Centers for Medicare & Medicaid Services
COVID-19 Office Hours
April 23, 2020
5:00 p.m. ET

Alina Czekai: Good afternoon. Thank you for joining our April 23rd 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 provide an opportunity for providers on the front lines to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and health care systems to increase hospital capacity, rapidly expand the health care work force, put patients over paperwork, and further promote telemedicine and Medicare.

And whilst members of the press are always welcome to attend these calls, we do ask that they please refrain from asking questions. All press and media questions can be submitted using our standard media inquiries form, which can be found online at cms.gov/newsroom. And any non media COVID-19 related questions can be directed to our mailbox, which is covid-19@cms.hhs.gov.

And we'll now take our first question. Operator, can you please open up the lines to take questions.

Operator: Yes. And if you would like to ask a question during this time, please press "star" "1" on your telephone. And we do have a question from the line of (Rosie Fussell).

Rosie Fussell: Good afternoon, and thank you for continuing to have these Office Hour calls. They're very helpful. I have a question about HCPCS U0003. The description of the HCPCS requires that testing be performed using a high-

throughput method. And "high-throughput" is defined as greater than 200 tests per day done on that platform.

However, we have two different high-throughput methods that we're using for our testing. But we are unable to get the reagents needed to perform more than 200 tests per day on most days of the week. It's still very, very difficult for us to obtain the supplies, even though we are using two different companies' methods to do coronavirus PCR testing.

So my question is, even if we don't have the reagents to do 200 tests a day, but the platform's documentation gives a throughput of greater than 200 tests per day, may we continue to use HCPCS U0003?

Ing-Jye Cheng: Thank you for that question. This is Ing-Jye Cheng. And I am sorry that this continues to be such a difficult situation in terms of making sure that everything is available for testing. I think that we've heard across the board that there are bottlenecks throughout the process.

With regard to your specific question about when U003 can be billed. The code descriptor itself talks about tests that make use of high-throughput technologies, as ascribed by the ruling. And, you know, you restated the definition – that the platform has to – more than – be able to process more than 200 specimens.

The ruling does not stipulate whether or not 200 specimens are actively run a day. So I think the situation that you describe, where you are running a test – an RT-PCR test – through a platform where you have that documentation that has the platform meeting the definition, as stipulated in the ruling, would be billable at – using U003.

Rosie Fussell: Thank you very much. I do appreciate it.

Operator: And we do have a question from the line of May Ru.

May Ru: Yes. This is May Ru (inaudible). Can you all hear me?

Alina Czekai: We can. Thank you.

May Ru: Great. My question is with respect to telehealth in the context of emergency departments. We're wondering – sorry, let me pull up the question. I didn't expect to get through this time, because I usually don't – here we go.

So CMS has confirmed that medical screening exams in emergency departments may be performed via telehealth by a qualified medical professional acting within their scope of practice, and approved by the hospital's governing body to perform MSEs. If a qualified staff member has not been approved by the hospital's governing body to perform MSEs, can the hospital apply for a waiver to allow this staff member, such as an RN, to perform the MSE via telehealth?

Karen: So this is Karen. This is related to the (inaudible) requirements. I can't specifically speak to the telehealth component of this. RNs who have been trained by the governing body are able to conduct the medical screening examinations. There are – it's something that can be applied for in terms of a waiver – an individual waiver.

We have not issued a blanket waiver for this at this time, but it is something that can be applied for on an individual basis. I don't know if there's someone on who wants to speak to the telehealth component of this – the medical screening examinations.

Male: So in terms of telehealth, under current rules the telehealth requirements would apply if the practitioner furnishing that service was not located within the hospital. And in that case, if that individual met the requirements to fill under the physician fee schedule, then that person could bill for those services via telehealth.

That said, if the – if this is happening within the hospital itself, and just using electronic means, then the service would be reportable by the hospital, and if applicable, by the professional, not under the telehealth rules, or under the requirements for telehealth, but rather just as – as a normal service.

May Ru: Thank you.

Operator: You have another question from the line of Ronald Hirsh.

Ronald Hirsh: Hi. Three quick ones. An orthopedist is in private practice, and he or she employs therapists. If the doctor orders physical therapy, and one of their own therapists performs that via telehealth, can't that be billed via incident two rules, using the 95 modifier and the proper physical therapy codes?

Male: So – appreciate the question. Generally, I think we've looked at those sorts of services in terms of telehealth as not being able to be provided. Now that they're newly on the telehealth list, I think we are taking a look at those, and I would expect guidance to be forthcoming shortly.

