utilize that or just the COVID-19 portion.

Connie Leonard: I would say we'll take the stamp back and think about the stamp. Electronic would be best, but we'll think about the stamp and get some guidance out.

(Sherri Mahaney): Understood. Thank you for your time.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Rick Faranda). You may now ask a question.

(Rick Faranda): Hi, thank you. Again, thank you for having the phone calls again. You know, I think we all know that we are still waiting for CMS to add PTs, OTs, SLPs as telehealth providers.

So, I first have a comment. Are you going to, I guess, give guidance to the Medicare contractors? Because there are two that we know of, Noridian and National Government Services, who are telling PTs, OTs, SLPs that telehealth is now covered by Medicare for PT, OT and SLP.

And they're actually paying the claims that are submitted by PT, OT and SLP providers for the – they're billing telehealth. They're putting in place the service code 02 and then they use the modifier 95 on the CPT code and these are being furnished by a physical therapist, by a speech language pathologist.

And Noridian are paying the claims and National Government Services are paying the claims saying CMS added – I think it comes back to on the day of March 30th when you issued that interim final rule.

You did a very good job in the final rule stating it's not covered by – you know, PTs, OTs, SLPs have still not been added yet as telehealth providers. Unfortunately, in the supplemental six or seven-page document that you put out, you mentioned about adding therapy services as covered telehealth services and that's why I think the Medicare contractors are paying the claims and therapists think that it's OK. And that's number 1, guidance for that.

And also, you know MACs are giving guidance to therapists to bill the e-visits with the 95 modifier as well. So – and I do know there's an interim final rule sitting right now with the office of management and budget, it's been there since last Tuesday, that, you know, we seek – when this comes out, this is going to kind of make this null and void, what we're talking about right now.

But when are you going to issue guidance to the MACs, how to process the claims for the e-visits, the telephone services and with the correct modifiers? Because it's such a huge problem that people are doing the e-visits, the telephone services.

With the e-visits, they're using the therapy-specific modifier, the GPG NGO with the CR but they're not getting paid. They're not getting paid per telephone service. But, yet, when they bill telehealth, they get paid.

Male: Sure. So, first of all for bringing that to our attention, also for articulating, I think, what is a confusing series of events given how quickly things are changing. We certainly appreciate hearing about that. I think you've diagnosed the problem pretty accurately and we'll certainly take that into advisement.

Obviously, we'll talk with the contractors to make sure that we get the best information available to providers. And as the guidance continues to get released, we think the complete picture will be clearer. And hopefully the educational work that we need to do in terms of the instructions to everyone will be effective and solve the problems that you're appropriately raising, thank you.

(Rick Faranda): Yes. And if you don't – thank you. And, again, I guess what – I would ask that when this addition guidance does comes on, additional information does come on because again we do believe CMS will add therapy providers to telehealth and it's probably going to get retroactive to a certain date.

Which then when it goes retroactive people are going to think that it was always that way, so I guess I would just ask for when you do the clarification the guidance, that yes we are going retroactive but it didn't become effective until whatever date the rule becomes effective going retroactive.

Otherwise people are going to think APTA, AOT and ASHA had been giving them wrong information for the past three or four weeks if that makes sense?

Male: That certainly does, and we appreciate that so thank you.

Male: Thank you very much I appreciate your time as always.

Operator: Your next question comes from the line of Shay Vaughn; you can now ask your question.

Shay Vaughn: Hi, can you hear me?

Alina Czekai: We can thank you.

Shay Vaughn: Thank you I wanted to ask about accelerating payments. I've been trying to get information regarding how these accelerated payments will be shown in the electronic remittance file once that advance payment starts to be recouped and what remittance code will be provided.

So that providers can easily tell when their importing their remittance that that payment has been taken and how it applies to the patient. Is there any specific direction regarding how this will affect electronic remittance?

