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

Alina Czekai: Good afternoon. Thank you for joining our June 23rd CMS COVID-19 Office Hours. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai leading stakeholder engagement on COVID-19 in the Office of CMS Administrator, Seema Verma.

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

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

We'd like to begin our call today with some updates on recent CMS publications and guidance. Last week, on June 17th, CMS published a set of FAQs on the end-stage renal disease quality incentive program specifically regarding the exceptions for dialysis facilities affected by COVID-19.

The FAQs review the extraordinary circumstances exceptions policy for the ESRD quality incentive programs, including which reporting requirements are accepted, the impacts of those exceptions and helpful links for further training and information. These FAQs can be found on CMS' current emergencies page under the section Clinical and Technical Guidance for Healthcare Facilities.

Also last week on June 19th, CMS published an FAQ on SARS-CoV-2 surveillance testing, which answers several questions on using pooled sampling procedures. And this guidance can be found on CMS' current emergencies page under the section Clinical and Technical Guidance for Labs.

Finally, CMS has published another round of updates to the broader FAQs document for Medicare providers which can be found on CMS's current emergencies page under the section Billing and Coding Guidance.

And a few specific highlights that are pertinent to questions raised on this office hours calls include waiving requirements that the clinical diagnostic laboratory tests for COVID and flu must be ordered by a treating physician or non-physician practitioner; explanation of the different codes for use in COVID-19 specimen collection; expanded guidance on CMS's Hospitals without Walls Initiative, specifically the extensive updates include details on the following; appropriately billing and coding for services furnished by hospital outpatient department that are temporally extended off campus including to the patient's home, several common scenarios and detailed information on codes that can be used; an explanation of which modifiers will be applicable; information on how to temporarily expand an outpatient department to include off-campus locations; and finally, an explanation of which hospital outpatient therapy education and training services can be furnished in a temporary expansion location and when the originating (sites) can be built.

Additionally, we released extended guidance for RHCs and FQHCs in terms of which furnish – services – excuse me – can be furnished remotely or as distant sites as well as guidance on direct supervision requirements and specimen collection.

And we also released updated information on the Medicare Telehealth services list and updates on which providers can furnish Telehealth services and when audio-only services are appropriate. And all of the updates made to the guidance were extensive and we've only provided today a snapshot on our call. So, please do review the FAQs to see the comprehensive set of updates made to the FAQs.

And finally, there were several questions from past office hours that we were able to take back to our CMS colleagues for follow up. And while the answers to these questions can be found in the updated FAQ, we'd like to share the answers to those questions on today's call as well.

Our first question, if a COVID-19 diagnostic laboratory test is performed prior to the procedure in HOPD, ASC or office, is it included as part of the procedure? And the answer to that question is, if a COVID-19 test is performed prior to the procedure and billed separately it is not bundled into the payment for the procedure. Specifically, with regards to the hospital setting, if the hospital is billing for specimen collection for the COVID-19 test along with another hospital service the payment for the specimen collection would be packaged into that of the procedure.

If the ASC or physician office has obtained a clearance certificate, the ASC enrolled as a laboratory or physician or non-physician practitioner office can bill for tests under the clinical laboratory fee schedule. That's the certificate permits them perform, separate from billings for the procedure that is being furnished.

Our next question is, is there any difference for partial hospitalization programs from any of the other hospital outpatient department billing guidelines you have provided? Is there an exception for PHP in any way?

And the answer to this question is, while hospitals and community mental health centers will be permitted to provide certain PHP services using telecommunication technology and temporary expansion location of a hospital, all PHP requirements are unchanged and still in effect. Patients receiving partial hospitalization services must be under an individualized plan of treatment as previously established in regulation.

And our final question that we received, can a physician provide Telehealth services if he is residing out of the United States for a month? Can a physician provide Telehealth services while residing in his second home out of the country and unable to return to the United States due to COVID-19?

In regards to both scenarios, the physician has a practice location in the United States. And the answer to this question can be found in our FAQ dated June 19th. And in that FAQ, we note that Medicare cannot pay for services that are furnished by a physician or practitioner located outside of the United States.