Ronald Hirsh: OK. But, again, this is a private practice. This is not a hospital based, or facility based, billing. So technically it really should be allowed even now as an incident two service.

But to go on. NGS has said that if a provider is under a targeted probe and educate audit that they are not eligible for an accelerated payment loan, because they're under investigation for fraud. Is TPE a – really a fraud investigation?

Connie Leonard: Hi, this is Connie Leonard. And a provider under targeted probe and educate is eligible for an accelerated payment. And we will make sure that the MACs understand that. There might have been some confusion early on, but they should all understand it now. And we'll double – we'll double check with them.

Ronald Hirsh: Thank you, Connie. And the third one is since hospitals can't get SNFs to accept qualified patients, I'm wondering if Tiffany is ready to allow acute care hospitals to bill for SNF care that they're providing to patients while they're waiting for an actual SNF to accept them?

Male: So this is a – this is a question about sling beds that is more broadly beyond those that – that are currently allowed under – under an agreement. We are continuing to look at that issue to see if there's some broader flexibility.

But I would note that our – our policies have, and do always, allow that SNFs work with hospitals under arrangements should they find that to be a – a mechanism that might work for them.

Ronald Hirsh: OK. Thank you.

Operator: And we have another question from the line of Andy Sage.

Andy Sage: Hey. This may be a simple one for you guys, actually. Well, maybe not. OK. So there was question asked – do we have to get MSPs on all telehealth patients for each visit, from the hospital perspective?

Male: Can you repeat the question?

Female: So, sorry – yes. Go ahead.

Andy Sage: Yes. Do we need to do MSP questionnaires on all telehealth patients that are – have telehealth from the hospital side?

Karen: So this is Karen. You're referring to medical screening examinations?

Andy Sage: No, no. I'm sorry. Medicare secondary questionnaires for Medicare secondary payers. I know there's been some allowance for some of the forms that we're having to get for patients. But do we need to complete a questionnaire on all telehealth patients for that?

Male: I don't know that we have an answer to that here today.

Andy Sage: OK.

Male: I think there is one, though. I don't – I have to say I've been watching all – you know, obviously all the guidance that there were coming out. I don't remember seeing anything that would change our current rules about MSP.

Andy Sage: OK. OK.

Male: But, you know, if – if it's an issue, or a question that persists, then please let us know. And we can also get an answer to your question if you get to (inaudible).

Andy Sage: OK. OK. And real quickly. To receive a hundred percent of the Medicare allowed amount that includes the co pays or deductibles on outpatient claims, should we add the CS modifier to all lines that have cost sharing potential, or just to the E&M line for a visit?

Ing-Jye Cheng: Thanks for that question. This is Ing-Jye. You should be adding the CS modifier just to the services specified in the guidance that we've provided. So I think E&M is one of those services.

Andy Sage: It does say that, "Add the modifier CS to items and services related to COVID." And then in another spot it talks about it being on the E&M visit code. There's two different guidances that are kind of conflicting with each other. So we were curious if that would be clarified.

Ing-Jye Cheng: We can certainly take that back to – to clarify it. But I – it would be limited to the services that the law specifies.

Andy Sage: OK. Thank you.

Male: It might help if you send us both guidances, by the way. Alina will have an e-mail address.

Andy Sage: OK. I'll send those over. Thank you. That's all.

Female: Sure. And I can give that e-mail address now as well. It's covid-19@cms.hhs.gov.

Andy Sage: Thank you.

Female: And now for our next question.

Operator: Yes, we do have a question from the line of Rick Wanda.

Rick Wanda: Hi. Thank you. I first want to thank you for answering the question about physical therapy (inaudible) position. Exactly the same as you did back on April 14th. So it's good that, back then, you did say that you look at the provider of the one doing the telehealth. And since PTs and OTs are not considered telehealth provider, that was your rationale why they could not do incident two.

So I assume – and again, I know we're waiting for that interim final rule. (Inaudible) with OMB, hopefully, to finish being under review, and be published.

With that said – and I've brought this up to your attention before – we're seeing the MACs, like Meridian, Novitas, National Government Services, you know, paying I'd say erroneously right now for telehealth services that are under the NPI number of a PT, of an OT, of an SLP. And they're not processing the e-visits correctly with the CR, and the GP modifier, for example.