Diane Kovak: Hi this is Diane Kovak, so I don't think we have the right code from our office of financial management here. I do know that there is messaging upon remittance advice that will indicate any adjustment to payment that's as a result of paying back of the accelerated payments. I can't tell you right now what the exact messaging is on that, but we can certainly take that back.

Shay Vaughn: Okay, thank you so much.

Operator: Your next question comes from the line of Mark McDavid; you may now ask a question.

Mark McDavid: Thank you so much this is Mark McDavid with Seagrove Rehab Partners and thanks again for having these calls. I would hope that after we get through this pandemic together that we can continue to keep some sort of dialogue like this, these have been very, very helpful.

Maybe not twice a week but something like that would be great. I had a couple of questions, one I just wanted to piggyback on what Rick had to say about PT, OT and speech and telehealth.

You know we are getting a lot of questions about that and I think a lot of beneficiaries are currently going without care simply for fear of going into their outpatient therapy locations and coming in contact with someone, or you know, things like that.

So, any further clarification or the sooner we could get clarification on that the better we would greatly appreciate. Really my question that I have today really revolves around PT, OT and speech inside of skilled nursing facilities and billing for set up time.

In the current REI manual set up time is allowed to be counted on the NDS for therapy services as we prep for that patient to be - for that service to start. My question is about P.P.E.

So now that we're in a situation where P.P.E. is ever present and it is adding time to the beginning and ending of treatments and slowing therapists down from going from one patient to the next.

And realizing that at the end of the day minutes aren't, "billable", as they used to be under the old (inaudible) system. Would you consider P.P.E. to be counted or the donning and docking of P.P.E. to be counted in that set up time calculation?

Male: I think that's probably the first we've heard that specific question we can go back and take a closer look at it.

Mark McDavid: Okay, thank you.

Operator: Your next question comes from the line of Sandy Sage; you may now ask a question.

Sandy Sage: Thank you, thank you guys for having these calls. I just had a quick comment before my question before the question on the PT, OT, speech, it may be confusing because those evaluation codes are on the telehealth list of codes so maybe that's another confusing point for people as to whether or not they can bill them with telehealth.

The other thing is there was a question that came up today for the CG modifier for RHC telehealth. That's usually used if there's going to be a co-pay applied, would it be used currently on the RHC telehealth with the CF modifier. Would you use both the CG and the CS?

Male: I think for the telehealth you would use the 95 at present.

Sandy Sage: Okay.

Male: For any telehealth service.

Sandy Sage: And not the CG?

Male: Not the CG.

Sandy Sage: Okay.

Male: And then the CS would be if it were related to COVID testing—

Sandy Sage: Okay the other—

Male: --unless it resulted in that.

Sandy Sage: That makes sense, that makes sense thank you so much. The G2023 and the 2024 we understand that that's for independent laboratories going to SNF or non-inpatient – non-hospital inpatients.

I guess our question is, the hospitals are the ones taking the risk by getting the COVID specimens and then the labs are receiving that from the hospitals and they're running the tests and billing the tests.

But the hospitals get no reimbursement for the collection of the specimen. Has there been any more thought to another code for that collection or allowing hospitals to use one of those G codes when they do the collection?

Tiffany Swygert: Hi this is Tiffany, so currently those codes are able to be billed but they're not separately payable so those are very important comments and we'll certainly consider them. But they are already allowed to be billed by a hospital on the 13X.

Sandy Sage: Okay because we know that the labs are billed, the independent labs are billing them, and we were told last week that they were the only ones that could so that's good to know we can. But they're not actually the ones

collecting all these specimens, it is the hospitals that are collecting most of them in our area at least.

So, we'd appreciate it if there was some kind of payment for the risk that the hospitals are taking, so thank you very much.

Tiffany Swygert: Thank you for your comment.

Female: Sorry before we move onto the person I just wanted to mention, we are working on some billing guidance for RHC's, for me there might be a question about this CG modifier so I'll just say keep an eye out for some guidance that will hopefully be coming shortly.

Sandy Sage: Okay thank you so much, we appreciate you guys doing these.

Operator: Your next question comes from the line of Marcus Lewis; you may now ask your question.