As always we appreciate your questions and we are working to resolve them as soon as possible and please do continue to keep in mind that the questions discussed on this call are general representative questions and your specific circumstances might be different; therefore, the information provided may not always be applicable to your unique circumstance and you're welcome to always reach out to us at our COVID mailbox which is covid-19@cms.hhs.gov.

And with that, we will take questions from the audience. Please do 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, simply press “star” then the number “1” on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Our first question comes from the line of Barbara Cobuzzi, from CRN Healthcare Solutions. Your line is now open. Please ask your question.

Barbara Cobuzzi: Excuse me – wait a minute. Can you hear me?

Alina Czekai: Hi. Yes. We can hear you.

Barbara Cobuzzi: OK. (Inaudible). I think you'll be answering my question in terms of you published the FAQs to further clarify the Hospitals without Walls, so I think I got that. That's why I want to ask is when the FAQ is going to come out so I'll go look into them.

Alina Czekai: Excellent. Thank you. We'll take our next question.

Barbara Cobuzzi: Thank you.

Operator: Our next question comes from the line of Shay Vaughan from Allscripts. Your line is now open. Please ask your question.

Shay Vaughan: Hi. Thank you for taking my call. I wanted to ask about the place of service that needs to be used, if an FH – I mean FQHC is conducting COVID testing in the community with volunteer EMTs that are going to elderly housing complexes, that service, of course, the patient's home or apartment, should they use the place of service home?

Ryan: Hi. Just – in order to best answer your question that it might be helpful is, are you asking what place of service code the FQHC would use in that bill?

Shay Vaughan: Yes. Yes. We're billing in that scenario.

Diane Kovach: Hello. This is Diane Kovach. FQHCs don't include the place of service on the claim.

Shay Vaughan: So, even for the COVID testing for that particular lab that doesn't need to be billed on the CMS 1500, that will be billed on the UV, of course?

Diane Kovach: Correct.

Shay Vaughan: OK. Thank you.

Operator: We have our next question from the line of Rosie Fussell from AdventHealth Care. Your line is now open. Please ask your question.

Rosie Fussell: Good afternoon. I have a question about convalescent plasma. If we are using methods that are outside the Mayo Clinic's publish method, is there going to be a HCPCS code created for this blood products that we can use to bill because our blood supplier is definitely billing us?

Alina Czekai: Hi. I don't think we have anyone on the call right now who can answer that question. Do you mind submitting it to the COVID-19 mailbox?

Rosie Fussell: I would be happy to do that. Sure.

Alina Czekai: Thank you.

Rosie Fussell: You're welcome.

Operator: Our next question comes from the line of Sue Thomas from University of Kansas. Your line is now open. Please ask your question.

Sue Thomas: Hello. This is Sue Thomas. I have a question about the billing for the specimen collection. And I did read the recent publication that talks about, is the Medicare Matters that talks about using 99211 in the physician's clinic situation that we'll be billed incident to. I'm trying to understand the difference we have both provider-based and non-provider-based.

So, are you saying in a non-provider-based clinic we would bill the 99211 in addition to or instead of a specimen collection fee? And then when that same similar service in a provider-based clinic would be bill on 99211 or the C89 code? I think it's C9803 as the other collection.

Tiffany Swygert: Hi. Sure. So, for the provider-based which would be considered the hospital, the appropriate code to bill would be HCPCS code C9803 and that only – that could only apply for the hospital setting. So, non-provider-based or office-based clinics would not use that code for a specimen collection and in fact the C9803 code specifies in the descriptor that it's for hospital outpatient clinic visit specimen collection. So, it is for sure within the descriptor just for hospital outpatient clinic use.

Sue Thomas: OK. But when it's the non-provider-based clinic, which code would we use? 99211 plus G-code or only the 99211?

Ryan: So, you would only report the 99211 for the specimen collection if you weren't reporting as another applicable code. And so that would include if the manner of the specimen collection was better described by a different code or for example if they were – if the visit that were being performed would be properly reported with a higher level E&M code then you would just report that higher level code. So, the 99211 for the specimen collection only when it's – when that's the only code that would be reported.

Sue Thomas: OK. So, G2023 which is in the lab fee schedule cannot be used in a non-provider-based clinic?

Ryan: Correct. Correct, the G-code will be used by independent laboratories.

Sue Thomas: OK. That was very helpful. Thank you.

