Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
December 08, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 3129517

Operator: Good afternoon and welcome to the CMS COVID-19 Office Hours. My name is (Celine) and I will be facilitating the audio portion of today's interactive broadcast. All lines have been placed on mute to prevent any background noise. For those of you on the stream, please take note of the options available on your event console.

At this time, I would like to turn this show over to Stefanie Costello. Please go ahead.

Stefanie Costello: Thank you, and good afternoon. Thank you all for joining our December 8th CMS COVID-19 Office Hours Call. We appreciate you taking time out of your busy schedule to join us today. My name is Stefanie Costello and I'm with the Partner Relations Group in the Office of Communications at CMS.

Today's office hours is going to provide an opportunity for hospitals, health systems and providers to ask questions of agency officials regarding CMS's temporary actions that empower local hospitals and healthcare systems to increase hospital capacity to CMS hospitals without walls, rapidly expand the healthcare workforce, put patients over paperwork, and further promote telehealth and Medicare.

While members of the press are welcome to attend these calls, we ask that they please refrain from asking questions. All press media questions can be submitted using our media inquiries form which may be found at cms.gov/newsroom/media-inquiries. Any non-media COVID-19 related questions for CMS should go to covid-19@cms.hhs.gov.

We'll begin our call today. Now, so operator, if you can please open up the lines for our first question. Please keep your questions to one question or one question and a follow up. Thank you.

Operator: At this time, I would like to remind everyone in order to ask a question, press "star" then to number "1" on your telephone keypad. Again, that is "star" then the number "1" on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. We have our first question coming from the line of Rick Gawenda. Your line is open.

Rick Gawenda: Hi, thank you. In the final rule, I just want to confirm that we have those (leaves as they ticks) level two codes G2061 through G2063. And it's my understanding that effective January one, those will now become CPT codes 98970 through 98972. Just clarification that during the public health emergency, those CPT codes will still be able to be billed by facility settings like rehab agencies, hospital outpatient therapy departments, et cetera.

However, once the PHE is declared over, those codes that appears then can only be billed by providers that submit claims on a 1500 claim form, i.e. private practice. Is that summary accurate?

CMS – Ryan Howe: That is accurate. So, the policies that apply to those codes during the – we're establishing the interim rules during the public health emergency, will continue to apply into the New Year even though the coding itself has changed, and then those policies only apply through the end of the PHE. So, it's exactly as you as you described.

Rick Gawenda: OK, thank you very much.

Operator: We have our next question coming from the line of Barbara (inaudible). Your line is open.

(Barbara): Hi, thank you. In the final rule that came out last Tuesday, there's a couple of tables that have times for the CPT codes 99202 through 99205 that are different than the time is found in the AMA CPT manual. Are these times just for showing how the RVU were calculated or are these the times that are expected to be used when calculating these E&M codes?

CMS - (Emily): Hi, yes, this is (Emily). I can take a question. So, the times that should be used for purposes of level selection when choosing a level selection based on time are the codes or are the times that are listed in the CPT code descriptors. The

times that you're referring to in the rule that was to illustrate what we use for purposes of our rate setting process. So ...

(Barbara): That's exactly what I thought. Thank you.

CMS - (Emily): ... you should use it ...

(Barbara): Yes.

CMS - (Emily): OK, great.

(Barbara): Thank you very much for confirming that.

CMS - (Emily): No problem.

Operator: Next question coming from the line of (Slavka Bartolova). Your line is open.

(Slavka Bartolova): Hello, thank you for taking my question. Can you hear me please?

Woman: Yes, we can.

(Slavka Bartolova): Great. Thanks. My question is related to the skilled nursing facility that has a valid CLIA certificate to be able to perform the lab testing. And this is relating to the rapid testing that the skilled nursing facilities are doing for COVID-19. We are using CDC approved rapid test kits that some of them we received as free kits from the government, but now we ran out of it and they had to go and purchase a new kit.

Are we allowed to bill Medicare for these tests now? We are not really talking about the Medicare Part A residents because we know that that is included in the consolidated billing. But we are testing also residents that are not on a skilled level of care and they have Medicare Part B coverage. Are we allowed to bill for these rapid tests to Medicare for these residents? And if we are, what would be the appropriate code to use for that?

CMS - Demetrios Kouzoukas: So the tests that you're talking about, they are the ones that came from the department or they are the ones that – is that the scenario talking about or is it something (inaudible).

(Slavka Bartolova): The actual – we are actually using BD Veritor machines and then Binax cards. But they are not the cards that we received for free. We had to go ahead and we had to purchase additional supplies because we already used whatever was given to us for free. So that's what they're using. They are rapid tests.

