Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
Moderator: Alina Czekai
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OPERATOR: This is Conference # 5787874

Alina Czekai: Good afternoon. Thank you for joining our April 28th, 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 administrator Seema Verma.

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

And while members of the press are welcome to attend these calls, we do ask that they please refrain from asking questions. All press and medial questions can be submitted using our media inquiries form, which can be found online at CMS.gov/newsroom.

Any non media COVID-19 related questions can be – can be directed to our inbox, (covid-19@cms.hhs.gov). And today we'd like to begin our call with some questions that we've been hearing from the field. And please not that some of these issues are still being worked on.

But we wanted to provide a status update to you all in anticipation of questions on these key topics. So our first question for today is can you confirm if the 1135 waiver is also waiving the requirement for the ICU step down three midnight stay rule for a patient to be placed in an L-TECH facility. So I'd like to turn that question over to my colleague, Michele Hudson at CM to address this question.

Michele Hudson: Hi, thank you. Yes, this is Michele Hudson. It sounds like this question is asking about the CARES Act provision, which waives the statutory patient criteria for long term care hospital cases to qualify for the relatively higher (LTCHPPS) payment.

And that's applicable to all long term care hospital admissions during the public health emergency period. And that waiver does include waiving the at least three day ICU stay as well as the payment requirement for L-Tech patients to be directly admitted from an IPPS hospital.

So yes, under that provision Medicare will pay the higher LTCH payment rate for all in patient admissions.

Alina Czekai: Great. Thanks Michele. And another question that we've been receiving is about the appropriate usage of the modifiers in scenarios that are COVID-19 related. Specifically, these topics included rural health centers, telehealth and COVID diagnostic test.

And the topic of coating and modifiers remains under consideration at the agency. And the agency is working on how best to provide simpler tools on modifiers. And while we don't have any new information to share today, we look forward to sharing updates in the near future.

And another question that we've been receiving is about additional guidance on service requirements for telehealth in general, especially including PTs, OTs, and SLTs and other rehabilitation professional status.

So additional guidance on telehealth is under consideration at the agency. And we are working on this issue. And while we don't have any information to share today, we look forward to sharing additional updates in the near future.

And then a final pre-submitted question for today, is the Medicare secondary care questionnaire required on all telehealth payment from the hospitals perspective and I'd like to turn this question over to my colleague Sherri McQueen in the office of financial management.

Sherri McQueen: Hi, yes. Thank you. The answer to the question is yes. The Medicare secondary payer questionnaire is required for telehealth. The questionnaire is used to identify situations where there could be other insurance that the beneficiary may have that could potentially be primary to Medicare. So the questionnaire is required.

Alina Czekai: Great. Thanks, Sherri. Operator, we'd now like to take live questions from the phone.

Operator: As a reminder in order to ask a question please press "star," "1" on your telephone keypad. We have a question from a participant. Please state your first and last name. Your line is now open.

Female: Hello.

Alina Czekai: Hi. Yes, we can hear you.

Operator: For the participant who speak earlier, you may state your question, your line is open.

Female: You can hear me.

Alina Czekai: We can hear you, thanks. What is your question?

Female: All right, thank you. Yes. It would – it'd be nice if the operator would be able to tell the person's name that they're talking to. It's hard to tell with everybody online who is actually the live call.

But my question – I have two questions. One is it was state on April 11th that CMS release in the CARES Act and under the Family's First Corona Response Act that they would be covering reimbursement for the antibody testing for the COVID-19.

Our laboratory is in the process of getting ready to provide this our patients but there is still no reimbursement or any guidelines on the PPP code 86769 for the antibody testing. Do you know when that will be released?

Ing Jye Cheng: Hi, this is Ing Jye Cheng and your question is about when CMS will be releasing payment rates related to the new CPT codes, the two new CPT codes for the serological antibody tests for (SARS COVID 2) and my understanding is that we have provided instructions to our MACs to establish pricing for those codes and that should be available shortly.

If there are specific questions, I would definitely encourage following up with the MAC, I believe they are concluding the process at this point of establishing those prices and making them public shortly.

Female: OK. And then is there still no availability for facility ancillary staff to bill any of the telephone telehealth services on a UB04 claim.

Tiffany Swygert: Hi, this is Tiffany. That's correct. We don't have further – a further update on that at this point. Again, under the hospitals without walls initiative, hospitals are able to furnish hospital outpatient services and provider base departments, which may include expanded sites because the provider based rules under the regulations at 413.65 were waived in their entirety for the duration of the public health emergency.

As hospital can choose to make the patients home provide base to the hospital to furnish services directly as long as they're furnishing the hospital. However, there is not at this time a provision for telehealth services provided from a hospital.

