Centers for Medicare & Medicaid Services
COVID-19 Call with Ambulatory Surgical Centers and Freestanding EDs
Moderator: Alina Czekai
April 30, 2020
12:00 p.m. ET

OPERATOR: This is Conference #: 4366486

Alina Czekai: Hello, thank you for joining our April 30th CMS COVID-19 call for the Ambulatory Surgical Centers and Freestanding EDs. 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 Administrator Seema Verma, here at CMS.

Today we are joining by numerous CMS subject matter experts who are here to answer your questions. I'd first like to turn it over to Eric Miranda-Marin at the Center for Medicare. Eric, over to you.

Eric Miranda-Marin: Thank you, and good afternoon everyone. Let me begin first by thanking each of you for the work you guys are doing, so make sure you are continuing to treat patients and contribute your resources to the healthcare system during this time. I'd also like to thank you all for joining us to discuss the flexibilities that the Department and CMS have rolled out to ensure that ASCs and Independent Freestanding Emergency Centers are able to contribute their resources as we work to address the COVID-19 public health emergency.

Our healthcare system is evolving rapidly to confront the challenge this new virus poses. Ambulatory Surgical Centers and Independent Freestanding Emergency Centers and other provider sites have a critical role to play in facilitating this evolution. This call is our opportunity to more fully address some of the questions we have received about the changes we have recently made, as well as an opportunity for us to address additional situations you may have encountered over the past several weeks.

We are listening to stakeholder feedback on these programs and on the situations you are encountering, and we are diligently working to address the feedback we receive, as the healthcare system rapidly evolves to meet this

moment. We have provided a number of flexibilities to ASCs and Independent Freestanding Emergency Centers to ensure that we are able to capitalize on their capacity and the extraordinary capabilities that they have to treat patients.

The CMS Hospitals Without Walls initiative allows ASCs and IFECs to treat patients under arrangement, with a hospital or to be temporarily become a provider based department of the hospital to allow for more rapid triage and treatment of patients in the setting based best suited to their needs.

Alternatively, ASCs and licensed IFECs are now able to enroll as hospitals through an expedited enrolment process, so that they can perform the full range of services for which they are appropriately resourced. We expect these changes to ensure that hospital capacity is reserved for the most complex patients, or for patients suffering severe cases of COVID-19.

We recognize that ASCs and IFECs are not typically large facilities, and particularly in the case of ASCs, the suspensions of elective procedures, which we recommended and which many of you diligently complied, have resulted in financial challenges to your ability to continue operation.

I hope that those of you who needed assistance in this regard were able to access resources that were available in our Advanced and Accelerated Payment Program. For those of you who have not yet accessed these funds, we are no longer accepting applications for the advanced payments for part B suppliers, and we are re-evaluating all new and pending applications for our Accelerated Payments Program.

Funding will continue to be available to hospitals and other healthcare providers on the frontlines of the coronavirus response, primarily from the Provider Relief Fund. Unlike financing provided through the Advanced and Accelerated Payment Program, these funds do not need to be repaid.

If you are interested in learning more, or if you require additional liquidity, please visit hhs.gov/providerrelief. We look forward to a continuing dialog with each of you, as the healthcare system continues its evolution to allow

providers to focus on care, and to empower patients. The feedback we receive on this call and through the numerous other communication channels we utilize will ensure we have a robust framework in place for the healthcare system to utilize its full capacity to treat patients.

At this point, I'd like to turn the call back to Alina, our moderator, so that we can hear your questions, your comments, and your concerns. We have an amazing team joining us on today's call, and while I cannot guarantee immediate answers to every question, I hope our dialog yields insights which we can take back to address. Thank you again for the amazing work you are doing to treat and care for patients during these challenging times.

Alina Czekai: Great, thanks, Eric. Operator, we'd like to open up the call for questions from the line. Thank you.