Operator: We have our next question from the line of Ken Herrick from New York QHS. Your line is now open. Please ask your question.

(Ken Herrick): OK. So, on the telephone code, the 99441 through the 443 for a hospital-based clinic, with Medicare adding these to the Telehealth services, would this also, if it was a provider-based clinic that's we bill that being delivered in this method, be applicable to bill the Q-code, the Q3014 or because of the additional reimbursement that was given to these codes for the pandemic that would not be applicable, because the additional rate would in compose everything with AMB actual visit for the 99441 through the 443?

Emily Yoder: Hi. This is Emily Yoder. I would ask you to please submit that question to the COVID-19 mailbox, and then hopefully we can look into that and get back to you.

(Ken Herrick): OK. I actually did. I submitted it last week after the call and didn't get a response. Should I go ahead and submit it again to make sure it was received?

Emily Yoder: Sure. Alina, how would you recommend that should be handled?

Alina Czekai: Sure. So, if you sent it last week, I believe our colleagues have the one week or so turnaround. So, we will note your name and do a search for that email so no need to resend it. So, thank you for submitting.

(Ken Herrick): OK. That's enough.

Operator: We have our next question from the line of Stacey Hill. Your line is now open. And Stacey Hill is from Franciscan Medical. Please ask your question.

(Stacey Hill): Hi. Yes. Thank you for taking my question. I am wondering for 99211, if the patient comes in to one of our drive-up clinics and does a self-swab in the presence of a nurse, are we able to still report that 99211?

Demetrios Kouzoukas: So, when there's a service being furnished in terms of the nurse checking in with the patient and making a visual assessment, et cetera and the

purpose of that visit is for the specimen collection, then the 99211 can still be reported.

(Stacey Hill): Perfect. We just wanted to clarify to make sure we were doing things appropriately. So, that is great to hear. Thank you.

Operator: We have our next question from the line of Dianna Sue from Maryland Hospital. Your line is now open. Please ask your question.

(Dianna Sue): Good afternoon. Thank you very much. Can you all hear me correct well?

Alina Czekai: Yes, we can. Thank you.

(Dianna Sue): Perfect. Thank you again for holding these office hours calls. Have been on them since the beginning and find them very helpful. We do have a question with regards to the federal government's expectations for operators of alternative care sites to report under the quality reporting requirements. We currently assumed that alternative cares have been not subject to the quality reporting program requirements but we wanted to just confirm with that.

Female: So, I'm not sure if we have anybody from Center for Clinical Standards and Quality, if not I think we will have to take that question back for them.

(Dianna Sue): OK. Sounds good. We'll be submitting that via the COVID-19 email then. Thank you very much.

Female: Thank you.

Operator: We have our next question from the line of Jill Young from Young Medical. Your line is now open. Please ask your question.

Jill Young: Again, I want to express my extraordinary thanks for you guys for hosting these events. They are tremendously helpful. In several places in both of the final rules in the FAQs, there's reference made to patient's financial liability with regard to consent. And there's a statement that's made regarding the patient services, when they're initiated by the patient that, that is shown by the patient's consent.

And so, I'm trying to get handle on what exactly is required for patient consent in the documentation? And also, I have a lot of physicians who are very concerned about the initiation by patient. What is initiated by patient in the documentation or are you saying that – saying the patient understands they have financial liability needs both requirements at the same time?

Ryan: So, for many services paid on the Physician Fee Schedule, there are specific regulatory requirements regarding patient consent. And for most of those services, therefore, they mainly are related to services that are none – that don't ordinarily take place and in-person. And so, I'll set my head I think for services like the virtual check-ins.

Jill Young: Right.

Ryan: Free phone calls and for certain of the care management services as well as for some of the patient monitoring services there are explicit and service specific requirements for patient consent.

And to those that the patient consent is known in the medical record, I think generally, that there needs to be some sort of note of patient consent haven't changed, I think. There are certain of those cases where in the – (interim) rules we have tried to broaden the rules so that there is a greater flexibility as to perhaps the sequencing of when that consent is noted and for things like that.

For the services for which there is implicit consent, I think, I don't know if that's the term you use but for services for which there's not an explicit service level requirement for consent, I think our general expectation is, is that, patient's generally are consenting for services when they are in person and they know that they receive them.