My question is are MACs supposed to take direction from CMS only via a transmittal notice? Because it seems like the MACs went and took the interim final rule, plus that six-page document you put out, and tried to implement all these changes without guidance from CMS. So I guess my question is how does CMS issue the guidance to the MACs, and do the MACs just do this incorrectly by themselves?

Diane Kovach: Hi. This is Diane Kovach. And – and thank you for bringing this up again. We did hear you when you brought it up at the last call, and we have gone back and talked to the MACs about this.

The MACs certainly take direction from CMS in terms of implementations of our rules and regulations. And I'm sure you can appreciate things have been moving very quickly, so on occasion, there are things that may be implemented incorrectly. So we are working closely with them to clear this up. So again, thank you for bringing this to our attention.

Rick Wanda: No, and thank you for all you're doing. I mean, I – you have many, many things to do, so we all appreciate your time, and just trying to make sure we

get the right information to the PTs, OTs, SLPs out there. So again, thank you for all you're doing.

Male: Thank you.

Operator: And we have a question from the line of Elias Laconney.

Elias Laconney: Hello. Thank you for the opportunity to ask questions. In response to the public health emergency, we appreciate that CMS has broadened access to Medicare telehealth services. And so to that end, there are services like CPT code 95249, for example, that describe continuous glucose monitoring that could be safely and appropriately provided via telehealth, but are not included on CMS' list of telehealth services.

So my questions are, how is CMS evaluating updates to the list of telehealth services? What's the process that we can use to identify potential services that should be added to the list? For example, should we submit those in comments to the interim final rule? And does CMS anticipate updating the list of telehealth services in the near future?

Male: So – so that's a great question. There's two different pieces that I kind of want to respond to you. First, there are a lot of services that are paid on the physician fee schedule, for example, that don't generally describe in person services. And we don't directly add those to the telehealth list.

The telehealth list is for services that are generally provided in person, and – in which case the – the standard restrictions on telehealth services apply. But there are many services that are inherently, sort of, non face to face, or usually non face to face. And those services don't need to be on the telehealth list in order to be furnished using remote communication technology. So a lot of the patient monitoring codes, and things like that, don't need to be on the telehealth list in order to be furnished remotely.

We are continuing to be interested in hearing about services that aren't on the current list that need to be added. And we're actively thinking about our approach to being as receptive as possible, as physicians and other

practitioners explore and maximize the use of communication technology in the – in the context of the – of the public health emergency.

And so we're happy to take comment on the interim final rule, as well as reaching out to us directly in terms of services that, again, are normally furnished in person, but can be provided via communication technology.

Elias Laconney: Perfect. Thank you so much. If I may, I have a quick follow up question. And this is following up to a question that was asked on a previous call, regarding the waiver of clinical indications for coverage in certain LCDs and NCDs.

So, for example, the LCD for external infusion pumps provides coverage for the pumps and the related drug supplies. So the question is does CMS' waiver of clinical indications for coverage mean – in this LCD, for example – that the external infusion pump and the related drug supplies will be covered, even if the drug is not officially listed in the LCD?

Male: I don't know that we have our coverage folks on the phone today. So we'll definitely take that one back.

Elias Laconney: OK. And I'll go ahead and submit that via e-mail as well, so that gets in the queue. Thank you very much.

Operator: We have a question from the line of Nancy O'Leary.

Nancy O'Leary: Hello, and thank you for taking my call. This question is a follow-up to something that was discussed on Tuesday's conference call related to serological antibody testing for COVID-19 and whether or not it does in fact fall under the CMS provision of coverage about cost sharing.

I'd like to refer to the FAQs about the Families First Coronavirus Response Act, which was dated 4/11 and specifically questioning Q4, which does appear to indicate that those tests do – or I needed to be provided with coverage that meets the requirements as section 6001 of the FFCRA. And I was wondering if you could comment on that, and whether or not this interpretation is valid.

Male: Could you tell just specifically which Q&A you're talking about. You said question 4 but which one is it?

Nancy O'Leary: Yes, so it's called FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act implementation part V2. That's the header on the document, and it's dated April 11. I did it send via e-mail to you earlier today on the COVID-19 web address.

Ing-Jye Cheng: Thank you. I think your question here is whether the new serological antibody test, the new blood – two new CPT codes that were recently issued – if those tests were ordered, if the attendant E&M visits would be subject to the 100 percent payment to the provider and the cost sharing modifier. Is that your question?

Nancy O'Leary: Yes, that is correct.