Operator: At this time, if you would like to ask an audio question, please press "star," "1" on your telephone keypad. Again, that's "star," "1" to ask an audio question. We will pause for just a moment to compile the Q&A roster. And your first question comes from, the last four digits of the phone number are 4149. Please proceed with your question.

Male: The question is regarding COVID-19 testing for patients getting elective procedures that are a new requirement after May 11th. Is this for all elective procedures, emerging procedures, and what is the protocol put in place?

Eric Miranda-Marin: Could I ask you to just be a little bit more specific with your question? I don't know if they muted the line already. Tiffany, are you able to address that, or do we come back for more specifics?

Tiffany: I think we may need a little more detail. It sounds like the question is whether there is a Medicare requirement to test patients for elective procedures, so I think we would need a little more detail, as I'm not familiar with that requirement.

Operator: The line has withdrawn the question. And our next question comes from 0353.

Female: My question is, is there a waiting period between cases for sanitation, with known COVID-19 patients if we elect to take known COVID-19 patients for elective surgery?

Eric Miranda-Marin: Do we have CCSQ?

Female: I don't think that we have any federal Medicare guidelines on telling providers about a waiting period, that I'm aware of. I don't know if our colleagues on the clinical standards and quality side have any information to share on that.

Karen Tritz: So this is Karen Tritz from the clinical standards side. I guess I would defer to CDC guidance on environmental cleaning, and to address COVID. I don't know if others – if my colleagues have other information they'd like to share, but we don't have anything specifically, and we'd really refer to CDC guidance on that.

Michelle Schreiber: Hi, this is Michelle Schreiber, also from the clinical standards group. I agree with Karen to refer to the CDC guidelines. We did put out the phase one document last week about some recommendations for restarting care, but in terms of specific questions, we would also refer back to what the best CDC guidelines are. However, if you send in your question in particular, we can try to explore it further and get back to you.

Operator: Our next question comes from 8570. Please proceed with your question. The question has been withdrawn. Our next question comes from 2395.

Female: Yes, my question is, is it mandatory for COVID testing to be performed on all patients?

David Wright: Hello this is David Wright, we do not have a requirement in place that requires COVID testing for all patients, unless somebody has information (inaudible).

Female: OK, thank you.

Operator: Our next question comes from 0730. Please proceed with your question if your phone number ends in 0730.

Female: My question is, is there a resource for securing PPE as we have been under severe allotments?

David Wright: This is David Wright again, what we typically have done is referred providers to their local or state health departments in terms of coordinating with them to secure supplies through the state. We don't have a role in the distribution of PPE directly through CMS.

Operator: Our next question comes from 9570. Please proceed with your question. The question has been withdrawn. Our next question comes from 6220. Please hold for your next question. Your next question comes from Ashley Green. Ashley, please proceed with your question. The question has been withdrawn. Your next question comes from Kara Newbury.

Kara Newbury: Hi, everybody. This is Kara Newbury with the Ambulatory Surgery Center Association. I first just wanted to say how grateful we have been for the tireless work that's been done by CMS during this time, from Administrator Verma down, so thank you all for your help.

I did want to ask a two-part question. Do you have any sense of how many ASCs have gone the route of enrolling as hospitals, under the Hospital Without Walls program, and is further guidance coming on that program? I know that one of the attestations speaks to 24/7 nursing and if the facility does not plan on being open 24 hours a day, seven days a week, so I just wanted to see how that was being handled. Thank you.

Male: It sounds like, maybe (inaudible) and then David.

Alisha: Hi, this is Alisha in Provider Enrolment, so I think we've seen about a dozen applications that have come in where the ASC is looking to convert to a hospital.

Joe: I was just going to answer the second part of her question related to if there were resources for ASCs to use, and yes, there are. There are frequently asked questions available from Provider Enrolment, and there's also a QSO memo from the CCSQ, and David, you can take it from there.