And I was trying to look everything that was published on the COVID-19 testing. And I understand that they should be able to bill for this rapid test, but I just want to make sure that that's the case. And also, I'm kind of – the way I'm looking at it, we should be able to use U001 or U002 HCPC codes for that.

CMS - Demetrios Kouzoukas: OK. So, I think that – so, it's really not about tests that are purchased by the government and given away. And you're also – and your question is not necessarily about billing for residences that are in a non-Part A stay, but it's a coding question about this particular test in which code if it's under.

(Slavka Bartolova): It's really, are we allowed to do it or not? Are we allowed to do this billing? We're using rapid test and we are obviously not going to do – we are not anticipating really doing billing for any Part A residence because that is included in consolidated billing, but we have to test every resident in the nursing facility. And if we test somebody that is not on a Part A stay, but has Medicare Part D coverage, are we allow to bill for the test that we perform for this resident.

CMS - Demetrios Kouzoukas: And is it a tested for a reasonable and necessary diagnostic purpose or something else that we've – another sort of ...

(Slavka Bartolova): Well, it would be considered I guess for diagnostic, the skilled nursing facilities have now mandates when they have to test, right, everybody. And my understanding is that under public health emergency, there are certain things that have been waived in terms of really obtaining a physician order for diagnostic test.

So, we're really testing everybody in order to figure out whether they are COVID positive or not so we can call them and we can prevent further spreading of the infection.

CMS - (Holly): Ma'am, this is (Holly) from the division of nursing homes. Hi there.

(Slavka Bartolova): Hi.

CMS - (Holly): The testing I understand – the testing that you're referring to is outbreak testing, when performing outbreak testing in your facility, correct. That is required by CMS.

(Slavka Bartolova): Yes. Yes.

CMS - (Holly): Yes. OK. Unfortunately, I am not on the billing side. We're in, I mean, the division of nursing homes where we set the sub regulatory guidance. So, now, I understood what you were talking about. I don't know if that provides additional clarification for others from CMS on the call. But this is a CMS division or a nursing home requirement.

CMS - Demetrios Kouzoukas: So, we have a document that we put out that explained the application of the Medicare coverage criteria to nursing home situations. And (Tamara), you'll have to remind me or our caller here what it provided for with regards to outbreak testing or this kind of search scenario.

I'll say that it's best that you take a look directly at that document, because sometimes people use a term like outbreak testing and maybe they mean something different from what we were speaking to in that document or in other places. So, it's just important to make sure that you're thinking about this in an apples to apples way. But with that, I don't know if (Tamara), if you have more to share.

CMS - (Tamara): I think I have JoAnna Baldwin, who is really the expert here. I think she can give more on this one.

(Slavka Bartolova): OK.

CMS - JoAnna Baldwin: Hi. To echo what Demetrios said, if you want to e-mail the COVID mailbox, we can make sure we reply back to you with the educational information that we have out there about when testing is covered in the nursing home setting. We also have some further guidance that tries to clarify that when testing is appropriate in nursing home testing, may also very likely apply to other congregate living settings.

I think some of that information was distributed through our Medicaid chain of policies so we could get you that information as well. But the information that's being referenced does lay out the situations in which testing would be covered in the nursing home setting.

So I think that document will be very helpful for you. As far as which particular code to use for the test, I'm not the person that answers that particular question, but I am sure we could get that back to you as well.

(Slavka Bartolova): OK. So, what are you suggesting for me is to send you an e-mail regarding this?

CMS - JoAnna Baldwin: Yes.

CMS - Demetrios Kouzoukas: Yes.

CMS - JoAnna Baldwin: And then I will be able to provide you with the link that goes directly to the educational information that we have published about testing in that setting.

(Slavka Bartolova): OK. OK. All right.

CMS - Demetrios Kouzoukas: It's an online article, is what it is I think.

(Slavka Bartolova): Well, I have looked at the MLN 11815 and 11927. And reading through that, I don't think that that was that clear that I couldn't really establish or 100 percent kind or be 100 percent sure that that's what the case is.

I'm not sure if there is anything else, any other MLN articles that maybe I need to look at, but these two, I already kind of tried to educate myself on it,

but I'm not sure that I can 100 percent determine that that's what we should be doing.

CMS - JoAnna Baldwin: I'm sorry, I don't know that an online article by number, but we can make sure you have access to the one you referenced.

(Slavka Bartolova): OK. All right, so I don't hold you any further, I'll just send an e-mail, describe the situation and hopefully, you guys can get back to me with the educational material that we need. Thank you so much.

CMS - Demetrios Kouzoukas: Thank you.

Operator: We have our next question coming from the line of Kathy LaPierre with UCI Health. Your line is open.

Kathy LaPierre: Thank you for taking my call. On the 2020 E&M changes, when we're using time to choose the level of service, can we include resident time at that point in an academic center or do we – is it just teaching physician time?