Ing-Jye Cheng: And I think we need to take that back. I think you're right in pointing out that there are sort of – pointing back that there is – the law actually speaks pretty clearly about it, but we do want to take that back, and we'll able to get back on future hours.

Nancy O'Leary: Thank you very much.

Ing-Jye Cheng: Sure, thank you.

Nancy O'Leary: OK, bye.

Operator: You have another question from the line of Jenny Lieberman.

Jenny Lieberman: Hi, this is Jenny Lieberman. Thank you for taking our call. So I think I know the answer but I just want to clarify. Are physical therapy assistants allowed to provide eVisits using the G2061 to G2063 codes, or are those codes limited to PPs, OTs and SLPs?

Male: So those codes are – describe services of the professional who bills for them. So they would be just for the PTs, OTs and SLPs for – yes.

Jenny Lieberman: OK. And can those be billed on hospital UB forms?

Male: Yes. For the …

Jenny Lieberman: (Like) …

Male: You know, for the – for those professionals in the hospital setting.

Jenny Lieberman: OK. And one more question. If ordinarily the patient is being treated by a multidisciplinary team of providers, let's say for a diagnosis of stroke with hemiplegia and aphasia, for example, can a physical therapist and a speech language pathologist both provide treatment using the G codes in the same seven day period? For example, in this case, the PT might bill a G0261 GP and the speech therapist may bill G2062 with a GN – within the seven days, would that be permissible?

Male: That should be, but we'll get back to you. I think that comports with the policy intention but given how quickly some of these policies are changing, I want to make sure that we've implemented the instruction set to accommodate that.

Jenny Lieberman: OK. And one last. Can an RN who is a CDE bill for a G0108 when conducting an interactive synchronous virtual patient visit?

Male: Can you remind me what that G code is.

Jenny Lieberman: That's individual education for diabetes management. You know what, let me look at that exactly.

Male: And is this – this is in the hospital setting?

Jenny Lieberman: Yes.

Male: And the question again is?

Jenny Lieberman: Can an RN whose a certified diabetes educator, CDE, bill that code? It is on the list.

Male: It is on the list for telehealth services, you're saying?

Jenny Lieberman: It is. I'm just wondering about – because RNs are kind of being excluded, so that's why I'm asking.

Male: Right. So RNs are – wouldn't bill for those services on the physician fee schedule. And so they'll be – I think we're still thinking about the hospital billing when the – when services that are on the telehealth lists are being furnished and reported.

Jenny Lieberman: OK. So that's yet to be determined. Is that correct?

Male: Right, correct.

Jenny Lieberman: OK. And can a registered dietitian bill for a 98702 or a 98 – I'm sorry – when – I have those CPT codes wrong (inaudible) get to a 97803. When they're conducting an interactive synchronous virtual patient visit? Those are their MNT visits – medical nutrition therapy.

Tiffany: Yes, so you're talking about the hospital …

Jenny Lieberman: Yes.

Tiffany: … clinical staff at the hospital billing. So right now, hospitals are not eligible to bill telehealth services. They're professional services that are billed via telehealth. But under the hospitals without walls initiative, there are – there's an ability, because of the provider base rules, that were waived for hospitals to furnish services outside of the traditional walls of the hospital, to the extent that the conditions of participation that were not waived can be met. So that would include the patient's home or other alternative or temporary expansion locations of the hospital that are made provider-based. But there is – based on current policy, there's not a provision that allows a hospital itself to furnish a telehealth service.

Jenny Lieberman: OK. But an eVisit, as in, the rehabilitation professionals, is that allowed?

Tiffany: Again, if you're talking about the hospital billing, all of the codes that are payable, all of the HCPCS codes that are payable, are found on addendum B

of the OPPS. Either the – I believe there's not of them that is payable for hospitals. The hospital regulations require on the outpatient side that the service be furnished in the hospital. So again, that can include alternative sites that are determined to be part of the hospital, but it does not allow for something that is telehealth. Hospitals were not authorized to furnish telehealth visits.

Jenny Lieberman: It's my understanding there's a differentiation between telehealth services and an eVisit. Are you kind of viewing them as the same in this context?

Tiffany: No. You're right. There are distinctions, and both statements are true though. So hospitals are not an eligible site to furnish telehealth services. And as far as I'm aware, although I don't have the specific codes that you were thinking of in front of me, I do not believe that those are billable – are separately payable by hospitals.

Jenny Lieberman: OK. That includes the diabetes as well as the G codes that I proposed for the rehab professionals? Is that correct?