Female: OK. So like an RN – a certified RN that's certified in the (DFMT) program where the dietician and the RN are certified underneath that program and can do those diabetic soft management training services.

The dietician is allowed to do a telehealth visit but the RN is not at this time even though they're certified and certified underneath that program to see the patients, they're not allowed to do any telephone or televisit services.

Tiffany Swygert: In the case that you're mentioning, the RN is an employee of the hospital, correct?

Female: They are but they're certified under the (DFMT) as a certified provider to provide the diabetic self management services.

Tiffany Swygert: Right.

Female: Those services are built underneath the plan of care of the dietician or the provider. But they are able to provide those services. So the only difference is now they're over video because of the COVID-19.

So now because of the video we're telling them they can't bill for the services because they're recognized for video but they're still providing the same care they normally would have and have been certified to do.

And a face-to-face visit with that patient. We have quite a big backlog on patients that need their diabetic training. But we just don't have enough dieticians and the RNs that are certified underneath the program aren't allowed to do it by the telehealth service.

Tiffany Swygert: Understood. Thank you for the additional detail. That is one particular area that we are looking to release additional guidance on. So we thank you for that question and hope to have new guidance on that soon.

Female: OK. Thank you so much.

Tiffany Swygert: Thank you.

Operator: Your next question is from the line of (Ray Delinda). Your line is now open.

(Ray Delinda): OK, thank you. Question, I want to go to physical therapist and telehealth. So prior to the March 30th rule being released, therapy services were not considered a covered telehealth service. So a PT could do telehealth. And because it was essentially non covered by Medicare, they could Medicare patient cash, ABN is not required. Now as of March 30th CMS did add in the CPT codes commonly used by physical therapists as covered telehealth service.

But, as you stated earlier, had we still not added physical therapist. So my question is if a PT now and again we're going to assume nothing goes retro,

but assuming a PT does a telehealth and Medicare patient today, charges them cash because it's not covered, do they have to issue an ABN because therapy services are now temporary covered? Or do they not have to issues the ABN because PTs are not a covered telehealth provider hence it's still statutorily non-covered.

(Ryan): That is a great question. I think as you point out just to reiterate we're actively taking a look at what the flexibilities are to address those questions. That said, an important distinction here is that the list of services that are able to be paid when furnishing telehealth doesn't change the coverage of those kind of services. From Medicare perspective the list of telehealth services is not – it doesn't change the coverage requirements.

(Ray Delinda): OK.

(Ryan): It's – those are payment rules and so the statutory restrictions in terms of both the list and the – who can furnish the service via telehealth and bill and be paid by Medicare doesn't change the coverage criteria but rather those are payment rules. I'm not sure that the – that's a long winded way of saying that I don't think that the addition of the therapy services to the telehealth list changes the rules relative to an ABN et cetera.

(Ray Delinda): So, then an ABN, if we want to could issue a voluntary ABN just would not be required to give one?

(Ryan): And others from CMS should weigh in but that the policies wouldn't change based on the inclusion or the telehealth services – of the therapy services on the telehealth list.

Alina Czekai: OK.

(Ray Delinda): I appreciate your response, thank you very much.

Operator: Your next question is from the line of (Jim Collins), your line is now open.

(Jim Collins): Thank you, very much. This (Jim Collins), the recent round of funding for the CARES Act provides for substantial fraud and abuse initiatives. The most

commonly provided services these days are telehealth and there's a couple of standards that are just not defined by Medicare. First is they said that the level of service could be dictated exclusively by time or exclusively medical decision making.

There's currently two different increments associated with time, there's the 2021 rule, which is addressed in the coronavirus app. And then there is the time standard that go with the doc – go with the code definition. With medical decision making there is not definition of what medical decision making is or at least what it takes to go from one level to the next.

There used to be a Marshfield Clinic audit tool that Medicare distributed to each of its contractors but they did not make it a standard. And right now some contractors do not make public what they use. So, right now, we could be audited for billing for telehealth services and either one of the options as far as documentation goes are not defined.

And then, of course, there's the CS modifier which, I believe you said you're going to be reviewing and getting back to us. The legislation specific to that is pretty clear cut. It says we should be using the CS modifier for evaluation of such individuals for purposes of determining the need of such individual for such product.

So, I'm wondering if CMS has the authority to overwrite that specific legislation? What's the time standard? What's the medical decision making standard? And then can we use the CS modifier the way the government wrote it?

(Ryan): Sure, thank you. So, the – I'll start with the question about time. We've certainly heard that question in the interim final rules that was released we allow for that flexibility and there would be the time associated with the code to (inaudible) 2020 not the time associated for the coding in the future.