CMS - (Emily): Hi, this is (Emily). So while I am sort of the person here who does physician payment policy on this call, I actually don't know the answer to this question, because it's not one of my subject areas. I don't know, Ryan, if you know, offhand, if not, we'll have you send it into the mailbox.

CMS - (Ryan): Yes, we can take a look at. It's a good question. I think it would be similar to the rules that would apply before the 2021 changes, but we'll take a look and make sure that we answer that question. Thank you.

Kathy LaPierre: Great. I'll send that to the e-mail then. Thank you.

Operator: You next question coming from the line of Tim Wolters with Citizen Memorial Hospital. Your line is open.

Tim Wolters: Yes, thanks very much for taking the call. On the CARES Act, section 3710 provides for a 20 percent increase in the DRG weight for inpatients with COVID. We are still a community hospital and so I wanted to test a couple of payments to make sure we were getting it. And we are getting the payment increase on our remittance advices, but it's not on the DRG weight.

I got a detailed PSR report just to confirm that and the DRG weight has not changed. What CMS is doing is adding it only to the payment amount. And I did check your FAQ's and on the current billing FAQ that's on page 33 of that 159 page document, question 10, confirming that we do get the add-on for our hospital specific rate.

The problem is that at year-end on our cost report, we have to file our final reimbursement based on the aggregate DRG weights for the year times our hospital specific rate. So what's happening right now what will happen is we'll get 20 percent throughout the year, but then we'll pay it all back on the cost report.

So, I wanted to check and see if CMS was even aware of this issue and or what's being done to correct it to make sure we get to keep our reimbursements.

CMS - Demetrios Kouzoukas: Could you elaborate a little bit on what you mean by pay it all back on the cost report?

Tim Wolters: Well, again, the DRG weights are not being increased 20 percent. Only the – we are getting the DRG weight times our payment rate and then 20 percent is being added to that payment amount, but the DRG weight is not changing. So, when we get to year-end, we're going to add up all our DRG weights, that's the way the cost report works for us.

Sole Community Hospital and Medicare-dependent hospitals for that matter, we take our toll DRG weights times our payment rate, and that's our total reimbursement for the year. And we compare that to what we got throughout the year and we pay the difference back or CMS pays us if we were underpaid.

But so in other words, because the DRG weight is not being increased, we're not going to get to keep that money at year-end. We're going to pay it all back. It'll just be our normal DRG payment unless CMS provides for a separate adjustment line on the cost report some way where we can claim that separately.

But we'd have to do that by literally going to our claims for the year and adding up all the extra 20 percent payment amounts. It's not shown anywhere. It's just buried in our payment amount.

CMS - Demetrios Kouzoukas: I see. Any error in SCH or MDH?

Tim Wolters: Yes. We're still community.

CMS - Demetrios Kouzoukas: OK. OK, its helpful to have that scope. I think we're going to have to take this one back, unless I've got anyone on the line who has got any greater insight to share now. OK. So, I apologize. We don't have an immediate answer on that one. I think we'll have to go and talk to our inpatient and folks in the folks who sort of work with the SCH and maybe even getting the cost reporting people.

Tim Wolters: OK.

CMS - Demetrios Kouzoukas: But we'll take it back.

Tim Wolters: Would it help if I sent an e-mail to the COVID-19 box or do you need more information?

CMS - Demetrios Kouzoukas: I think so. Yes. I think that would – it certainly wouldn't harm to make sure we get the question right.

Tim Wolters: OK. It's covid-19@cms.hhs.gov. Is that right?

CMS - Female: Yes, that is correct.

Tim Wolters: Yes. OK. All right. Thank you. Appreciate it.

Operator: Next question from Inice Rowe with Inova Health System. Your line is open.

Inice Rowe: Hi. Can you hear me OK?

CMS - Female: Yes.

CMS - Female: Yes we can.

Inice Rowe: OK, thank you. We're calling from a hospital system and we plan on administering the monoclonal antibodies in a hospital outpatient department, it's off campus. I'm trying to find out if the PO or PN modifier in L2310E address will be needed. And if CMS expects for the monoclonal antibody to be the only item on the claim, so like, for instance, if the patient had an injection or some other type of infusion during that same visit, would that have to be billed on a completely separate claim?

CMS - Diane Kovach: So, this is Diane Kovach, and I am not sure about the answer for whether or not it needs to be billed on a separate claim. So, unless someone else knows the answer to that, we might have to get back to you on that one. And I think it would be best to send that one in for us just to make sure we don't lose sight of it.

Inice Rowe: OK, and that would be for monoclonal antibody infusion that I'm referring to. And then what about the PO or PN modifier and L2310E address? Is that going to be required for that M-code infusion?