And historically, that's how we've worked at Medicare Telehealth services that the consent is inherent because the patient is having a face-to-face interaction with the doctor or other practitioner even though it's through audio-video means. I don't know if I answer your question.

Jill Young: Well in the FAQs, it says and I'm going to quote, "we expect that these services would be initiated by the patient and they're talking about the G2010 and 2012. And it goes on to say ...

Ryan: Got it.

Jill Young: As for the G2012, we know that the service is initiated by the patient, this means that the patient must consent to the service. So, I'm trying to understand that leap of initiated by patient to consent.

Ryan: Sure. So, I think when we established those codes, sort of add in a little bit of the context to when we established those codes and the initial requirements for patient initiated, I think the expectation was that in the – in the discrete case for the service it would be the patient contacting the physician practice for example to set up ...

Jill Young: Right.

Ryan: That virtual check-in but it wouldn't be the practice sort of looking at their roster and checking in with their patients and then charging the patient ...

Jill Young: Right.

Ryan: For those check-ins but rather the broader sense of patient initiated so it doesn't necessarily mean that for that particular technological connection that the patient needed to place the call rather than receive the call but the – but the patient was initiating the contact from an overall perspective.

Jill Young: So, how do they tie that – again, saying these means the patient must consent to the service as initiating by the patient? That's the leap I'm not understanding.

Ryan: I think both of those – both the consent would need to be noted for the separate billing for those services and that the – that the patient was initiating. So, that's the – the logic is, is that because the patient was informed that they might be billing for these services and the patient – and then the patient

initiated that there was content for both. So, overall billing sort of mechanism and then they – and the discreet service by way of the patient initiation.

Jill Young: OK. All right. It's still a little blurry for me but I appreciate your time.

Ryan: Thank you. We'll – we will take a look at that, at FAQ and see if – and see if we can clarify.

Jill Young: Yes. From 49 – OK, with new line 49 on the listing and it references back to the 2019 Physician Fee Schedule Final Rule in that language, that language have been kind of brought forward and it just – for physicians that are very nervous about this initiated by the patient and they're trying understand how that ties into consent for financial liabilities. So, that would be wonderful. Thank you very much. I appreciate it.

Ryan: OK. Thank you very much for bringing it to our attention.

Jill Young: OK.

Operator: We have our next question from the line of Christina Ridgeway from Audio Family Medicine. Your line is now open. Please ask your question.

Christina Ridgeway: This is my first time calling in so, there was – I was trying to get my word. We have a standalone drive-thru clinic and a lot outside facilities where we refer our patients for preoperative screening just to get that negative as recommended by the CDC. We have submitted to the COVID-19 email and asked the appropriate diagnosis to report when they're asymptomatic patient with no known exposure. And we're getting denials for the Z11.59.

Do you have any guidance of only responses that there's no national policy when you do refer to our contractor which we have and they also have no guidance? And it seems that there's a lot information on what to do with 99211 and other areas but nothing on when we have an asymptomatic patient for pre-op setting.

Diane Kovach: Hi. So, this is Diane Kovach and I think, if you're not getting guidance from your MAC we will probably have to take that back and or talk the MAC about

that. If you could, if you have already, sent in your question with the MAC that you work with and that would be great.

Christina Ridgeway: Yes, we did send it to (inaudible) and they just referred us to the AMA.

Diane Kovach: OK. Have you – have you submitted your specific question to the COVID mailbox?

Christina Ridgeway: Yes, ma'am.

Diane Kovach: Ok, great. So, we will then without a question.

Christina Ridgeway: Oh, we did get that answer back and we were just told that there was no national policy or guidance and to refer to our MAC.

Diane Kovach: Right. Now, I understand you're saying that the MAC has referred you to the AMA. So, we will look into that.

Christina Ridgeway: OK. Yes. The only diagnosis that was advised when ICD-9 released their guidance for COVID-19 with the asymptomatic screening was to be the Z11.59 and that's not being accepted, so.

Diane Kovach: OK. We will look into that.

Christina Ridgeway: Thank you so much.

Diane Kovach: You're welcome.

Operator: We have our next question from the line of Victoria Torra from Private Practice. Your line is now open. Please ask your question.