David: Yes, thanks Joe, and I'll defer to our team as well, but the 24/7 nurse requirement is something that has not been waived, and so I believe our expectation continues to be that as these facilities are voluntarily applying to serve as a hospital, that that requirement would stay in effect, but again, defer to Danielle or Karen or Erin if you guys have additional on that.

Erin: Thanks, David. This is Erin (inaudible). I think that the thing to be clear about is, there are several options for ASCs. If they are choosing to enroll on their own as a hospital during the public health emergency, then they are required to meet the hospital conditions of participation, and one of those is the 24-hour care.

There's other options, and I'll ask Tiffany and my colleagues in Payment if I get any of this wrong, but with the Hospitals Without Walls, there's other options for ASCs if they just wanted to provide some sort of outpatient care, or not necessarily providing the 24 hour care, but that would be through partnering with a hospital doing under arrangement services or becoming provider based to another hospital, and I'll defer to CM to see if there was anything that I might have missed with that.

Tiffany: That's exactly right, Erin, and this is Tiffany. I'll just echo that. If there are concerns about not being able to meet the hospital conditions of participation that have been modified for the duration of the public health emergency, there are those other options that (Erin just mentioned, so for both inpatient services under arrangement, as well as for outpatient services, therapeutic services as a provider based department of a hospital, and notably there is no limitation to the type or nature of services that can be furnished through any of those options, so whether you are becoming a hospital yourself, the general rules of what hospitals may provide would apply.

If you are becoming a provider based hospital outpatient department, you are still able to furnish any service that a hospital outpatient department would furnish, so we think that there's a lot of flexibility there, and we certainly understand that things are moving very quickly, and there very well may be some facilities who have an ability to meet the requirements to enroll as a

hospital themselves, and certainly, where there is a surge capacity need to do so, we thank you for doing that, and we hope that you will.

For others, where the needs may be different or the resources may be a little bit different, there are other ways to partner with hospitals, as well, to do hospital services, and then of course, if those are not options, even remaining as a surgery center, there are flexibilities to do that, as well.

Obviously, the recommendations that have been out regarding elective procedures may have changed some of what's being done. We continue to evaluate those recommendations, and are certainly happy to hear any questions, comments, concerns about further guidance or recommendations that would be helpful, to hear from CMS. Thank you.

Operator: Your next question comes from the line of (Donna Jennings).

Donna Jennings: Hello, this is (Donna Jennings) from Texas Health (inaudible) Surgery Center, and I'm calling in regards to tiered procedures and acuity of patients. Of course, we limit the acuity of patients, as an ASC, but the tiered procedures – we plan on going live on May 11, and that's here in Texas, and to the best of my knowledge, that would include all elective procedures. Is that correct?

Marion Couch: This is Marion Couch in the Office of the Administrator. I think you might want to consider a more nuanced approach, in conjunction with your state and local health department. It should be based on clinical need, and so, we are thinking that you might want to prioritize those planned procedures that are being backlogged based on clinical need, in terms of which ones go forward first. Is that helpful?

Donna Jennings: Yes, ma'am. We were planning on doing certain procedures, but we just wanted to clarify from a regulatory perspective if there were strict limitations from CMS's perspective. Of course, we will prioritize the level of need. For example, say we were doing a colonoscopy, a colonoscopy for need, but it wasn't considered urgent enough to be done during the previous (inaudible) so yes, we will be prioritizing for sure. I just wanted to know if there were any legal or regulatory guidance on that. So thank you.

Marion Couch: Thank you for asking. It's a great question. We really are asking folks, and that's what the recommendations state, based on clinical need. Those are the ones that should be prioritized to go forward, and then of course, you want to make sure that you have enough PPE and healthy staff et cetera, so in case you surge, you will be able to accommodate that. Otherwise, based on clinical need, you're all set to go.

Donna Jennings: Thank you, ma'am.

Operator: Your next question comes from Bonnie Reed).