But, we understand the need for more guidance there on that specific question and we're actively taking a look at that. In terms of the medical decision making we did not address any changes to the way medical decision making is currently looked at. And as you're pointing out those standards differ based in

terms of the guidance that the MACs would provide in different scenarios and in terms of the auditing.

And so we certainly take your question and we're taking a look at what we can do in terms of giving proactive national advice and more forthcoming there. In terms of the modifier the same issue applies. Our understanding and the current guidance relate to the services that are specifically mentioned in the statutory provision. But we expect to address that as well.

(Jim Collins): So, the legislation though says is very clear and the only place that has questioned that is this forum that we're in right now. A lot of people have pushed back saying that somebody on this conference call, one of the CMS representatives is the only place that has ever suggested that we can't use the CS modifier when indicated.

Do you have the authority to override that legislation I guess is what I'm – I don't think you do. (Inaudible).

Demetrios Kouzoukas: What we're talking about here is really about being faithful to the legislation. Obviously people may have different views and to the (inaudible) that we're publishing things with comment periods, we'll be interested to hear those as part of that. And even to the extent we're not always interested to hear different statutory limitations. So, informally not to the extent we can.

(Jim Collins): OK, until we get guidance ...

Demetrios Kouzoukas: There's no question about the constitutional provisions at play here and so we're more than happy to – if you send you legal interpretations and other comments to us, we'll obviously take them into account as we can.

(Jim Collins): OK. Since the concern is there's a lot of government funding that's to audit and penalize but we don't know what the rules are. So, I'll stop there and look forward to your future guidance, thanks.

Demetrios Kouzoukas: Thank you.

Operator: Your next question comes from the line of (Amy Maverick). You line is now open.

(Amy Maverick): Hi, there. Thank you for taking my question. I am a hospitalist and I work with large hospitalist group that's across multiple states and multiple hospitals in those states. And one of the things we've been trying to do with COVID-19 is to mobilize some physicians who are in areas that are not experiencing surges of COVID into other areas. But one of the things that we've run into is that certain states, when we're trying to get emergency privileges, or even just hospitals when we're trying to privilege our hospitals.

Our hospitalist in a hospital are wanting to give our hospitalist emergency privileges that are technically volunteer. So they're having to sign forms that says that they're volunteering. And so my question to Medicare is, if I have hospitalist who has volunteer privileges at a hospital are they, volunteer emergency privileges, are they able to submit claims for the services that they provide to patients while they're a volunteer?

So, can they submit claims for the services we provide to Medicare beneficiaries and get reimbursed for those services?

Ing Jye Cheng: Hi this is Ing Jye Cheng. So, you're asking whether or not the hospitalist surveying in a different state who are privileged under emergency circumstances could submit a bill for those hospitalist services? Is that ...

(Amy Maverick): And even – yes and even in the same state.

Ing Jye Cheng: For the professional services?

(Amy Maverick): Even when they're in the same state. I might have a hospitalist in a state who goes 30 minutes away to another one of our hospitals. But the only privileges they can there is volunteer. And it's really the volunteer part that is the question. If technically they're – they have privileges that are volunteer can they submit claims to Medicare and get reimbursed for those services that they are providing to the patients while they have volunteer privileges?

Ing Jye Cheng: Certainly, I don't know that our blanket waiver speaks specifically the type and degree of hospital privileging. We've issued – the agency has issued blanket waivers regarding life insure across state lines. I don't know that we have a applying) directly on that. And so in the absence of a direct written statement from the agency on that, I don't know that the public health emergency would necessarily change the ability of a physician to bill before or after the emergency was declared.

In other words, if it was possible to bill before the emergency started under those privileges then it should be possible to bill now. But, we would have to do a little bit more research to develop a direct answer to your question.

(Amy Maverick): OK. We just hospital who that's they didn't I don't think had the forethought on it when they wrote their by-laws. And so they're giving us volunteer privileges we just don't understand if we can get reimbursed for services if we're technically working as a volunteer. So that – if you all could clarify that that would be great.

Ing Jye Cheng: We will look into it, thank you.

(Amy Maverick): Thank you.

Alina Czekai: Next question, please.

Operator: Next question is from the line of (Kate Beller). Your line is open.

(Kate Beller): Hi, thank you for taking my question. I had a question as to whether a certain contractual relationship could be used by a rehabilitation hospital that's in the same system as an acute hospital where a rehab could stay in the acute hospital allowing the rehabilitation hospital to stay COVID free in the interest of infection control and patient safety for patients in that rehab hospital?

To clarify the rehab hospital, not a unit at the acute hospital but rather is in the same system.