Marcus Lewis: Hi I want to echo everybody's comments about these calls. I really appreciate having the opportunity to have it and I want to echo Mr. McDavid's comment that maybe after COVID is over we continue this in some way, shape or fashion.

My question is in regards to the RHC's and the guidance that was recently resulting and the cost report requirements that cost for furnishing distance site telehealth services will not be used to determine RHC error or FQHC PPS rates and they will need to be reported on line 79 of worksheet A which is other than RHC costs are non-reimbursable. And I'm just curious of the intent on why this is going on worksheet A and not officially in the error rate?

Male: So, I think it's fair to say that is the way law's written. So, I think as a general rule, I think, from CMS's perspective we wouldn't, sort of, get into the intent from which it's really congresses to answer. But those policies are a direct application of what's in those statutory provisions in the law.

Marcus Lewis: Okay so it's a reflection of the law and I guess, you know, with the hospitals without walls and you know these are replacing services that are usually

completed in a clinic and once COVID is done will be. But if it's restricted to the law then it's understandable. I appreciate you taking the time.

Male: Sure.

Operator: Your next question comes from the line of Jean Rothall, you may now ask your question.

Jean Rothall: Yes, my question is about the DR tradition code, it's actually about the in-patient 20 per cent add on. We're trying to see if it's been applied to some hospital payments, but we can't quite tell. I know it needs to have a COVID-19 diagnosis; does it also have to have the DR condition code in order to get the 20 per cent adjustment on the in-patients?

Diane Kovak: Hi, so this is Diane Kovak. So the 20 per cent adjustment is something that we're coding into our system so do I not know that we have to have that modifier on there for our condition codes – for the payments to be appropriate but we do expect to have the DR condition code and the CR modifier for any item where we've had a form or waiver.

But, kind of, the balance we've been giving is if you need that the payment is contingent upon a form or waiver, go ahead and put the CR and the DR on it will not impact payment if you have it on there and it's not required.

Jean Rothall: And is there a way – where does the adjustment factor show up? You didn't change the relative weight for the DRG's right?

Diane Kovak: That I don't know so we will have to – don't necessarily have the specifics on that right now we'll probably have to get back you.

Jean Rothall: Okay.

Diane Kovak: Although I have some people that are typing at me as we speak, and it looks like that you're correct and that we did not change the DRG weight.

Jean Rothall: Okay, thank you.

Operator: Your next question comes from the line of Joanne Shay-Boyce. You may now ask your question.

Joanne Shay-Boyce: Yes, hello I had some questions on the CS modifier that were answered previously. My next question has to do with some new codes that were established for labs, specifically U003, U004 and we're looking to get some input from CMS as to how far back does this go?

It reads, as if these should be attended back to March 18th however our MAC, NGS, is using the date that this was issued, this ruling, and this is CMS ruling 2020-1R, that was published on 4/14/2020.

Ing Jye Cheng: Hi thank you for your question this is Ing Jye Cheng, MACs are correct. CMS ruling 2020-01-R was effective April 14th of 2020 and the two codes referenced in that ruling U0003 and U0004 are payable as of April 14th 2020.

Joanne Shay-Boyce: Okay all right. So how it reads in the conclusion is a bit different and I think might be misinterpreted but we're hearing it from the horses' mouth here, that they are correct that it is to be April 14th, 2020.

Ing Jye Cheng: That's right.

Joanne Shay-Boyce: All right, thank you very much.

Operator: Your next question comes from the line of Adelaide La Rosa. You may ask your question.

Adelaide La Rosa: Hi, thank you for taking my call I really appreciate it. There is a lot of confusion on how the hospitals will be compensated with this 20 per cent based on patients prior to April 1st discharge.

The principal diagnosis would be the condition that bought the patient in and then the secondary diagnosis would be the COVID code starting with B and I apologize not having it at my fingertips being 79 so forth. And after April 1st the principal diagnosis would be the U071 with the exception if the patient came in and was local septic or there are guidelines that the patient is also a OB patient or if it's an AIDS or newborn.