Bonnie Reed: Hi, my question was regarding an ambulatory surgery hospital that converted to an acute care hospital, in anticipation of the surge of COVID patients. That surge never occurred, so there are no patients there, and they are planning to cease operations for a few months, instead of converting back, just in case there is a resurgence.

We just wanted to make sure there was no prohibition on them temporarily closing the facility for a few months, before converting back, and they did receive accelerated payments. I don't know if that has any impact, and they will obviously pay back, but just want to make sure it's OK if they cease operations for a few months, and make sure there's no resurgence, and then convert back to an ambulatory surgery hospital.

David Wright: This is David Wright with the Center for Clinical Standards and Quality. One thing I would recommend is they work closely with their CMS location, where they are located, to ensure – there's not technically something that allows for a certified provider to temporarily close, so they will need to work with their CMS regional office on making sure, and going through the state, to make sure that whatever they plan to do is going to be approved, so they don't wind up being in a situation where it could be considered as a cessation of business, that could lead to a termination from the Medicare participation, so just work with your state, and through them, the CMS regional office, on that issue.

Bonnie Reed: OK, thank you (Pause).

Operator: Your next question comes from the line of William Prentice.

William Prentice: Thank you. I'm the CEO of the Ambulatory Surgery Center Association. My question was actually already answered, but I do want to take this opportunity to echo Kara's thanks to CMS and everyone at HHS, from the Secretary to the Administrator on down for your hard work during these very trying times. You have been very, very helpful to the Ambulatory Surgery community, as we have been dealing with both the postponement of surgeries, and now our efforts to try and resume them, so I just want to once again thank you all for your hard work, and much appreciated.

Operator: Your next question comes from the line of (Lisa McCluskey).

(Lisa McCluskey): Hi there. My question is regarding the CARES Act Provider Relief Fund. We did receive the first round of payments, so then I went on and went through the General Distribution Portal. We did receive a certificate of completion but no email. I'm assuming if we received the certificate of completion, there's no further action we have to take, and that second round of relief funds will be forthcoming at some point in time. Is that correct?

Diane Kovach: Hi, this is Diane Kovach. I'm not with OFM but I just want to clarify, are you speaking about advanced and accelerated payments. Are you talking about the funds (inaudible) that are being dispersed by HRSA?

(Lisa McCluskey): I'm talking about the fund (inaudible) not accelerated payments. We did not apply for that. I know that's closed. I'm not talking about the accelerated payments.

(Diane Kovac): So the thing that you're talking about is not handled by CMS. It's handled by HRSA so unfortunately that's not a question that we can answer.

(Lisa McCluskey): OK, thank you.

Operator: Your next question comes from (Shanra Alfano).

(Shanra Alfano): Hi there. I'm asking just a little more specifically on the topic of clinical need, as I'm sure we are all trying to interpret to the best of our ability. We're trying

to take the cases moving forward, as you say, that are clinically necessary. We're going to eventually move into the ENT and endoscopy realm.

Obviously, COVID testing prior to, and then requiring isolation prior to them coming in et cetera, but when we're getting those cases such as arthroscopies with meniscal repairs that are documented as debilitating and necessary, we're trying to weave in and out of and follow the guidance that we're getting from CMS, but we also want to stay within those parameters and continue with social distancing, and space the patients out as necessary, but is that something – I know it's kind of a specific procedure, but is that something that's OK to proceed with?

Marion Couch: This is Marion Couch again, and thank you for your question, and thank you for talking about screening your patients and testing them to the best of your ability prior to having them undergo surgeries or procedures. I think we are trying to make sure we're doing this balancing act of making sure patients are able to get in a safe way the procedures they need, knowing that not all areas have the testing capability that they need.

To the extent that you can do what you described, that would be ideal. You need to protect, obviously, not only the patient, who, let's say, are asymptomatic carriers and undergo a procedure, might be an increased risk for adverse outcomes, but also the staff in the room, when you talk about Otorhinolaryngology or dental procedures for instance.