Tiffany: So all those other codes can be furnished in a hospital, right, and to the extent that the patient's home or an expansion of the hospital is furnishing those services, those would continue to be payable hospital services under the hospital outpatient system. But if you're talking about completely remote, where neither patient nor clinical staff of the hospital is in the hospital, that is not permitted.

Jenny Lieberman: Clinical staff would be in the hospital and they would be communicating synchronously with the patient in their home.

Tiffany: So it's a home with provider based to the hospital, then yes, that is allowed under the hospitals without walls waivers that were ruled out earlier.

Jenny Lieberman: OK. Thank you very much.

Tiffany: Thank you.

Operator: Your next question comes from the line of Sanja Kukso.

Sanja Kukso: Hi, there. Thank you. Last week's call, a caller mentioned the three CPT codes that are missing in the code set for E&M visits of a new patient in the domiciliary setting, and you acknowledged this was just an error and would be updated. I just wanted to highlight again, it's the three lowest codes in the new patient domiciliary code set, 99324, 99325 and 99326. We're wondering if there will be an updated list published soon. We've received quite a few denials on our new patient visits because of this.

Male: I thank you again for the question, and we are actively working on that issue, and hope to have guidance out shortly.

Sanja Kukso: Great, thank you. Just one other quick question. On the interim final rule, we noticed the section – it's actually pages 135 to 137, clarifying that during this pandemic, practitioners are allowed to select their E&M level based on either total time or medical decision making, but that applies only to the office outpatient visit codes. Could you please clarify if domiciliary or home visit codes are included in those interim guidelines, or if they will be included?

Male: They are included under the current rules and in price apps, because what the final rule did was to adopt the changes that will apply to the office outpatient codes beginning in January, early, for the purposes of the PHE. And in terms of the services furnished via telehealth, I point out that in some cases it may be that the office outpatient codes could be appropriate, if the – if that kind of care is better described, even if the patient is not in an office or an outpatient location.

Sanja Kukso: OK. Thank you so much.

Operator: And your next question comes from the line of Tom Morton.

Tom Morton: Hi. Regarding telehealth, what I was wondering is if there's been any change or any changes being considered on which apps can be used for telehealth visits, especially questioning about Zoom, making sure it's still OK, and if there's any contemplated changes with it.

Male: So in terms of Medicare payment policy, there's no prescribed application requirements, other than the interaction be audio and video. The HIPAA

requirements are handled through the HHS Office for Civil Rights, and they have waived the – many of the HIPAA requirements regarding the applications that are used in the delivery of health care services, and I think we'd need to refer you to them regarding the specific applications. But my understanding is that they've generally waived the requirements during the PHE.

Tom Morton: Thank you.

Operator: And your next question comes from the line of Simone Fishley.

Simone Fishley: Hi. Simone Fishley. Can you guys hear me?

Tiffany: We can, thank you.

Simone Fishley: I just wanted to clarify one question that Jenny Lieberman ask. The G2061 to G2063 are the eVisit codes. So those are the codes – those are not telehealth code. We wanted to know if those codes are covered under Medicare, and can RN or dietitian use those codes?

Male: So the – understood the question A. I think there's a part of it that we'll need to get back to you on. For professionals who bill for their professional services on a professional claimant are paid on the fee schedule, then those codes are payable there. In terms of the – those whose services would be reported directly by the hospital, I think we'll have to get back to you on that question.

Simone Fishley: OK, great. I also have another question. For a patient that comes into the emergency room that has the emergency level visit – that's the 998 code – and also the observation code, and COVID-related, should the CS modify or be on both the E&M level visit and the observation visit, or just one?

Tiffany: You can put it on both. Observation services are one of the categories of services for which cost sharing is laid. And so to the extent that's a – the payment is mapping to a comprehensive observation services payment, all of the cost sharing associated with that would be waived, even if the visit is packaged into that.

Simone Fishley: OK, great. Just one last question. For a patient that are coming in for surgery, and the facility decides to do pre-op testing for, you know – a COVID pre-op testing to make that the patient doesn't have COVID – coronavirus before the surgery, would that be considered medically necessary and will Medicare cover that?

Male: So on the medical necessity piece, I think we'll have to take that to our coverage people. But I'll say that if you're looking for something (young), what I can assure now, which is that medical necessity, the terminations are easily made at the MAC level, and so the most accurate for the MAC that you work with would probably be given by them rather than us. I hope that helps some.