(Andy): So, right now there are two approaches that may provide some of the flexibility that you're looking for. One under the interim final rule that we

released a few weeks ago, we do allow an under arrangements type of relationship between and IPPS hospital or an acute care hospital and a free standing inpatient rehabilitation hospital like what you're describing. So, you could examine that type of relationship.

The other type of flexibility that may work is that we have waived under the CARES Act what's known as the three hour rule, which provides more flexibility in terms of the intensity of the rehab that would be performed for residents, for patients.

(Kate Beller): OK, appreciate that. Yes, we were thinking about the under arrangement defining the scenario. I was believed it would be a bit of a flip with the hospital having the patient, the rehab patient in the acute hospital setting and the rehab hospital contracting for their care through their nurses and other staff. But we can go back and tell the hospital they can examine that, those rules and see if it's apply in their scenario.

(Andy): Great, thank you.

(Kate Beller): You know what, (Andy). I've got one other quick question that's come up quite a bit among some of our members is whether our team conferences can be performed virtually. Again in light of the infection control and safety concerns and recommendation regarding social distancing.

(Andy): Yes, I think Medicare has not generally spoken to that. But I think our non-specifistic probably provides the flexibility to make sure that the right types of social distancing are available in this emergency for that type of interaction.

(Kate Beller): OK. So we can tell hospitalist just make sure they document appropriately who attended and just make sure that everything is again in writing.

(Andy): That's right.

(Kate Beller): Fantastic. Great, thank you so much for your time, I appreciate it.

Operator: Next question is from the line of (Sandy Sage). Your line is open.

(Sandy Sage): Thank you so much. This is related to the new program for uninsured patients. The CARES Act says that items and services dispersed to an individual during an (ER) visit that results in the order for the COVID test is the services relates to the evaluation of such individual for purposes of determining the need for a test. There's been some confusion. The guidelines were put out yesterday that say only – they will pay only if there is a U071 of the primary diagnosis.

If an uninsured patient is seen in our hospital ER with multiple COVID symptoms and they do a chest x-ray, they do the flu test, the strep test, and finally the COVID-19 test when other diagnoses were ruled out, the patient was seen and had treatment that led to that test, but if the COVID test comes back negative, they're not allowed to code that U071. So are we then supposed to bill that uninsured individual or are we supposed to bill through the uninsured program because it won't be paid and then we won't be able to balance bill because there's no primary diagnosis of U071 on the claim?

Demetrios Kouzoukas: Hi. This is Demetrios here. So I think this is about the uninsured program and as you had mentioned.

(Sandy Sage): Right.

Demetrios Kouzoukas: And so, that relates to some guidance that HRSA has released, and obviously we can pass your question onto HRSA, but we don't have the expertise to answer it here since it's another agency.

(Sandy Sage): OK. Alright, thank you very much.

Operator: Your next question is from the line of (Christopher Shunk). Your line is open.

(Christopher Shunk): Hi. Thank you for taking my call. So one of the items are Medicare administrative contractor in the state of California had a presentation maybe two weeks ago or so, and they talked about documentation requirements where we need to state who is actually participating in the visit. So if it's family members and medical assistants, something like that, and I haven't seen anything in the actual CMS interim final rule or any other CMS formal documents that actually state that. Is this information true that we have to document other people who are in there – in the visit and call that out

specifically to support billing that service, or if it's not documented will it – will we still be able to bill it.

Demetrios Kouzoukas: So I don't know that we – it doesn't sound particularly familiar. Obviously there are a lot of documents being put out. Maybe you can get us a copy and we can take a look.

(Christopher Shunk): Sure. I can definitely send you the presentation. Is there a specific email address or way that I can send it to you guys?

Demetrios Kouzoukas: Yes. Alina, you want to share that?

Alina Czekai: Sure thing. You can send it to our COVID mailbox, which is covid-19@CMS.HHS.gov.

(Christopher Shunk): OK, great. I will get that sent out today then.

Alina Czekai: Sure thing. We will be on the lookout for it. Thank you.

(Christopher Shunk): Thank you.

Operator: Your next question is from the line of (Jonathan Gold). Your line is open.

(Jonathan Gold): Hi. Thanks again for taking the time this evening. My question pertains to therapy and telehealth although a little bit different than we had discussed before. Specifically wanted to know if therapists could provide some services remotely either by telehealth or some other situation where they're outside the patients room, in the inpatient rehabilitation facility setting particularly now given the waiver under the CARES Act that waives the three hour intensity of therapy requirement. There's many hospitals that are obviously trying to limit exposure, but they weren't sure whether they would be permitted to provide some therapy services from outside the room using some sort of technology. Thanks so munch.