So, the hospitals are really not sure at this time how they will be compensated and how these cases will be identified. Is it based on whether there is a principal diagnosis of COVID or it's secondary or is it going to be based on the DRG's that have been stated out there?

Demetrios Kouzoukas: So, this is one I think there is an answer to, Ing Jye do you want to take it?

Ing Jye Cheng: Sure, I think you actually answered your own question as you were walking through. Section 37(10) of the Cares Act directed us to increase the payments by 20 per cent and the diagnosis codes you mentioned are in fact the diagnosis codes that need to be on that claim.

So, one of those is the 97.29 and that's for cases before April 1st or discharges occurring on or after January 27th and on or before March 31st, 2020. The other code that would trigger the 20 per cent is U07.1 and that's for discharges occurring on or after April 1st, 2020. The U07.1 is the new ICD-10 code that identifies COVID-19 and that's effective as of April 1st.

Adelaide De Rosa: So, whether it's a principal diagnosis or a secondary diagnosis, we will see a 20 per cent. So, it's not going to be based on what DRG generates it's based on the presence of these codes on the claim?

Ing Jye Cheng: That is my understanding and we can confirm and circle back on that.

Adelaide De Rosa: Yeah, I think that's' very important and then I guess the question is, we have billed our cases in March so what happens on those cases? Is CMS going to go back and adjust the payment on those and then I guess we keep dropping these claims and the question is, are we going to be expected that these claims will be scrubbed going back how far?

Is it going back from January 1st, you know, as we continue to bill that they will be looked at and then if these codes exist then the 20 per cent will be on the claim?

Diane Kovak: So, in this case we are auto re-processing, not back to January I don't but during the period of the PHE, so you don't have to resubmit these claims.

Adelaide De Rosa: So, you don't have to resubmit the claims you're saying?

Diane Kovak: Correct.

Adelaide De Rosa: And from what period on are you saying it's from – its not February it's from March? Did we not have cases in February?

Diane Kovak: So, others are correct me if I'm wrong, I think we are bound by the dates of the PHE, the Public Health Emergency Declaration. But we can certainly go back and make sure we clarify that.

Adelaide De Rosa: Yeah. And I guess that's what the hospitals were trying to understand is it based on the DRG? So, you're saying it's not on the DRG so I can bring that back and that we just continue to bill these claims and they will be (Inaudible). So that's what we're comfortable in saying at this point, is that true?

Diane Kovak: I'm sorry could you repeat that please?

Adelaide De Rosa: I guess how will – we will – we obviously are as patients are being discharged, we're coding them and we're billing these claims out. I guess when we expect to see payment or how would we know we get paid? Is this going to just go back?

Have they started to pay their 20 per cent? Maybe that's a better question and if they haven't paid it are, they going to adjust the payments and how would we see that?

Diane Kovak: So we will automatically reprocess the claim so the provider doesn't have to take any action and I did get some clarification that it's PPS claims for discharges on or after January 27th and long-term care claims for admissions on or after January 27th is what our directions say.

And so, we will reprocess the claims so you don't have to take any action and on your remittance advice it will show that the claim was adjusted.

Adelaide De Rosa: OK, and so again I appreciate your time in taking this question. The other thing is because that CS is unclear as to what hospitals should do for the

outpatient claims, hospitals are in the situation starting to hold up, you know, multiple – I should say numerous amounts of claims.

So the sooner you can give us some guidance on what to do with that CS, whether it's just on the E&M or if the patient comes in with COVID, and obviously they're going to do a CAT scan or an X-ray to evaluate the extent of that disease. You know, when will we find out if we should be putting that modifier also on any tests related to that patient, for example, that comes into the ER, and treat and release?

And we know we have numerous, numerous amounts of accounts, and with the hospitals suffering with cashflow as it is, if there's a way to get that out to us sooner that would be very appreciative.