So we, again, think that it ought to be based on clinical needs, and I would guide you towards sites such as the American College of Surgery, where they talk about having a committee that can help you decide what clinical need might be most – the best prioritized in your community, your facility, your health system, so I think I would – we don't have regulations on that, but I think, if I could point you one place, it would be to a site like the American College of Surgeons, which has very thoughtfully put out guidance, which the AMA and the AHA have supported. Have I answered your question?

(Shanra Alfano): Yes, thank you.

Operator: Your next question comes from the line of (Ronald Hersh).

(Ronald Hersh): Hey there, first, I'm not going to thank you, but I would like to send you a Hickory Farms gift basket, if you give me your home address. Short of that, my question really is about under arrangement for surgeries, so if an ASC goes under arrangement from a hospital, and they're independent, what is the hospital's obligation as far as record keeping, on what happens to the patient during their stay at the ambulatory surgery center.

Clearly, the ASC has its own medical records system and documentation, but must all of that then get transferred to the hospital, which creates an account, has the medical record, billing record, et cetera, or can they just send the claim to CMS and then pay the ASC the negotiated rate?

Tiffany: Let me start – this is Tiffany. I'll start and I'll turn it over to my colleagues and the Center for Clinical Standards and Quality. When an ASC is functioning under arrangement to a hospital, what is seen by CMS is the hospital claim, and so, it's not considered a hybrid ASC hospital service, or anything other than a hospital service, so the arrangements are between the provider, so in this case it would be between the hospital and the ASC, but there would be no facility bill from the ASC to Medicare. It would only be the hospital billing for a service that was furnished to it under arrangement by another entity.

In terms of medical record keeping and documentation, I'll turn it over to David Wright.

David Wright: Erin, would you mind taking that one?

Erin: Sure, and I'll refer to my colleague, Danielle, who's also on the line. What Tiffany said is correct. It would be considered a hospital patient at that point, which is under the hospital's control. Danielle, I don't know if there's anything else you wanted to add in terms of documentation or anything.

Danielle: No, I would just add on that they would be subject to whatever the medical records requirement that hadn't already been waived by the hospital – is what they would have to follow in that.

(Ronald Hersh): OK, thank you very much.

Operator: Your next question comes from the line of Camille Bonta.

Camille Bonta: Hi, thank you. This is Camille Bonta, and I'm calling on behalf of the American Society for Gastrointestinal Endoscopy. I also wanted to echo what others have said in thanking you for holding today's call, and the other weekly calls, and all the tremendous amount of work that the Agency has been doing to help providers.

We also appreciate the recognition that the COVID has had – the financial impact on ASCs, that is, had to suspend non-urgent procedures, which has led to most endoscopy centers closing their doors. Resumption of procedures is slowly occurring in ASCs across the country, and ASGE has developed a clinical guidance for reopening endoscopy centers.

I wanted to loop back around to the first question that was asked today, that is relevant to reopening, and I believe what that caller was asking had to do with Medicare coverage of COVID pre-procedure testing for those ASCs that are conducting COVID testing onsite prior to procedure. I assume this will fall under a medical necessity, and will be reimbursed, and there won't be any challenges there, but I think that's what the first caller – that's what his question was centering on.

Do you have any additional guidance with respect to coverage of pre-procedure testing, and I don't know if this will come up, but if a Medicare beneficiary had a COVID test and then are coming in for a procedure, maybe that COVID test was a week ago, or two weeks ago, that there aren't going to be any issues with retesting that patient?

Operator: Your next question comes from the line of Julie –

Tiffany: Sorry, let us answer that one first. This is Tiffany. I'm not sure that we have the right folks on the call to answer that specific question, but I think we do better appreciate what the question was, which is, sometimes there is a

medical need to test the same patient for COVID-19 more than once, and whether there will be any coverage restrictions on that. Is that the question?