(Victoria Torra): My name is Dr. Torra like Torra, sorry. So, I had a few quick questions. I heard that you said about the 9924 – the 99211 in the level one visit, you said nurse. Should that be a nurse or should be able to be an MA?

Ryan: It can be, I think, I've had to look at the code descriptive but I think it's clinical staff.

(Victoria Torra): OK. Perfect. And then I had a question about the 2021 ruling, like codes coming in where the time that you've been reviewing the chart and documenting is part of the overall medical decision-making time to be counted, it's my understanding that that's now effective due to the pandemic, is that correct?

Emily Yoder: Yes. So, this is Emily. What we said in the first airing of final rule is that for purposes of the office outpatient visit from furnished via Telehealth. We would adopt the framework that is very similar to what we finalized for CY 2021. That time or medical decision-making could be used for purposes of level selection and that the time was considered to be all time that on the day of the encounter not just consent face-to-face with the patient.

(Victoria Torra): OK. And then does that include like if you had – that like the patient, I had the ethics. So, the patient will MyChart me and will say blah, blah, blah and I document how much time it takes me to review it and respond back and they keep going back and forth and like, you know what let's do a video visit because I need to be able to see something.

And so, then we do a video visit a day or two later, does the time that I spent on the MyChart to get them to this video visit that they had initiated, does that get included in the billing for the time overall? For that video visit.

Emily Yoder: Sorry. I was on mute.

(Victoria Torra): OK.

Emily Yoder: I was just going to ask that you submit that question to the COVID-19 mailbox so we can take a look.

(Victoria Torra): Well how – what's the number I – my thing when – come in as the beginning?

Emily Yoder: Sure. The email address is ...

(Victoria Torra): Oh, yes.

Emily Yoder: Sure. It's covid-19@cms.hhs.gov.

(Victoria Torra): So, at CMS?

Emily Yoder: Correct.

(Victoria Torra): HHS dot gov?

Emily Yoder: That's right.

(Victoria Torra): So, two H, H as in Harry?

Emily Yoder: Correct.

(Victoria Torra): OK. Thank you.

Emily Yoder: Thank you.

Operator: We have our next question from the line of Sarah Tooker from (inaudible). Your line is now open. Please ask your question

(Sarah Tooker): Yes. Hi. Thank you so much. So, we were an Acute Care Hospital and as we reconfigure some portion of our COVID unit back to non-COVID care and to accommodate for the (preferred) just coming through our hospital now that is a pent-up non-COVID demand, we are going through sense of, "cleaning procedures" and essentially taking some rooms offline and experiencing short term but severe past issues related to the public health emergencies.

And so in that context we're looking through the FAQs that CMS's public relating through hospital services specifically an FAQ under hospital services number 19 that provides guidance to hospitals needing to transfer a patient through a temporary acute care location like a military field hospital and that advises us to follow existing IPPS transfer policy rule.

But my question really pertains to whether or not that same logic can be extended to tertiary hospital would be permitted to transfer a patient who has an inpatient order that's boarding in our ED due to COVID related capacity issues to another acute care hospital within our health system that has a separate Medicare (fit in) not a military field hospital but another acute care

hospital and with both hospitals be permitted to submit a claim following the existing transfer policy rules.

Demetrios Kouzoukas: So, I don't think we have any of our folks from the Acute Care Division, if we do, they should speak up but if – and that's what the transfer policy ultimately relates this rule. We need to get that question to the right people.

(Sarah Tooker): OK. So, I'm going to submit it to the mailbox?

Demetrios Kouzoukas: Yes. Please.

(Sarah Tooker): OK. We will do that. Thank you very much.

Operator: We have our next question from the line of Maureen Hollasky from Perci Virtual. Your line is now open. Please ask your question.

(Maureen Hollasky): Hi. Thank you for taking my call. In a previous FAQ, there was direction given that if the provider of record or an inpatient was in the same location as the patient, but you virtual technology to keep the distance from the patient that, that claim should be billed as a face-to-face visit. Is that – would that stay the same after the PHEN where if the provider is in the same location that uses technology, they would always be able to bill as a face-to-face visit or is that something that was – is allowed because it's an emergency.

Emily Yoder: Hi. This is Emily. So, – no please go ahead Ryan.