Tiffany Swygert: Thank you for your comment. I think for now the guidance that is out is what folks should follow and so, again, that does talk about the specific codes that are defined in the statute as a testing-related service, as a medical visit.

But again, we appreciate your question and if there are other codes that aren't specifically mentioned in the statute that would be – if we're able to, that would be in later guidance. But folks shouldn't be holding up claims that are consistent with what's already listed in the guidance.

Adelaide De Rosa: So it's on the E&M. But if we – if we go and drop these claims and you change it, how would we then – you're going to – you're telling me they're going to – it's going to be reprocessed on Medicare's side to receive the additional reimbursement if that gets considered?

Tiffany Swygert: I'm saying that the guidance that's out right now is the official guidance but – go ahead, Diane.

Diane Kovak: Thanks, Tiffany. So in terms of reprocessing – sorry, the answer that I gave for reprocessing was for the – for the 20% IPPS you were just talking about. I think in this case we would have to consider, as we clarify our guidance, if we would be able to automatically reprocess those claims or not. So we would have to stay tuned for the answer to that one.

Adelaide De Rosa: OK, thank you, as again, I appreciate it and I also believe this is such helpful – even if you got to do these calls after the crisis is over, once or twice a month, it really gives us a chance to ask some questions that there – sometimes it's just not clear when we're reading the rules and regulations. So thank you, and hopefully you guys stay safe.

Demetrios Kouzoukas: Thank you.

Operator: Your next question comes from the line of Devon Seibert-Bailey. You may ask your question.

Devon Seibert-Bailey: Yes, hi, my name is Devon Seibert-Bailey, thank you. Many – the providers who received a portion of the funding distributed pursuant to the CARES Act must attest to the compliance within certain terms and conditions of payment.

One of the conditions on that states that, "For all care for presumptive or actual case of COVID-19, recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient."

Does this condition apply to all patients who present to a facility with symptoms of COVID only, or any patient who receives a test regardless of the appearance for the – so for instance, if a patient comes in and does not come in for COVID specifically, but is coming in for – let's say they reopen elective surgeries and they're just automatically testing every single patient – does because they've been tested for COVID now require them to also say that they cannot be balance billed? Thank you.

Demetrios Kouzoukas: So CMS is not administering that particular program, but if you send your question on we can get it to the right place.

Devon Seibert-Bailey: All right, thank you.

Operator: Your next question comes from the line of Marcia Nusgart. You may now ask your question.

Marcia Nusgart: Yes, good evening and thank you so much for all of your help in answering so many of our questions. One of the areas that we were still trying to figure out is whether the CMS is going to allow the hospital outpatient department wound centers to receive a facility fee for telemedicine originating from the center.

And we have sent a letter, you know, to CMS asking a number of different questions. This is one of them and I wasn't sure whether it was actually defined yet, and if you could help us with this we would really appreciate it.

Tiffany Swygert: Hi Marcia, nice to hear from you, this is Tiffany. We don't have any specific guidance on that particular question about hospitals and telehealth, or telemedicine, at this point. But I do want to take the time to remind folks of the CMS "Hospitals Without Walls" initiative. And so …

Marcia Nusgart: Right.

Tiffany Swygert: … within that initiative there are waivers, including waivers of the provider-based rules, which allows hospitals to make provider-based to the hospitals' alternative locations that are related to the public health emergency. That can include the patient's home, though, to the extent that there is a need for the hospital to furnish the service in the patient's home.

That's already allowed and billable, but I think the question that you are asking is really about, you know, can they bill for that service even if they're not there. And one question that I would just have back for you is, if you're talking about wound care, it's not clear to me how that is done remotely, if there's, you know, wound dressing and, you know, making sure that there's no temperature and things like that. So it's not clear to me exactly what portion of the service could be done remotely.

Marcia Nusgart: Why don't I send you an email on it and – or you and I can have a conversation with it offline so we can let some other people address this, but we do have some thoughts on this since many of our members, you know, do provide telehealth and – from the hospital outpatient area they do – they are providing some of the telehealth areas.