We may have lost that caller, but let us take that back. I think the caller was right. The underlying rules about services being reasonable and necessary, and providers and practitioners being able to document the medical necessity have not changed, and so what I've heard described broadly – sounded like the description was of a medically necessary test and service, so we can take that back and see if that's somewhere where we can give more guidance, as well. Thank you.

Marion Couch: This is Marion Couch again. The last part of your question about whether the beneficiary got tested a week or two prior to the procedure, I really think you want to be careful and test as close to the procedure as you can, and also add in a quarantine for that patient, just to be as safe as you possibly can. Thanks.

Operator: Your next question comes from (Julie Myer).

(Julie Myer): Good afternoon. We're an ambulatory eye surgery center located in Cleveland, Ohio, and I was wondering if there was any special requirement starting back up with our elective procedures, for general anesthesia to be offered.

Marion Couch: This is Marion Couch again. I'm not sure I understand. Can you elaborate on that question?

(Julie Myer): As far as an elective procedure, if we do a general anesthesia, are there any other special requirements other than the safety protocols of PPE that we need to require for our anesthesiologists and CRNAs to intubate and place LMAs for our patients.

Marion Couch: I would refer you to the CDC for that. We do have concern that there might be aerosolization of virus particles for intubation procedures, for instance, so you'll want to follow the CDC guidance on that. Thank you.

(Julie Myer): OK, thank you.

Operator: Your next question comes from (Susie O'Keefe).

Fred Turner: Hi, this is Fred Turner, and we've got a question about our ASC. We suspended operations temporarily for less than 30 days in light of COVID, and we are prepared to resume operations now, and just want to understand what notification process is required for CMS and AAAHC. Thank you.

David Wright: Yes, this is David Wright. I'll address at least part of that based on the previous answer we gave, and that is, if you've notified the state survey agency that does your licensure, of your temporary closure, and if there's communication with the CMS regional office, we'd just encourage you to circle back on that. Otherwise, I don't think that there's a specific requirement, and our team can correct me if I'm wrong, that there's a particular notification made other than that if you are otherwise, resuming your normal operations.

Operator: Your next question comes from (Danielle Sparks).

(Danielle Sparks): Yes, my question also goes back to the pre-operative testing, so you did clarify a little bit of that as far as coverage under medical necessity, but our question still remains with specific coding guidance. Do you know if CMS is planning on issuing, since the routine pre-op testing is currently not covered by Medicare, will there be any additional coding guidance for ordering physicians?

CMS: I'm not sure that we have someone who can answer that specific question. I do think it's an important question, so let us take that back.

(Danielle Sparks): Sure, thank you.

Operator: Your next question comes from Mark Hood.

Mark Hood: Yes, I have a very specific question about testing and our CLIA license. There are machines available that will do COVID testing and will provide rapid results. However, they are considered moderate to high complexity. Our license allows us to do low complexity testing. Are there any options to use a machine such as that with our current CLIA license?

David Wright: Hi, this is David Wright. No, unfortunately, so there are devices that do allow testing under a certificate waiver, and so there are some of those available on the market, but if it's been classified by FDA as requiring moderate to high complexity labs to be able to perform those testing, then CLIA follows those recommendations and guidance in terms of the restrictions on what you can do under the specific certificate.

So the short answer is, it's unfortunately – no, you are not able to run any tests that require, otherwise moderate or high complexity under a certificate of waiver.

Mark Hood: Thank you.

Operator: Your next question comes from Diana Buck.

Diana Buck: Hi, my question is regarding the extended use of facemasks in surgery centers. Most of the CDC guidances focus on healthcare settings that are dealing with COVID-19 patients. Even though ASCs will be screening all patients and staff who enter the facility for COVID systems, are ASCs to assume all patients may be potentially infected, and so should follow all those guidelines, such as everyone wearing a face mask at all times?