CMS - Diane Kovach: So again, I don't know that we have got anybody that can answer that question, unfortunately, on the call right now.

CMS - (Ryan Howe): Yes. Diane? I don't know if David here on the call, but the payment for the administration for those should be, I would think she'd be relatively consistent and therefore the modifiers wouldn't be required. But I don't know if (Davis), if you had to jump off. Otherwise, we can follow up on that one.

Inice Rowe: All right, thanks. So I send it to the COVID e-mail box, is that what you're saying?

CMS - Ryan Howe: Yes. Yes. Thank you.

Inice Rowe: OK, thank you.

Operator: For our next question coming from the line of Ardith Campbell with Vitalware. Your line is open.

Ardith Campbell: Hi. My question also has to do with the monoclonal antibody administration, and when the patient has a reaction, so for instance, let's say they get nauseous and needed the injection of Benadryl. Is that injection of the Benadryl supposed to be like an initial administration or should the add-on code be used?

And then a follow up question I have is, if the patient has a reaction and they have to discontinue the administration, would you want the M-code for the administration to be reported with modifier 52 for a reduced service?

CMS – Ryan Howe: So I think in both of those cases, we can take it back if you can send those questions in writing to the e-mail box. And I'd also recommend that you contact your MAC for particular coding guidance as it applies, but we will also take a look as well and certainly appreciate the question.

Ardith Campbell: All right, thank you.

Operator: For our next question comes from the line of (Christina) (inaudible) with (inaudible) physical therapy. Your line is open.

(Christina): Hi. Thank you. I was wondering is CMS willing to eliminate the plan of care signature requirement during the COVID-19 public health emergency. This is necessary because even during normal circumstances, compliance with physician signature requirements and poses a significant logistical and administrative burden for both therapy providers and physicians. It takes valuable time and resources away from delivering patient care. So, waiting for a plan of care certification can force delays of clinically significant care.

CMS - Demetrios Kouzoukas: I think we have at times had our colleagues from CPI on. I don't know if we do today. My brief recollection is that there may have been some kind of discussion or guidance we put out around electronic signatures or alternative means, either specific to the pandemic or otherwise.

But I don't know that – I don't know that we've provided the kind of flexibility you're looking for. We will have to pick that one back too, I think.

(Christina): OK, thank you.

Operator: We have our next question coming from the line of Kim Yelton with WakeMed. Your line is open.

Kim Yelton: Hi, yes. I just have a general question in regards to hospital at home and being able to bill those patients as inpatients and kind of how would you bill for room and board. So, basically, just a general analysis of that if I could get it? Thank you.

CMS - Demetrios Kouzoukas: What we've said on hospital at home billing is that the billing would work just like other inpatient billings in terms of the amounts and the codes. And I don't know if that answers your question, but that there isn't – the thought is that this is representative of the entire DRG payment amount that would normally be given in the traditional hospital, the services being provided in this circumstance under essentially a waiver of certain limitations that relate to where the actual patient is located vis-à-vis others.

Kim Yelton: OK. So like for room and board, would you consider that the normal inpatient rate per se or like an adjusted rate for them being at home?

CMS - Demetrios Kouzoukas: No. Our plan and intent is to pay the normal rates just like we would if the patient were literally in the hospital.

Kim Yelton: OK. Perfect. Thank you so much.

Operator: For our next question coming from the line of Heidi Sylvia with Rhode Island Hospital. Your line is open. Heidi Sylvia, your line is open. You may ask your questions.

Heidi Sylvia: Hi, thank you. I had a question regarding patient being discharged and transferred to our alternate care facility, our temporary hospital. We just wanted to understand what discharge disposition we should be using if the transfer is happening not between the same NPI or does it have to be?

CMS - Demetrios Kouzoukas: And the question is around the coding?

Heidi Sylvia: The discharge disposition coding, the transfer code on the acute hospital claim where we're moving a patient from a hospital to an ultimate care facility, still in an acute level, but freeing up said at the post hospital.

CMS - Demetrios Kouzoukas: I think we're taking this.

Heidi Sylvia: Yes. I did see some documentation when they created the new source code referencing 69, but it wasn't clear in the documentation.

CMS - Demetrios Kouzoukas: I think we'll have to take this one back some as well.

Heidi Sylvia: OK. Thank you.

Operator: We have our next question coming from the line of (Liz Clark) with UC Davis Health. Your line is open.

(Liz Clark): Thank you for taking my question. This is in regards to the acute hospital care at home program. So, I understand from the earlier question that the billing would be just like other inpatient billing.

But my question regards, do we have to notify CMS or the Medicare administrative contractor of the addresses of the patient's home where the inpatient care will be provided or is it going to be treated like other inpatient areas, search locations, that as long as we're billing under the hospital CCN number we don't have to notify you.