(Ryan): Yes. While we haven't spoken to necessarily all of the ways in which that type of therapy could be provided, as you've noted there is flexibility under the three hour wavier rule to provide care in a different way. So as long as that type of care would be (inaudible) the type of flexibility for the hospital to do

so as long as it's in the best interest of the patient and that the patient was getting the care that's necessary for recovery.

(Jonathan Gold): Great. Thank you so much.

Operator: Next question is from the line of (David Picman), your line is open.

(David Picman): Hi. Thank you taking the call and thank you for having all of these. My question relates to the delivery of annual wellness visits by telehealth. When these are added to the rest of the tele-eligible services I think in 2015 originating sites were still other clinics and hospitals. But now it's expanded to patient's homes.

So I guess my question is, well, for the delivery of certain elements of the AWV like documentation of height, and weight, and blood pressure it's difficult to do that in patient's homes. So, I know you've been asked this question before, but I guess I'm trying to ask when can we expect guidance on how to delivery annual wellness visits when the patient is in the home how you can document blood pressure, weight, et cetera?

Demetrios Kouzoukas: OK, I ...

(Ryan): So I think – oh ...

Demetrios Kouzoukas: Go ahead – is that (Ryan)?

(Ryan): Yes.

Demetrios Kouzoukas: Go ahead.

(Ryan): (Inaudible) we appreciate the question, and you're certainly right about the context. That the codes that are on the telehealth list range based on assumptions on where the patient situated include healthcare settings.

In terms of the necessary portions of the annual wellness visit, I think that we can – we have said that to the extent that the patient reported elements (some of the things that you're talking about) could certainly be included, and I think we need to take back more specifically any – take back the requests for more

specific guidance about how that would be documented. But we certainly understand the question, so thank you.

(David Picman): Yes. Thank you. Because the longer – as the pandemic goes on and telehealth becomes a vital way to reach patients these – the ability of your AWVs is important just to check on patients, identify cure gaps, et cetera. So the issuance of that guidance would be appreciated. Thank you.

Operator: Your next question is from ...

(Ryan): Great, thank you again.

Operator: Your next question is from the line of (Estrian Aveen), your line is open.

(Estrian Aveen): Hi. Can you hear me?

Alina Czekai: We can, thank you.

(Estrian Aveen): Great. Thank you for taking my question. I have a question about modifiers for off campus provider based departments. As providers start to plan and think about ramp-up and backlog planning they might consider off campus facilities to meet anticipated demand quickly. Non-grandfathered, or non-excepted provider based apartments require the use of the PN modifier on claims and that triggers a reduced reimbursement rate.

I was wondering if there was anything out there to suggest, or if CMS was considering that new departments established under the public health emergency, and that is those departments being established to meet the demands caused by COVID but not necessarily for treating COVID, whether those new departments need not apply that PN modifier?

Female: Hi. Thank you for that question. One clarifying point for you – are you talking about brand new departments or departments that were already grandfathered or accepted that we're billing under the OPPS previously?

(Estrian Aveen): So this would be non-grandfathered.

Female: OK. So for non-grandfathered the law is pretty clear, and those are not paid under the OPPS, they are paid under the applicable payment system which is the physician fee schedule amount. And so I don't want to give you any false hope on that.
However, with respect to departments that are already accepted, that is something that we are looking to give more guidance on. As you may be aware there's already existing provisions related to relocation of an existing department, and there's in extraordinary circumstances, process that's already in place for that.

We are looking in to the current rules as relate to already accepted off-campus departments, however I do not believe that we have an ability or much flexibility with respect to the off-campus departments that were not grandfathered. And so for those departments that were already billing at the lower rate under the PFS, they should continue to append the PN modifier which will continue to trigger payment at the PFS equivalent rate.

(Estrian Aveen): Great. Thank you so much. I just wanted to check if there was anything out there and I appreciate your response.

Female: Sure.

Operator: Your next question is from the line of (Krista Barnes), your line is open.

(Krista Barnes): Hi, this is (Krista). My question is about telehealth, but it's also a little bit broader than that. The position that you all have stated in both the FAQs and on these calls (it said) if the provider and the patient are both in the same locations – so at the same provider somewhere a video encounter is not telehealth and can be billed normally. My question is, is that CMS's position all the time and not just during this emergency period?

(Ryan): Yes.

(Krista Barnes): Great. Thank you.

(Ryan): Thank you.

Operator: Your next question is from the line (Brendesh Welki), your line is open.

(Brendesh Welki): Hi there. Thank you so very much for taking my call, I greatly appreciate it. So I have a couple of questions. Number one, we've been hearing – and you've somewhat addressed it at the beginning of the call that CMS is evaluating under the CARES Act whether or not to extend telehealth to therapy services and other non-physician practitioners such as audiologists, lactation nurses, registered dieticians, et cetera.