If I could just ask one more question, though, in terms of we've received information from the Medicare contractors that the NCCI editing has been updated to allow payment for a wide group of previously designed services, and what was interesting is that the information posted on the MAC website, though, is very vague.

So when we're looking up the NCCI information on the CMS website, it appears that nothing has been changed. So is there someone that might be able to help elaborate on which NCCI edit updates have been made?

Diane Kovak: Hi, this is Diane. So there were updates made to NCCI for telehealth for – to allow our waiver for telehealth to go through.

Marcia Nusgart: OK, but I think that what we were trying to be able to figure out is that for some of the NCCI edits, that you would be able to bill for services that are provided at the same time.

Tiffany Swygert: Maybe we can take that one back as well and see if there's some additional guidance. It sounds like, Marcia, you're saying that the update on the website is not specific enough so it's hard to tell what actually changed.

Marcia Nusgart: Exactly, from the MAC.

Tiffany Swygert: OK, let us …

Marcia Nusgart: Yes.

Tiffany Swygert: Let us take that back.

Marcia Nusgart: OK. And lastly, has CMS relaxed any of the LCD MCD medical necessity DME criteria requiring the in-person preservice interaction? This would be really helpful and would allow medical equipment suppliers to provide the virtual demonstrations or trainings on the medical devices to the full.

For instance, this is more on the pneumatic compression pumps with LCDs, and they also have an MCD medical necessity criteria that requires the patient receive the preservice in-person. Initial treatment with the devices showed the patient can operate the device and tolerate the treatment.

And unfortunately, you know, during this pandemic the in-person patient interaction is not desirable or even possible in many cases, yet the patients do have the clear medical need for DME covered by the LCD or the MCDs. So what we were hoping to be able to do is to allow the virtual demonstrations and training that could be provided post-delivery that would meet the spirit of the criteria.

So I wasn't sure whether this is something that someone on the phone could answer or whether Jason might be able to help us with this, because it's really important for those that do provide this particular service.

Connie Leonard: Hi, this Connie Leonard. Have you been able to provide those via telehealth?

Marcia Nusgart: This is one of the – what we want to be able to do is try to do this but, unfortunately, in the lymphedema MCD that isn't allowing that, and that was really the – so that's what we were trying to figure out, there could be some relaxation of this.

It was a medical – and, Connie, we can send you that information. This is in a letter that we had sent to Demetrios and Jason as well as obviously Secretary Verma.

Connie Leonard: Yes – no, thank you, I'm sure I can get it. I think those flexibilities might actually already exist but we'll take this back and we'll provide some additional clarification if we think we need to. Thank you.

Marcia Nusgart: Thank you so much, and again, we just so appreciate CMS being so responsive and appreciate these calls. And it's just really unprecedented, so thank you so much for your time.

Operator: Thank you. Your next question comes from the line of Tracy Field. You may now ask a question.

(Tracy Field): Hi, this is a question related to the relief fund money and again, the acceptance of the terms and conditions. I know that there have been continuing changes on the website, the portal, for what the terms are but it

doesn't – the statute provides for lost revenue as also a basis for the acceptance of the money.

And I know that obviously we want to make sure we're signing those attestations appropriately. Is there going to be a change that will also account for that in terms of lost revenues for that attestation, please?

Demetrios Kouzoukas: This is a program that's being run elsewhere than CMS so we will – we can take that question and if you email it, get you to the right place.

Tracy Field: Can you clarify where to email that kind of question, because the attestations are changing frequently without notice and providers are unsure of what – to what their attesting on any given day, frankly.

Demetrios Kouzoukas: Alina, do you know what the right email address is so you can send them all up?

Alina Czekai: Sure, yes, I'll have you direct that to the CMS one and we can shepherd it to the right folks. It is covid-19@cms.hhs.gov. And again, I'll flag your particular email and make sure it gets to the right folks.

(Tracy Field): Thank you.

Operator: Your next question comes from the line of Rosie Fasel. You may ask a question.