CMS - Demetrios Kouzoukas: That I don't know. Diane, I don't if you have a (inaudible) (pitch) it over to our acute care colleagues.

CMS - Diane Kovach: Yes. I think that probably those folks would have to answer this question.

(Liz Clark): OK. So should I submit it to the COVID-19 question or website rather?

CMS - Demetrios Kouzoukas: Yes.

(Liz Clark): OK. Thank you very much.

Operator: Now, our next question coming from the line of (Jennifer Goth) with Texas Health Physician. Your line is open.

(Jennifer Goth): Hi. Yes. I was just checking to see if we're able to bill a separate E&M service for patients who are receiving the (inaudible) infusion service, if the facility is delaying MO239. Could you hear me?

CMS – Ryan Howe: So, you're talking about the infusion of – you're referring to the infusion of the monoclonal antibodies?

(Jennifer Goth): Yes.

CMS - Ryan Howe: Sure. So, the same rules would apply as vaccine administration. So, to the extent that there's a separately furnished evaluation management visit, then a separate code to be reported.

(Jennifer Goth): OK, great. Perfect. Thank you.

Operator: You have our next question coming from the line of (Joyce Good) with Essential Health. Your line is open.

(Joyce Good): Yes, good afternoon. My question is related to first of all the vaccine and antibiotic codes. The bulletin that was released said that CMS is saying that we shouldn't bill for the actual vaccine or antibody on the claim. But the fee schedule amount is set at a penny. CMS has never allowed us to bill for an admin fee without a corresponding vaccine or medication.

Do you want us to submit the vaccine or antibody with the penny and then put it in the non-covered column similar to the MedLearn Matters article that talks about products that are received for free?

CMS – Diane Kovach: So we – if you're getting the vaccine for free, then we do want you to leave report the administration and go for that on the claim. The reason instead of depending on the fee schedule is in the event that someone would go for it, and we would not be paying for it, but the preference is that you only submit the administration.

(Joyce Good): So I had called NGS about this and they told me to put the penny on according to the MedLearn matters 10521 that was updated in 2018.

CMS – Diane Kovach: OK. We will certainly make sure that the MAC's are all saying the same thing here. We can specifically reach out to NGS on this issue.

(Joyce Good): OK.

CMS - Diane Kovach: Thank you.

(Joyce Good): So you're saying no penny on the claim.

CMS - Diane Kovach: We're saying don't sell for the vaccine itself when you get it for free so you can put it on the plan.

(Joyce Good): And you even instructed the MAC to pay an admin fee without a product because they've never done that before.

CMS - Diane Kovach: Yes, we have.

(Joyce Good): OK. And then the other question is for the antibody. The bulletin says that CMS is going to be processing this just like other vaccine claims and waiving co-pays and deductibles. So the question is, if the antibody is administered to an inpatient who isn't – their primary diagnosis isn't COVID-19, but they could benefit from it, should we be creating a one to one claim separately for the antibody to be billed separate from the DRG similar to the vaccine?

CMS - Diane Kovach: Yes, you should.

(Joyce Good): Is there a reason that wasn't put in any of the bulletins?

CMS - Diane Kovach: I don't know, but we can certainly look into that and see if we can do an update.

(Joyce Good): Yes, that would be great. That's my question. Thank you.

CMS - Demetrios Kouzoukas: We have some FAQs that we are hoping we can get out that just provide a little bit more direction and guidance around how the monoclonal

antibodies are treated. And I think the bottom line point is that if you look at the vaccine toolkits, it's a bit unconventional because we don't normally think of something like a monoclonal antibody treatment as a vaccine, but that is the route that we went with in terms of being able to pay for the service and item. And so the vaccine guidance is generally applicable to the situation as well, if that's helpful until the guidance comes out in writing and you can see that too.

(Joyce Good): Thank you. Appreciate it.

Operator: We have our next question coming from the line of Dr. Judy Neff with St. Elizabeth Healthcare Group. You line is open.

Judy Neff: Hi. Thanks for taking my question. One is I just want to report an issue, and the other one is to ask if CMS has any advice or assistance for it. Our healthcare system has just over the last week started getting denials from Medicare Advantage plans for COVID admissions including medically necessary admissions where people or patients have been administered remdesivir.

And so just over the last couple weeks, we've had – now, we're up to nine of these roll in where the Medicare Advantage plans are wanting us to accept observations that is when we all know IV remdesivir is a five day course. But – so one, I wanted to report that to CMS. And because certainly putting us through an appeals process is not consistent with CMS action of trying to put patients over paperwork.

And second, besides reporting it, I'm just wondering if there's anyone specific at CMS who can work with me on that or give me some advice on how to deal with that.

CMS - Demetrios Kouzoukas: You could reach out to our Chief Medical Officer for Parts C and D, Jeff Kelman.