I am wondering – this was actually brought up four weeks ago, and I'm wondering when we'll be actually getting any sort of guidance for the hospital-based services? Currently we're holding well over 10,000 claims, which is a lot of claims. And do you know when you'll be having guidance provided to the hospitals surrounding this? That's my first question.

Demetrios Kouzoukas: So, this is Demetrios here. It's a topic that we know is really important, we are obviously focused on it, and it does take a little bit of care in terms of how we go about it. The last thing we'd want, obviously is to put something out and then have a lot of confusion on calls like this or elsewhere.

(Brendesh Welki): OK ...

Demetrios Kouzoukas: Obviously also a number of intersecting legal, regulatory, and policy issues – so we're definitely working on it ...

(Brendesh Welki): OK ...

Demetrios Kouzoukas: And I know that it's not soon enough, it couldn't have been soon enough if it was three weeks ago, so – and I get that.

(Brendesh Welki): It's very true, and I give you credit. I understand this is not an easy situation, nor an easy time that we're in. My next statement, rather, that I'm not sure if CMS has actually thought about, and that has to do with a lot of patients who have had outpatient therapy in the hospital-based services that have had interruptions of their care.

So therefore there's a gap in services, and therefore there's a gap in the certification – the plan of certification and re-cert that's required. So I think that CMS may need to provide some guidance surrounding that topic.

I'm not sure if anybody has brought it to your attention that if a patient – if they can't come in to the department and you're not allowing them to bill telehealth services, now you have patients that have gaps in services and therefore we are now having to do a lot of rework surrounding the plan of care cert – re-cert process. So I just would like to put a little nod out there if you could possibly think about that in the future that would be great.

And my final question is, is CMS allowing hospitals to bill the G2023 specimen collection? You have allowed it for clinical diagnostic laboratories but not hospitals which makes no sense considering the hospitals have to have people gown-up, full PPE in order to obtain the specimen collection yet we don't get the bill for it – we have to eat the cost and it's really frustrating.

So I'm wondering if, can hospitals bill for G2023 for obtaining the specimen to run the SARS COV2 test. And thank you again for taking my call.

Ing Jye Cheng: Hi, thanks, this is Ing Jye Cheng, I'll address the last question first and defer to some of my colleagues on the plan of care question. With regard to specimen collection in G2023, we – the code itself is broad, it talks about specimen collection.

However, in the last final – interim final rule we issued on this, it was finalized a code payable to labs, so we recognize and we've heard on this forum and others that hospitals and other entities believe there's also a need for it to be payable in other settings, so we've heard that. But at this time, it is payable only to labs.

(Brendesh Welki): I mean, do you – but I'm wondering, if you step back and look at the hospital-based entities, there's not been a lot of guidance provided by CMS, and that's really frustrating when we are taking care of these sick patients. And so I really strongly encourage CMS to provide some guidance for the hospital-based entities.

That would be super helpful, because what we're required to do, until we're given guidance in hold claims. And when you have thousands upon thousands upon thousands of claims held, it's really, really difficult. Everyone is in a financial trench these days, I get it, however, I just – I beg you to please provide some hospital-based guidance. And as far as ...

(Ryan): Go ahead.

(Brendesh Welki): ... the plan of care, I don't expect to have an answer, I didn't even think if anybody had ever thought of that given the current circumstances. Thanks again to taking my call.

Ing Jye Cheng: Of course, thank you very much. We do recognize how important this is, and we know that hospitals are definitely on the front lines right now mad appreciate your willingness to be patient with us, because these types of things take a little bit, as Demetrios was saying earlier of kind of winding through the legal and regulatory process and figuring out kind of where the statutory authority and the regulation intersect ad how the public health emergency comes into play. So it's something that's very much on our radar screen and we understand the need.

(Brendesh Welki): Great, thank you.

Operator: Your next question is from the line of (Annie Harris), your line is open.

(Annie Harris): Hello, thank you so much for taking my call, and I really do appreciate that you guys are doing these, they've been exceptionally helpful. I work at an FQHC and I've received conflicting information regarding the telephone services. So our phone evaluation services code is 99441 through 99443, and 98966 and 98968, billable by an (FQHC)? And if so, do we bill those out on an (UV) institutional claim? Or do they go on a (CMS 1500)?

(Ryan): Hello, at present, those services are not reportable but (FQHCs), but we certainly understand and part of it – we're actually taking a look at that and anticipate additional guidance in the near future.

(Annie Harris): Great, thank you so much.

Operator: Next question is from the line of (Donald Ritsch). Your line is open.