(Rosie Fasel): Hello, thank you again for having these calls. They've been so helpful. I want to echo the PAMA question that was asked at the start of the call, except this time for the laboratory payment amounts.

I understand that our reporting period has been pushed off another year to start January 1st 2022. But what we're going to report in 2022 is 2019 data, and although we've struggled mightily to collect this data, it doesn't make sense to me to report 2019 data in 2022 because that data is going to be quite old by then, and I wondered if there was any consideration being discussed for skipping this data collection period and just moving onto the next data collection period?

Operator: All right, your next question comes from the line of …

Demetrios Kouzoukas: Right, let's …

(Rosie Fasel): Wait a second.

Demetrios Kouzoukas: Let's see if we can get the – a bit of an answer there, at least as best we can. We certainly know that the (inaudible) payment collection is something that has required a fair amount of work all along the way. We'll take a look, obviously, at the kinds of input that you're providing here and elsewhere and – I don't know that we have anything to say in that regard (inaudible)

(Rosie Fasel): OK, thank you.

Operator: Your next question comes from the line of (Elise Rowe). You may now ask your question.

(Elise Rowe): Hi, my questions have already been asked, basically the same things that others have asked, related to the new AMA CPTs, if those will be codes that CMS will cover, such as the two antibody codes, as well as the 87635 CPT, also related to the PT,OT, ST and outpatient hospital services, you know, billing those on a UB.

But my other question that I didn't hear addressed is related to the new codes for the antibody testing. Are those going to be covered under the cost-sharing initiative with CMS?

Demetrios Kouzoukas: Tell us what you were referring to with – when you said cost-sharing initiative?

(Elise Rowe): The cost-sharing initiative as it relates to – that the patient will not have an out-of-pocket expense for the – for those particular codes.

Demetrios Kouzoukas: So under the clinical (ab fee schedule there isn't generally a cost-sharing. So I don't know …

(Elise Rowe): OK.

Demetrios Kouzoukas: … if that answers your question, yes.

(Elise Rowe): No, that does, and I think it may have been more related to the services for that, but perhaps I had the question wrong.

Male: (Inaudible) services. Tiffany, is that the question you've been answering a bit? At least a twist of it?

Tiffany Swygert: Yes, it sounds like you might want to go back and check if there's another twist to the question, but that is right if your question is about the new laboratory tests. Those don't have cost-sharing already so you wouldn't need to include the CS modifier. But if it turns out that there's really a different flavor of that question, go ahead and submit it to us via email and we can take a look.

Elise Rowe: All right, thank you.

Alina Czekai: And Operator, we'll take our final question, thank you.

Operator: Thanks. Your final question comes from the line of Krista Barnes). You may now ask your question.

(Krista Barnes): Hi everyone, my question relates to telehealth services and more specifically – it's a multi-part question. So my first part of the question is when you – I know that you are going to bill for those virtual check-ins and e-visit type codes. You all have said repeatedly that it's necessary to get the beneficiary's consent to bill, the reasoning being that they're going to have a cost-sharing obligation that might be unexpected when you're just having a phone call or an email or something like that.

Question one. Is it mandatory to get that patient consent to bill if you plan to waive the patient's payment obligation, like the co-pay? And then I'll wait for – and I'll pose – or do you want me to pose all of them now and then come back? Or …

Male: Let me answer that one quickly. So I think that you've articulated largely what the policy intent is behind the requirement, but the requirement will still stand regardless of whether or not you're – for that particular service, planning to collect the co-pay.

Krista Barnes: OK. Now, part two. Would it also apply to a telephone E&M, the new codes that – you all talked about an interim final rule, because I went back through it

and I couldn't find any reference to collecting the co-pay for a telephone E&M. Although I know you view those as quite similar to the virtual check-in.

Male: Do you mean in terms of the consent required for the telephone E&M?

Krista Barnes: Yes, yes.

Male: I don't think the same consent requirements apply. Although – I don't know if anybody else is on the call. If – Emily, if you're on you can tell me if that's right. She may have had to drop off.