Judy Neff: OK.

CMS - Demetrios Kouzoukas: And he can – if there's something that is sort of a particular issue, he keeps an eye on some of this kind of thing. Obviously, the application of to

midnight rule and sort of inpatient outpatient is not directly trans... it doesn't directly translate in the same ways in the MA.

Judy Neff: Correct.

CMS - Demetrios Kouzoukas: So it's – that there's also a question of how the plan approaches it, what your contract with the plan is like, and all the rest. But I think if you want to send, Jeff, Dr. Kelman, an e-mail and just let him know what you're seeing, it's always useful and good for us to know. And then obviously, if you have trouble with the appeals process, that's something that we do.

Judy Neff: Yes. I know you have the Medicare complaint process, which with Medicare Advantage, that's not – we've not found that to be very helpful in the past, because it sort of hands off if you are a contracted provider. But I just – some of these denials are just egregious. Most of the Medicare Advantage plans use MCG as their criteria and these cases meet MCG, but they just don't think the intensity of services there or they weren't hypoxic enough or for long enough.

So the reasoning is very scattered and not very medically sound. So, I wasn't – I don't know if other healthcare systems are having this problem or not, but I just wanted, one, to report it. Number two, hopefully get a contact to help me deal with it. So do you – is there a specific e-mail where I can reach him at?

CMS - Demetrios Kouzoukas: Maybe (Gel), can get you his e-mail after the call or you can drop us a line. But that's the name so, I can't give them you that much and then ...

Judy Neff: OK. So what's your e-mail that I can send a reminder if I don't hear back when you say drop us a line.

CMS – Stefanie Costello: You can use the partnership box. It's partnership@cms.hhs.gov and just put a little sentence that you'll need his e-mail address and we'll get that to you.

Judy Neff: OK, that'd be great. Thank you.

CMS – Stefanie Costello: Welcome.

Operator: We have our next question coming from the line of (Dawn Ricks) with Northern Healthcare. Your line is open.

(Dawn Ricks): Hi. Thanks for taking my question. I do have a question about the – it's concerning the 2021 Physician Fee Schedule E&M changes and specifically the code G2211. That's for the chronic condition complexity add on to the E&M codes. Can you give me maybe an expanded description or expectation of what that code to represent G2211 visit complexity chronic conditions?

CMS - (Emily): Yes. So, this is Emily. I don't think that we can say anything more specifically right now than what is in the rule. I know we tried to provide some additional clarification and provided some clinical scenarios as well. But beyond that information, I don't know – I don't believe that we're really in a place to say anything else at this time.

But we understand that there's still confusion about what that code should be used for and we certainly look forward to issuing additional guidance.

(Dawn Ricks): OK. You mentioned the clinical scenarios. Where are they?

CMS - (Emily): Unfortunately, I don't have the page numbers right in front of me, but they're certainly in that section – in the E&M section itself, but I realized that there's a lot of pages. So, if you can't find it, please send a note to the COVID box and I can – and they'll certainly route that along so that we can find specifically where it's at for you.

(Dawn Ricks): OK, All right. Thank you.

Operator: We have our next question coming from the line of (Linda Clark) with the Inova Healthcare. Your line is open.

(Linda Clark): Hi. So, if it were administering the antibody and the patient has an advantage plan, we're going to have to separate that infusion administration charge out to fee for service and we might have other incidental. Are the Medicare Advantage plans going to accept the claim if we were to just have incidental or would we just not be able to bill for those?

CMS - Demetrios Kouzoukas: So that would depend on the contract you have with the Medicare Advantage plan and the agreement that you've entered into about how you'll be paid for various services and under what kinds of schedules or coding and the like.

(Linda Clark): OK.

CMS - Demetrios Kouzoukas: Assuming you're in network. If you're out of network, then it would be treated just essentially in the payment – put away that fee for service (inaudible) works.

(Linda Clark): Yes. It would be a network for certain, most likely anyway. One other question. Do you have any idea of when the MAC might have the rights for all of the new COVID test? They don't seem to have that information yet.

CMS - (Sarah Shirey): Hi. This is a (Sarah Shirey). We can certainly reach out to them. I know that we have a guidance on our website with all of the MAC prices for the various COVID tests and we are in the process of making updates to that table. But we can check in with the MAC's as well, but they can give you the prices for the tests that they're pricing as well.

(Linda Clark): OK, thank you.

CMS - (Sarah Shyrie): Sure.

Operator: Our next question coming from the line of Brenda Schwilke with UW Medicine in Seattle, Washington. Your line is open.