Simone Fishley: Yes, we could definitely reach out to them and ask them that question. I just wanted to make sure, you know, we can paid for it, or we would get paid for it, if we happened to do it.

Male: Yes. I think – you know, on the coverage, I'd direct you to MAC. I don't know if – this is the outpatient setting you're talking about? I think I heard?

Simone Fishley: Yes, this is hospital outpatient.

Male: Serological test?

Simone Fishley: Right. So the patient is going to come in for a surgery, and they are doing the COVID testing – you know, the U code or the 8000 level code. If they do that on the patient and it's on the pre-op with the lab, and with other labs and other things, X-ray, would that cover that lab testing for the COVID?

Male: So we do have a payment rate. If it's reasonably necessary, we would have a payment rate to pay. The question about medical necessity, I'd go to the MAC. And hope that covers both parts some.

Simone Fishley: OK, thank you.

Operator: And your next question comes from the line of Sue Thomas.

Sue Thomas: Hello, this is Sue Thomas. My questions relate to the E&M that have been discussed before. When it's a provider-based clinic, I read the intention of CMS as to pay the global rate for telehealth E&M, and there's direction to use place of service 11. But there's nothing addressing place of service 19 or 22 for provider-based clinics, or the use of G0463 for the hospital to bill the technical portion of those use provider-based telehealth E&M.

Ryan Howe: So in terms of the professional claim, the instructions are to use the 95 modifier and apply the place of service code that would have been used had the use of telehealth not been necessary. So, in other words, in a provider-based clinic or outpatient department of the hospital, you would use the place of service code 19 or 23, and the telehealth modifier. And that's in order to maintain the level of payment to the professional that would have been paid were telehealth not used. And (Tiffany), I don't know if you want to answer the – I'm sorry, place service 22, I think it's the 22. (Tiffany), I don't know if you want to answer the clinic visit code element of the question.

Tiffany: Sure. So, for G0463, the hospital can bill that if the hospital furnishes the service in the hospital. So, the same answer that I was giving earlier about, you know, it depending on where the patient is and just kind of remembering – I know it's not intuitive, but under the waivers in effect right now under the hospitals without walls initiative, there are several places which may be determined to be part of the hospital for outpatient services.

And so to the extent that, you know, some place like the patient's home is where that visit is occurring. The hospital can bill for that. But outside of the patient being in the hospital, there is not a mechanism for the hospital to bill the full facility fee for that. There are rules about, you know, when the hospital's an originating site for a telehealth service, that have not changed. But I – am I answering your question about G0463, or was there another part to it?

Sue Thomas: I'm having trouble following. So, the patient is in their home and the doctor is in the provider-based clinic, which is the department of the hospital. So, in that situation, can the hospital bill the G0463?

Tiffany: No.

Sue Thomas: Okay. The confusing part about that is CMS saying their intent is to pay as they would have if it had been performed in person, so that seems to be true for places service 11 but not 19 or 22, and I don't understand why it would reimburse globally for non-provider based but not provider based.

Tiffany: Understood, and we're certainly looking to see whether there are additional flexibilities with the situation that you outline, but again, I think it's important for folks to be aware of the flexibilities that already exist under waivers regarding the provider based rules.

So, the hospital can certainly elect to make the patient's home provider-based to the hospital, in which case hospital service is furnished and end up provider-based department, which was the patient's home could be billed under Medicare. I know it's not intuitive.

Sue Thomas: Yeah, how we would do that? How would we make the patient's home provider-based?

Tiffany: Yeah, so all the provider-based rules have been waived. We are looking to put out more guidance on that, just because I think, you know, your questions are a great example that folks are like not really fully believing that the waiver's waived all of the provider-based rules. But they have, and so we think it can be helpful to get more guidance on that, so that's something we're working on.

Sue Thomas: I kind of feel like on one hand you're saying we cannot bill the G0463, but on the other hand we can if we call the patient's home provider based, but we just don't know how to do that.

Tiffany: Yeah, understood. It's…

Sue Thomas: Okay.

Tiffany: …something that we probably need to do some more guidance on. Thank you for that.

Sue Thomas: Great. One more quick question. We read about the CARES Act and that uninsured patients will have their – the provider's cost for delivering COVID-19 care will be covered for the uninsured, but we don't know what the logistics of that will be.

Operator: And the next question comes from the line of Mark McDavid.

Male: Just to – sorry…

Female: Sorry, we (inaudible)

Male: Yeah.