And if so, is it appropriate at this time of PPE shortage, for example like the OR team to wear the same surgical mask for multiple low-risk cases like (inaudible) instead of wearing a new mask for each case, and how are CMS allowing ASCs to loosen some of the restrictions that were previously placed on reusing PPE?

Marion Couch: I would just say that we follow CDC recommendations. CMS would not set those, so please follow CDC guidance, and what we can do is make sure that we are working with CDC, so that they are answering those types of very important questions that you just asked, but we would not be regulating that. That is CDC. And David, did you have anything you wanted to add?

David Wright: Yes, that's correct. I would also say, though, FDA, I'm aware, did issue some guidance on reuse of certain PPE and gowns, and so I would recommend that

you go and check the FDA site, as well, in terms of those recommendations for certain PPE reuse.

Operator: Our next question comes from (Camilla North). Camilla, your line is open. We have no response from that line. We'll proceed to the next question. Your next question comes from (Trudy Whig).

(Trudy Whig): Yes, this is (Trudy Whig) from (inaudible), and I wondered if you could speak to CMS conducting surveys for compliance with reopening of ASCs here in California. Is that being done all around the country, or out here, or is that false information?

David Wright: This is David Wright. We'd need a little more information on that, so the surveys that we've authorized since March 23rd include Immediate Jeopardy surveys, as well as what are called Focused Infection Control surveys. I know that specific to California, they are doing more Focused Infection Control surveys.

I don't think that we've issued explicit guidance to the states with regard to reopening surveys, so it could be something that they are doing under their state licensure, but if you want to follow up with us via email, we'll be happy to look into that a little bit more.

(Trudy Whig): Thank you very much, and we do appreciate everything you guys have done for us. It's a lot of work in a short amount of time, so thank you.

David Wright: Likewise, thank you all very much.

Operator: Your next question comes from (Melinda Gill).

(Melinda Gill): Hi, my name is (Melinda Gill). I work for (inaudible) Pediatric Dental Surgery Center. We treat only pediatric dental cases, which of course, puts us in the highest risk category. Dentistry is considered essential still in the state of Washington, so our ASC has not been permanently closed, but we've basically not seen any cases in the interim of the last six weeks.

My question is, we called to see if we would qualify for the CARES Act through the HHS, and we were told no, because it only is offered for Medicare, and we are Medicaid certified. I'm curious if you guys know, any sort of chance that that Act is going to be extended to Medicaid, and why they selectively only issued it to Medicare, not Medicaid.

Eric Miranda-Marin: This is Eric. I'm not sure that we have the right folks on the call. I think, OFM, I welcome you guys to take a stab at it, but the general Provider Relief Fund is being managed at the department level in coordination with HRSA. OFM, do you have anything to add?

CMS: I actually don't think OFM, our Office of Financial Management, is on this call, but it is correct that the only thing that CMS is administering is the Advanced and Accelerated Payment, and the Provider Relief Fund is being done as Eric said, through HRSA.

(Melinda Gill): I guess my question is to you, because I couldn't get clarification from HHS when I called and talked to the people there directly. They mentioned we were not qualified for that because we are Medicaid providers, not Medicare providers, but my understanding is, it's all under the same umbrella. Is that not correct?

Eric Miranda-Marin: Again, I'm not sure that we have the right people on this call to answer your question, but if you want to just send me an email, and I can see to it that I can direct your question to the appropriate people, so that you can get a response, and you can email me at eric.miranda-marin@hhs.gov.

Tiffany: We also have a COVID resource box that we've been directing folks to just to make sure that we can queue all of these questions appropriately, so Eric, if you don't mind, is it fine for her to use that inbox? It's COVID-19@cms.hhs.gov, the email box that's posted online.

(Melinda Gill): Thank you, do you mind repeating that a little slower?

Female: Sorry, COVID-19@cms.hhs.gov.

(Melinda Gill): Thank you so much. I really appreciate it, and I appreciate you guys' time. Have a great day.