Brenda Schwilke: Hi. Thank you so very much and I really appreciate you guys continuing to have these calls. I do have two questions. Very easy. It should be very straightforward. Going back to the actual not wanting the vaccine on the actual claim, my question is, if we put the vaccine on the claim with a zero dollar charge and an SL modifier, will you accept that? That's the first question. So I'll – and then I'll ask my second question after I get the answer.

CMS - Diane Kovach: So, if you're talking about claims for physician or non-physician practitioners on a professional claim, then no ...

Brenda Schwilke: No, facility aside. Sorry. Yes,

CMS - Diane Kovach: Facility? So, I know for facilities there are instructions on how to build for no pay services in our manual. I don't know the specifics of those. But (inaudible) facility.

Brenda Schwilke: So, (inaudible) modifier well. And so, triggers you guys to say don't – we got it for free.

CMS - Diane Kovach: Right. But I will say – but the penny charge does need to be on there.

Brenda Schwilke: Is there is the Excel modifier is what you're saying. I got it. OK. Fantastic. That's easy. Second question. I know that the COVID-19 vaccines are going to be the administration, maybe clear, administration, for people who are in patients who are hospitalized is going to be a separate payment in addition to the MSE or junior the DRG that were paid. My question is about that claim. Do you want it on a 12X bill type or a 13X bill type?

CMS - Diane Kovach: So I am not sure the answers. I'll hear – somebody – yes, I was waiting for somebody to give me the answer because with a 12X to fill in patient.

Brenda Schwilke: OK, great. You were like, yes. So, if you responded to IM total. OK, 12X (fill type). I've been there, trust me. Fantastic. Thank you so very much. Have a fantastic day.

CMS - Female: Thank you. You too.

Operator: We have our next question coming from the line of Kim Yelton with WakeMed. Your line is open.

Kim Yelton: Sorry, I just had one additional question. So, back with the hospital at home, billing the room and board. Do you know what revenue codes we would use associated with that?

CMS – Michelle Hudson: Hospitals should build the same revenue codes that they would use on any other alternative settings for inpatient care?

Kim Yelton: OK. May have an additional question to that, but I can submit it through your e-mail.

CMS - Michelle Hudson: Great, thank you.

Operator: We have our next question coming from the line of (Liz Clark) with UC Davis Health. Your line is open.

(Liz Clark): Thank you. This is in regards to provider based departments relocating to a patient's home during the PHE. And I understand that if you want to – if the hospital wanted to continue to be an accepted provider-based department, they have to seek a temporary extraordinary circumstances relocation request.

But in those cases where the hospital does not wish to seek that relocation exception request and the hospital bills with the PN modifier, is the hospital required to report the patient's home address, the claims as the service facility location in those cases?

CMS - Male: So if they're just going to build the PN modifier as a non-accepted off campus provider based location, they don't have to submit a temporary extraordinary circumstances relocation request that includes the patient's home nor do they have to include it on the claim for the address.

(Liz Clark): OK, because typically if you're doing anything in an off campus provider based location, you have to report the service facility location, but I'm understanding that during this PHE, we would not have to list each patient's individual home if we choose to just bill under the hospital's address with the PN modifier. Is that correct understanding?

CMS - Male: Correct. The address would be the department that is billing the service.

(Liz Clark): OK. Great. OK. Thank you very much.

Operator: For our next question coming from the line of Gretchen Case. Your line is open.

(Gretchen Case): Hi. Yes. I just wanted to go back to the question with regard to the antibody infusions and not charging for the drug even with a one-cent charge. If we use

the regular – I'm not quite sure how they'll do that because normally even eating built billing systems require the presence of the drug if you have an infusion.

Perhaps it's because of the unique N code, but that's just historically (inaudible) in other words, for normal billing processes. Do you have any more details on that?

CMS – Diane Kovach: Just that we have directed our contractors to be able to process the claims with just the injection or infusion without the actual vaccine or monoclonal on the bill. The reason being ...

(Gretchen Case): OK. I thought I heard earlier somebody mentions it, for the vaccine you would put the one cent charge.

CMS - Diane Kovach: If you bill for it as non-covered, then yes, we need you to include the one cent charge.

(Gretchen Case): If it's non-covered, OK. Just for information, there are not just the contractors that will have to make that adjustment. There are a lot of provider billing logics and all of our clearing houses and billing systems that have catches for where missing drugs, if you will. So that's going to have to be a lot of work on the provider side to get billing systems to allow that to happen as well.

CMS - Diane Kovach: So, as we said, the provider, you can go for it as long as you both (inaudible) as none-covered. It's different on the institutional side than on the provider side, because the institutional systems actually have the capability as systems to accept these none coverage charges where we actually do not on the professional claims processing system side.

So it's not our intention to make this more difficult for you. And so, you can continue to follow the non-covered items for your billing.

(Gretchen Chase): OK.

CMS - Diane Kovach: I mean, (it's true) outside.