Tiffany Swygert: So, I don't know if we have anyone on the line who can answer. The question was about payment to hospitals for the uninsured, and guidance on that. I don't know if Mr. (inaudible) is on the phone.

Male: Yes, so this is about the 100 billion dollar fund and also the one billion dollar fund. I think CMS is not administering those, but we know that others who are involved in administering them are working on (inaudible) disposition of those monies with respect to the uninsured, so I – we can always pass on questions. I think the technical ones are the ones more likely to get answers. Obviously all of the are important, and I suggest that's what we have to offer.

Operator: Now you have a question from the line of Mark McDavid.

Mark McDavid: Hello, this is Mark McDavid with (inaudible) partners. Thank you so much for taking my call and holding this forum. I had a couple of questions. One related to the clarification you issued on 4-21 entitled COVID-19 emergency declaration blanket waivers for healthcare providers, posted on the 21st. And you refer – and on page 9, to the three-day prior hospitalization as well as the 100 day a second benefit period.

So, essentially, the 1135 and the 1812 waivers. My question is, if we had a patient who exhausted their 100 days and they met the criteria for the waiver, if the day was day 100 and we continue to need to bill them, would tomorrow

be day 1 of the new benefit period, or do we have to have a one day break in order for them to access the new benefit period?

Male: So, I would point you to a number of the FAQs that are related to the three-day waiver, and take a look at those in terms of the specific scenario that you're describing and see how you would apply that.

Mark McDavid: Yeah, so there's a group of us that are trying to interpret those, and that's why I'm asking the question now, I guess, is because we all have differing opinion. Some are saying you need a one-day break because you have to end the previous benefit period. In order to do that, you have to start the 60-day break. And others are saying, well, you just – you would just roll it into the next benefit period, you don't have to start ending. But the language is confusing because it talks about beginning to end a benefit period.

Male: So, part of what you need to consider here is the particular skilled need of the beneficiary, and so I would – I would again – I would point you to the particular FAQ where what we describe here is that if the patient has a continued skilled care need such as a feeding tube that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the waiver as it is this continued skilled need care in a SNF rather than the emergency that is preventing the beneficiary from beginning the 60-day wellness period.

Mark McDavid: Understood. And so my – I guess my question I tried to clarify was if we meet the criteria in order to apply the waiver. So, let's say it's a COVID patient. The (inaudible) COVID at day 95 of their 100 days currently and their condition is such that we can skill them for the COVID diagnosis and the symptoms that are related to that. We exhaust their 100 days. At day 100, being today, is tomorrow a day 1 of a second benefit period, or would I have to have a one-day break?

Male: So, if you would find a scenario where this would apply, then the next period would be day 1.

Mark McDavid: So you wouldn't have to have the one-day break?

Male: That's correct, as long as what you're describing would fall within that waiver and does not apply here in terms of the continued skilled care need that's unrelated to the emergency.

Mark McDavid Understood. Okay. One other question, about a patient who has tangential diagnosis related to the COVID emergency. Long-term care patient who is in our building and we previously used say 90 days of their benefit and now they've started that 60-day break and we're in day 15, and they get pneumonia. We would normally have sent this patient out.

They probably would have had three days in the hospital and they would have come back. But the physician and the clinical team decided we can care for this patient in-house. They do not have a COVID diagnosis, but we didn't want to send them to the hospital because the hospital is overrun with COVID patients. Would the waiver apply here, because the tangential relationship of the emergency? Or because the patient doesn't have the COVID diagnosis, the waiver doesn't apply.

Male: So, we haven't opined on every particular scenario here because we do think that in many cases this applies to the particular circumstances of the community and …

Mark McDavid: Sure. Okay.

Male: … just would probably point to you that as kind of a broader framework with which to consider that particular question. We – you know, we – the primary purpose of this waiver is to help with the surge capacity in the hospitals.

Mark McDavid: I understand.

Male: And so, you know, certainly if you're seeing situations where the hospitals are overwhelmed and are not in a position to necessarily bring in patients, if a patient can be treated in another setting, we certainly recognize and understand that.

Should we be – should the community be in a different type of phase or a different type of circumstance, which we certainly hope all communities can

get to very shortly, we – you know, would probably recommend you think about it in that kind of context.

Mark McDavid: Absolutely. That makes a lot of sense. Thank you so much. I appreciate it.

Operator: And the next question from the line of Irene (inaudible).