Operator: Your next question comes from (Shay Vaughn).

(Shay Vaughn): Hi, I just wanted to ask regarding the Hospitals Without Walls, has CMS issued any specific billing requirements for how those claims should be submitted, or is there the understanding that they should be submitted as hospital claims on the UB-04 in electronic format?

Tiffany: I can start, and I'll turn it over to the Provider Billing Group. Hospitals Without Walls, the initiative is rather broad, and includes lots of things, so I believe what you're talking about is when a facility enrolls temporarily as a hospital. Is that correct?

(Shay Vaughn): Yes, that's correct. We're an ambulatory surgery center.

Tiffany: When that happens, when that facility is enrolled as a hospital, it would be using the same institutional claim forms that hospitals use, and so, it's no longer for purposes of Medicare for that time that it's enrolled as a hospital. It's no longer submitting the claim forms that ASCs typically submit. Does that help? And I think there are condition codes that I'll let Diane talk about, which condition codes should go on those claims.

Diane Kovach: The general answer is right – this is Diane Kovach – that you would bill as a hospital, and for purposes of the condition code, I think, Tiffany, you were referring to the DR disaster-related condition codes, and that condition code is used when there are any claims that were submitted that are under the umbrella of a former waiver, and so, I know there are some questions about whether the DRs should be used in every instance. I would say if you believe that it is under a formal waiver, then go ahead and put it on your claims. It will not hurt anything to have it on there.

(Shay Vaughn): Great, so there's no other special identifiers that should point out that this is a temporary situation for an ambulatory surgery center to bill as a hospital without walls.

Diane Kovach: Because in this case, you are be enrolled as a hospital, so you would bill as a hospital.

(Shay Vaughn): OK, great. Thank you for all of your help.

Alina Czekai: We'll take our final question, please.

(Trisha Frank): Hello?

Female: Hi, we can hear you.

(Trisha Frank): My name is (Trisha Frank). I'm an administrator of an ophthalmology surgery center in California, and my question is regarding reopening. If our local numbers of COVID-19 cases have not followed that 14-day downward trend. What is CMS's standpoint on reopening, and do surgery centers risk non-payment from CMS, for performing elective surgeries in this instance?

Marion Couch: This is Marion Couch. So you are describing a community where there's not 14 days of declining or stable numbers. You're not a low incidence area for phase 1?

(Trisha Frank): Correct.

Marion Couch: Yes, so I think you need to be very careful about that. I don't think we have specific regulations on non-payment, but I really think you need to be careful, if you've not met the gating criteria, and then you're in phase 1. That's all I can say.

(Trisha Frank): Do you have any suggestions in terms of that gating criteria, as far as what would be considered stable cases, like a certain number of new cases per day versus a much larger number, or –

Marion Couch: You know, I would really recommend you reach out to your state and local public health officials, and be sure to partner with them, because they're the ones that are really going to be thinking deeply about this, and you're going to want to be connected with them, so I think I would direct you to your public health officials.

(Trisha Frank): OK, thank you very much.

Alina Czekai: Thank you for your questions. Eric, any final remarks before we proceed to close the call today?

Eric Miranda-Marin: I just want to thank everyone for again, taking the time out of their day to join the call. Talk to us. Let us know what you are encountering and the questions that you have. We've got a lot of good questions here, and I know we have some things to take back and further chew on and assess, and we will do that.

We look forward to continuing our dialog and to the extent that you encounter any other problems, I think we gave the inbox earlier that you can send your questions and emails to. Can we just repeat that one more time so that folks have it?

Alina Czekai: Absolutely. That inbox is COVID-19@cms.hhs.gov, and again, we'll encourage you to continue to join our office hours every Tuesday and Thursday at 5pm Eastern, where we have all of our CMS subject matter experts on the line to answer your questions. This concludes today's call. Hope you all have a great rest of your day. Thank you.

End