(Gretchen Case): OK. Got it. Thank you. That's helpful. Thank you.

Operator: We have our next question coming from the line of (Shay Vaughn). Your line is open.

(Shay Vaughn): Hi. Thank you for taking my call. Regarding the (scan this) update to SD 2016 on new and expanded flexibilities for RHC and F2HC. In states that the MACs we're going to automatically reprocess claims with Hickspicks code G2025. For services published January 27th through November 16, 2020.

I wanted to know if – how can we expect those reprocess claims to look? Are there going to be certain parks and large, you know, adjustment reason codes and with those reprocess claims? And if so, do you know what they are?

CMS - Diane Kovach: I do not know what they are off the top of my head. There would be some indicator that the claim has been reprocessed, but I don't know that off the top of my head. So, if you could send that question in, then we could certainly help you with finance. That information.

(Shay Vaughn): OK. Great. I'll do that. Send that to the COVID e-mail.

CMS - Diane Kovach: Yes, please.

(Shay Vaughn): OK. Thank you.

CMS - Female: Thank you.

CMS - Female: And operator, can we take our last question, please?

Operator: Yes, we have our last question coming from the line of Ronald Hirsch with R1. Your line is open.

Ronald Hirsch: Hi, I'm honored. So two questions. Of course, one, actually they're both follow ups. The first one is that someone asked whether they could give monoclonal antibody to an inpatient where it's indicated to them because they're hospitalized for something else. That would still violate the FDA emergency use because it's only indicated for outpatients.

So although it could be billed on a one to one, I'm just wondering whether that's allowed. And maybe that's just something for you to contemplate. So let's – we'll leave it at that. My second question really is about pricing on the hospital at home issue, in the room and board charges. And that one of the concept is that hospitals must set their prices properly to reflect their actual costs.

And then that gets, of course, your whole cost charge ratio, yada, yada. But if the patient is at home, it is not the same cost that they're incurring if a patient is in a bed in a hospital. So, again, do you do want us to falsify documents and put a room charge like use a medsurg bed or a tele bed or an ICU bed and just use the normal charges we use or should we set a different price for that line? Use it as a med surcharge, but call it med surge at home?

CMS – Michelle Hudson: So for the second part of your question regarding billing room and board under hospital at home, you're exactly right. You should be – your charges that are reported on the bill should be related to the cost of the services and we certainly aren't asking for you to falsify anything. It's just you should be accurately reporting your charges.

Ronald Hirsch: So use like a med surge revenue code, not ICU, and then just come up with a number to try and accurately reflect the one nurse visit and the two phone calls or (inaudible) paramedic visits etcetera. OK.

CMS - Michelle Hudson: Yes.

Ronald Hirsch: Thank you.

CMS - Demetrios Kouzoukas: Yes. I think that with the hospital at home, the point is more that we're we don't – we're thinking of it as an inpatient admission. It's not a sort of a special subcategory. And so our usual rules around inpatient admissions would apply, including the ones that you were just discussing with Michelle, if that helps.

And then I think on the question of the EUA, and the terms of the EUA. We'll note that as something to be – that's an interesting and good point. I will say that the definition of the FDA label and what CMS considers to be inpatient

outpatient, and what's billed under inpatient, outpatient, you know, including within a certain number of hours of an inpatient admission and are discharged in the like that those all can be have subtly different meanings. And so, even though they have very similar words, so just worth noting that right.

Ronald Hirsch: Yes. You don't need to tell us they're confusing. We know.

CMS - Demetrios Kouzoukas: I didn't mean it that that way, but that is true as well.

Ronald Hirsch: Yes. Thank you all.

Demetrios Kouzoukas: All right. Well, thank you. I know, we got a few questions I think that we couldn't take on the call or answer on the call, but I think that this reflects our desire and need to give you feedback that's helpful. And I know that a number of these have prompted us to – or ones that were – we we've either heard or will hear are working on it even as we speak. So, let's appreciate the questions and thank you all for calling and sharing them while I'm doing it to answer them as best we can.

Stefanie Costello: And I'm going to plug one more. We do have another call this week on the hospitals without walls initiative. So, there might be some of your questions answered. It's taking place tomorrow, Wednesday, December 9th at 4:00 p.m. And if you didn't get that call information in your invitation this week, you can e-mail partnership@cms.hhs.gov.

And we also have that information posted on our coronavirus COVID-19 partner toolkit on cms.gov. So you can call into that if you are looking for additional information. If not, thank you again for joining us for today's office hours. Additional questions related to COVID-19 may be submitted by e-mail at covid-19@cms.hhs.gov.

And the recording and 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 image and scrolling to the bottom of the page. Thank you and have a good evening.

Operator: This concludes today's conference call. You may now disconnect. END