I think the same policy would apply to the extent that the consent requirements apply, but I'm not sure that they do. And so we can get back to you on that one.

Krista Barnes: OK. I actually agree with you. It's not necessarily rational but I – but I haven't found it, right. My third question is does that consent requirement apply to a normal video telehealth visit?

Male: No. So the consent for the face – once there's a – once there's a face-to-face component there's not any specific requirement for consent to be noted in the medical record, such as there would be for the virtual check-in.

Krista Barnes: OK.

Male: The – so those telehealth services are considered to be similar to other – to the same service when it's furnished in person in terms of the assumptions made about the consent of the patient.

Krista Barnes: OK. And then I – one last thing. I'm going to put a scenario out there and I think I know the answer, but let's see. OK, so say we have a patient who comes into a provider-based outpatient location that's within 35 miles of the main hospital. They come in for a visit that they're having in person.

Now, they need to have some sort of consult with a different specialty, and maybe that provider is back on the main campus of the hospital in their office and they want to do a video visit. When that patient shows up out at the

facility they are on the provider's campus, right? It's a provider-based hospital outpatient department and the physician is over in – on the main campus, in the same provider-based – in the same provider, right.

And you all have said a couple of times that if you're in the "same location" it is not telehealth, and you would just bill everything normally, even if they connect by video. Is that still the case even in this particular scenario?

Tiffany Swygert: Yes, so this is Tiffany. I can answer the part about the hospital. So if you're talking – as long as you're talking about the hospital, and the patient and the professional are in the hospital, that's already current policy that they can – the hospital can submit the facility fee.

But I think there's a twist to yours and you're saying that the professional is another part of the hospital from where the patient is, so I'm going to turn it over to my colleague, Ryan. If there's anything that we've said regarding telehealth in that space.

Ryan: No, I think – I think that's right. So under that scenario where the patient and the practitioner are in the same location, so that they're in the same hospital, then the telehealth rules wouldn't apply. The service could certainly be furnished and billed for, but it wouldn't necessarily need to be billed for under the telehealth provisions.

I think that the question would be are they in the same location if they're in an off-campus provider-based department for purposes of how the hospital would bill. And I think that that's a difficult question to answer. Tiffany, I don't know if you want to add anything on that but I – but ordinarily if you see two physicians in the same visit, then I think the hospital would bill the same way as they normally would.

Tiffany Swygert: Yes, I think that's right. Hospital billing is, you know – if telehealth is not involved the hospital would bill as normal, that's under Hospitals Without Walls even, where some – the patient can be in an alternative care site and still be – as long as that site is provider-based to the hospital and meets the conditions of participation that weren't waived and all other billing

requirements are met, I don't see an issue with the hospital submitting their bill.

But you have to take into account all of the other rules that still apply, including supervision for the hospital outpatient therapeutic service, most of which are now general supervision. So, yes, hopefully that answers your question. It's always hard to answer a hypothetical and so, you know, if there are more specific details that come up, that's always a good sort of question to ask your MAC.

But the general premise on the hospital billing side for the facility fee is correct. I don't hear anything in what you've said that would preclude the hospital from billing for their facility's service.

Krista Barnes: Great, thank you. Yes, that's sort of a bonus. My main question was just whether a telehealth – when the person, you know, is 30 miles apart connected by video but it's the same provider number, it's the same hospital, it's just a little bit illogical in your mind but it – you all have been consistent in saying that that is not telehealth and you should not use the telehealth codes. So, thanks, that's good.

Alina Czekai: Great, thank you for your question and thank you, everyone, for joining us this afternoon. This concludes today's office hours and we hope you'll join us this upcoming Thursday, April 23 at 5:00 pm for our next office hours. In the meantime, any questions can continue to be submitted by email at covid-19@cms.hhs.gov. This concludes today's call. Have a nice evening.

Operator: Thank you and this concludes today's conference. Thank you all for joining. You may now disconnect.

End