(Donald Ritsch): Hi, so as you can tell from all the questions, the auditors are all sensing blood in the water, so my question is, for telehealth visits, when you adopted things like G2010 in 2019, you specifically required patient consent. Now that you've allowed office visits to be billed as telehealth, I've found no reference that the patient must consent to the visit happening and being billed to Medicare. So is it correct that there's no required consent even though it might be best practice to do it?

(Ryan): Sure, can you state the specific code again?

(Donald Ritsch): In the old days, back when you allowed things like the e-visits with G2010, if you go under the 2019 fee schedule rules, it states that there must be patient consent.

(Ryan): That's correct.

(Donald Ritsch): But there's nowhere about now that we can bill 99214, that's a telehealth visit, there's nothing that states we're required to get patient consent, I envision the auditors those things. Yes, go ahead.

(Ryan): Understood. So the same rules for telehealth would apply under the public health emergency, that would have applied for those sorts of services, performed via telehealth before the public health emergency. So that would have only been applicable when the patient generally was in a rural area or in another healthcare setting; but there was not a requirement for those telehealth services for patient consent to be explicitly documented in the records the same way that there is for the codes describe is significantly briefer interaction through communication devices such as the virtual check-in codes, which those consent requirements are still in effect. But for the telehealth services, there's no specific ones.

(Donald Ritsch): Great, thank you very much.

Operator: Your next question is from the line of (Priscilla Frost). Your line is open.

(Priscilla Frost): Yes, I appreciate the opportunity to ask this question. We understand the part if a patient is impatient and is unable to return to their skilled services or to a nursing home because they're requiring us to have like one to two negative COVID tests. But if a patient presents and is in observation status, and they need to stay but it's not going to throw them over the necessary hours that we would normally expect to either discharge or fully admit, how should we be handling that from a billing purpose?

Alina Czekai: So the rules regarding observation services haven't changed nor have the rules surrounding the two midnight rule. So the actual details will depend on the specific in front of you. If you know that – if the to midnight rule suggests or states pretty clearly that if the physician expects the patient to remain in the hospital for at least two midnights, then payment under part A or inpatient payment is generally appropriate.

So I understand in this situation, it sounds like the expectation itself may not be know from the outset, however under the two midnight rule, that expectation can be revisited when more detail about the clinical needs of the patient are available. So unfortunately we can't – that is a very case-specific scenario that you just described, and I don't believe that there's a one stop-shop answer for you. But would just note that the observation rules for billing have not changed, nor has the two midnight rule for billing.

(Priscilla Frost): OK. Because that was our concern, is that we understood from the inpatient status, but it's that question of if the patient is stable enough to go back to the SNF ,the nursing home or whatever, but because of the fact of the COVID situation, they're not willing to take them back until you can prove that they are not going to test positive or bring back the disease.

Alina Czekai: Right, I think puts it into a little of a different question that has come up on the skilled nursing side. I don't know, (Jason), if you wanted to address that part of it?

(Jason): Yes, so I think there are probably a couple different aspects to unpack to your question. One is first with regard to the three day waiver for an in-treat to a skilled nursing facility, that three day waiver is applicable for whether the

patient would be inpatient, outpatient or perhaps even coming in directly from the community where there would be less than three days stay in a hospital.

But if – the second part of your question – and I think is one where we have – are still looking at what additional flexibility we can provide is where there may be a patient who is COVID-positive or potentially suspected to be COVID-positive and there's not a skilled nursing facility that is willing to accept the patient at this time because they're – just out of an abundance of caution. And so there is some concern about the lack of a swing bed type of arrangement, and that's something that we're continuing to actively explore as we're hearing this scenario more and more.

As skilled nursing facilities and nursing facilities across the board are looking to strengthen their infection control programs.

(Priscilla Frost): Well, this really became evident when the current change happened that there was concern about the increased number of nursing home patients or assisted living patients. And I mean this is their own patient, but they don't want to take him back, whether it be assisted living or whatever, they don't want to take them back until we prove to them that the patient is COVID negative. And so we need to know how to handle those situations.

(Jason): Yes, so let's – at the moment, the best guidance that we can provide is that if they have been admitted in-patients or have been admitted outpatient, then you should follow those type of payment rules as was just discussed.

And we're looking at whether or not we may be able to provide some additional flexibility for hospitals working in effect as – functioning as a skilled nursing facility with a swing bed arrangement and whether or not we may be able to provide some more flexibility when a discharge would be appropriate.

(Priscilla Frost): All right, I appreciate it very much, thank you.

Operator: Your next question is from the line of (Cindy Willies), your line is open.