Irene: Hi. Thank you so much for your time. My question is about modifier emergency declaration was effective on 3/13, that said that patients would not be eligible to cost sharing. We see that the modifier is effective 3/18. So my question is what happens between 3/13 and 3/18 for the patients that we have the COVID on.

Diane Kovach: So, this is Diane Kovach, I can just jump in. But I'm afraid I don't have all the documentation in front of me, but the – if the effective date is 3/18 then it would be from that day forward that cost sharing is not applied.

Irene: Thank you. That is – I understand that and how do we handle and how does it – how will it work for the patients between 3/13 and 3/18, when it was publicized to them that cost sharing was not applied, but then it will applied and we'll be billing them for their portion of it.

Male: Can you tell us a little bit more about the reference to what the – what was said and where in regards to the two different dates?

Irene: Yeah, so, President Trump emergency declaration was published on 3/13, was stated that patients wouldn't be responsible for copayment, co-insurance and cost to them essentially aspect of 3/13 which is (inaudible) but his announcement for emergency declaration was on 3/13. So patients are – if I was a patient, I would assume that effective that date, I would not have cost sharing for services related to COVID.

But if the modifier to 3/18 and we've been performing these consultations, you know, before then, how would – and they call to complain that they shouldn't be responsible for, you know, a bill or whatnot. How do we explain to them that just because it was announced on 3/13 means it wasn't effective until 3/18, or just the dates are a little bit off to me. It could my interpretation.

Male: I think we should take a look at the documents here referencing – I don't – the content and the description don't match in my head, but we should take a look at what they are and see if we can answer your question, for sure.

Irene: Thank you so much. I appreciate that. And then I had one quick question. If we are reporting the CS modifier on the EV E&M, do we have to look for the 876 – yeah, 6735 or the "U" code on the same claim, or is that not mandatory?

Male: I don't know that we have the answer to that one. Your question is about whether you need to put it on the same claim or whether or not you can submit it on different claims but for the same day.

Irene: Yeah, no, so, scenario is we have tested a patient for COVID, we did a swab, we sent it to the laboratory and the laboratory say that the specimen was not sufficient for testing, so we wouldn't be charging the patient for the lab portion of it, but it would still, you know, be a COVID related visit, so we would report a CS modifier on the E&M with it. Would that be okay?

Tiffany: Hi, this is Tiffany. So, the law says it results in an order for or administration of the lab test and so I think – and I'm – I was – I think only caught part of your question, but if I'm understanding you correctly, the fact that the test was ordered is what's important here. Does that answer your question?

Irene: Thank you so much. Yeah. Thank you so much. I appreciate your time.

Female: And we'll take one final question, please.

Operator: Yes. Your final question comes from the line of Kate Miller.

Kate Miller: Hi. Thank you for taking my last question. This is in regards to the intensity of therapy requirement that was waived both in the CARES Act and then in subsequent CMS guidance. And I want us to know whether this is specific to the intensity of therapy provision related to the three hours of therapy per week or per day or (inaudible) hours per week, or other provisions in that regulatory exception. For example, that the patient would have to be under the supervision of a rehabilitation physician.

Male: Yeah. So, what you're referring to is the – what's generally recognized to be the three-hour rule or three hour rule waiver that applies to what's generally recognized as being industry standard for 15 hours per week of intensive rehab therapy in an inpatient rehab facility. And that waiver is specific just to that provision of the regulatory text. The other provisions are conditions of payment and we do not have the authority to waive that absent rule making.

Kate Miller: Got it. So just to make sure we're clear when we get our – talk to our members, the intensive therapy requirement related to the three hours a day is waived but the other subsections of that regulatory exception, the patient still has to require active and ongoing therapeutic intervention of specific therapy (inaudible) sufficiently stable at time of admission and require specific supervision by rehab physicians, those all remain (important).

Male: That's right. At this time, absent any change in rule making, those requirements would remain in place.

Kate Miller: Okay. That's very helpful. Thank you.

Alina Czekai: Thank you for your question, and thank you, everyone, for joining our Office Hours tonight. We really hope you find these calls to be helpful resources as you're navigating COVID-19 in your local communities.

Our next Office Hours will take place next Tuesday at 5:00 pm Eastern, and in the meantime, you can continue to direct your question to our COVID inbox, which is covid-19@cms.hhs.gov. And a recording and a transcript of this call will be posted very shortly on the CMS podcast page, which you can locate by going to cms.gov, clicking on the coronavirus icon and scrolling to the bottom of the page.

This concludes today's call. Have a nice evening.

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