(Cindy Willies): Hi, thank you for taking my question. My question actually has to do with the RAC's and the relaxation of billing tell of how services. By the MLN that we have read, webinars will have occurred, there seems to be a conflict as to whether or not that E&M codes, telehealth codes, should have the modifier CG on it and the reason for the question is if CG is a trigger for the error rate, if it doesn't have it on there, would the claim process at the $92 reimbursement rate?

And that would eliminate any of the takebacks that are scheduled to occur in July and August.

(Ryan): So for – until the systems changes can be made, that CG modifier does need to be on there. Those system changes are necessary in the claims processing systems to make the $92 payment. And so, it's not that the – it's not that without that modifier, the $92 would be able to be paid and then help definitely. If anybody else is on the call that thinks that's not right, you should definitely weigh in, but that's my understanding of it.

(Cindy Willies): No it's ...

Female: (Inaudible), that's correct. Sorry to cut you off, but that is correct because we need to use the modifier until the changes are made in July.

(Cindy Willies): OK. So if, in fact, some of the claims went out without the CG modifier, would that still trigger the error rate, or would those get denied?

(Ryan): If the ...

Female: So it looks – I'm sorry, I'm just – it looks like there will be payment made without the CG, but we might have to go back and make sure we're clear on what will happen between now and whenever the changes made in July and I do believe there is some guidance that is – I'm sorry.

I'm sorry I'm getting some information from (both of them) speaking, but I'm not clear payment whether or not will be made, so I believe we are working on some additional guidance, so hopefully we'll be able to get that out soon. Looks like the answer is payment will not be made without the modifier.

(Ryan): But again, to reiterate, I would expect additional guidance to be forthcoming in the very near future because we understand this is a very confusing set of circumstances and we understand the importance of it. And so I would anticipate guidance being clear in the very near future. Thanks.

Operator: Your next question is from the line of (Christy Ming). Your line is now open.

(Christy Ming): Hi, I have a couple of questions. The first one pertaining to your bundle payment program. We're an orthopedic group that participates in the (BCCIA), have you come to a determination at this time on what will be happening during this timeframe that we have not been operating?

Demetrios Kouzoukas: Which program was it that you mentioned, the BCCI?

(Christy Ming): (BCCIA), yes.

Demetrios Kouzoukas: (Inaudible). Idon't know if we have my–CMMI colleague wants to go so we'll have to get that question over to them.

(Christy Ming): OK. Secondly, we are now ramping up to start slowly performing surgeries, and we have put – we have rescheduled some patients that are outside of 30 days, which according to hospital requirements, we will have to call these patients into more (H&P's).

We do not have a problem with doing these via telehealth, but is this something you typically – we've already charge – we've done a 57 and now here we are back having to go back and do the (H&P) again. Is that something we need to be charging for, should charge for, or just cannot charge for?

Demetrios Kouzoukas: This is (history) physical?

(Christy Ming): Correct.

Demetrios Kouzoukas: I think you'll have to forgive me, but break it down just a little bit more in terms of the contracts, the payment, the type of setting, and so on.

(Christy Ming): Certainly. When a patient comes into the office, we (typically in) and they make a determination to schedule surgery. We go over their full history and physical and report that information to the hospital. Some of our patients that we have put off have been longer than requirement, so we're having to call them and redo history and physical and confirm have you had the virus or not have the virus and all of that.

And we planned on doing that via telehealth and reviewing those H&P's, but the question was posed is that something we can charge for, not charge for?

(Ryan): So, there are a couple different questions there. To the extent that you would ordinarily charge separately for those services, generally the answer would be yes, that the changing circumstances obviously that we're talking about are probably similar to what happens if, for medical reason, a patient needs to delay a surgery over a longer period of time and then the same thing were to happen, so I – I think we can take the question back and see if there's a more global policy response.

But in general, the same rules would apply as if whether – as if there were peculiar circumstances for an individual patient that they would of applied that outside of the public health emergency.

(Christy Ming): I do understand that completely and what you're stating, but keep in mind there are hundreds of patients.

(Ryan): Right. Understood

(Christy Ming): So there's a lot of time and effort, so when you do take that back, if that could be a consideration, that would be wonderful.

(Ryan): Sure, sure, we certainly understand that. Thank you.

(Christy Ming): Thank you.

Alina Czekai: And on the question about the (business advanced) model, I did get word that CMI – (CMMI) is considering flexibilities for the model participants and expects to share information very shortly. And we are at 6 o'clock eastern, I'd

like to thank you all for joining our office hours today, we really do hope these calls are helpful, and we appreciate all that you are doing as our nation addresses COVID-19.

And our next office hours will take place this Thursday, April 30th at 5 p.m. eastern. In the meantime, you can continue to send questions to our email address covid-19@cms.hhs.gov. This concludes today's call, have a nice evening.

End