Ryan: I think that one clarification I'd make to the question with the – and I jumped into that I think I probably answered it before. It's not necessarily in all cases where the technology was used that it would be billed as a face-to-face or in in-person visit. I think there could be any number rules that would affect but the – but the Medicare Telehealth restrictions would not apply in those – in that scenario.

And so in many cases particularly for billing under the physician fee schedule many of the services would be reported the same as in-person services even if the communications were happening through technology – through

communications technology and that really the major takeaway should be that when the patient and the practitioner in the same location, the Medicare Telehealth rules don't apply or restrict.

And that policy would be effective even outside of the public health emergency given that the way of the law is written that governs for the Medicare Telehealth provisions.

(Maureen Hollasky): OK. That's great. Would you be able to put that in writing to clarify because in the FAQ I thought that it's specifically stated during the QIG?

Ryan: Sure. We can certainly take a look at that.

(Maureen Hollasky): OK. Thanks.

Ryan: And clarify.

(Maureen Hollasky): Thank you.

Operator: We have our next question from the line of Priscilla Frost from Trinity Health. Your line is now open. Please ask your question.

Priscilla Frost: Yes. Thank you for taking my call. My question is concerning our Telehealth during the waiver. Have you all got any kind of a timeline on the decision of the possibilities of what they're going to extend of the Telehealth services that we currently are using? And are we going to see a change eventually of some of the services that will be allowed for Telehealth?

Demetrios Kouzoukas: Oh, I can start and others may have more to add. The statured only allowed us to go so far outside the contacts of the public health emergency. In particular, some of the things that Congress did allowed us to bring Telehealth in the (PFS) contacts to out of patient's home and outside of rural areas that flexibility and when the public health emergency ends.

So, this in terms of, yes, don't have a crystal ball in terms of when that'll be. I think it depends obviously fair mount on what happens with the virus and the pandemic and so forth but I can't share that much in terms of what the statues

flexibility is and where it goes. I don't know if others on the team has more to offer.

Emily Yoder: Yes, this is Emily. The only other thing that I would add to what Demetrios said is that for the things that we have regulatory authority over. So, like the services that are on the Telehealth list, frequency, limitations, things like that were considering which and how many of those who want to maintain on a permanent basis and were we to keep those policies they would appear as proposals on the Physicians Fee Schedule under this proposed rulemaking that historically is issued sometime in July.

So, I would encourage folks to just sort of keep an eye on that because that would be where we would sort of make those proposals and seek public comment.

Priscilla Frost: All right. Thank you.

Operator: We have our next question from the line of Denise Wibber from UHS. Your line is now open. Please ask your question.

(Denise Wibber): Thank you and good evening. We have a question regarding clarification for hospital outpatient departments that are submitting patient home addresses for an extension of the facility. And the clarifying question we need to know, is for the Medicare population that are covered under a Medicare Advantage plan.

First portion of the question is will those patients also qualify for the facility technical component of a provider based clinic visit under the Medicare Advantage plans?

Demetrios Kouzoukas: So for the – with regards to the Medicare Advantage plan that you're talking about, are you an in network or out of network provider?

(Denise Wibber): In network.

Demetrios Kouzoukas: OK. So, the payment would depend on your contract. And the contract has been negotiated with the MA plan as an in network provider.

(Denise Wibber): OK. And then the second portion is whether or not we have to submit the patient addresses to those plans would also be payer dependent. So they're not obligated to follow CMS in that regard.

Demetrios Kouzoukas: No, not for a new network plan.

(Denise Wibber): Okay, thank you very much. Have a great night.

Demetrios Kouzoukas: Thank you.

Operator: We have our next question from the line of Louise Troy from Joy and Young. Your line is now open. Please ask your question.

(Louise Troy): And we really appreciate you having these calls. My question concerns hospital setting up swing beds. The authority has been granted and we're working with hospitals that are finding themselves dealing with the surges in Texas. Do you have to call in advance to – in this case it would be Novitas to their hotline – which has limited hours to get that approved before you start using swing beds.

Ryan: Yes, as a matter of utilizing this waiver, you do need to work with the MACs to be able to effectuate this waiver for a particular hospital.

(Louise Troy): That's a big deal in the circumstances we're facing now in Texas and especially in the eastern Texas area, because the surge is on and we're not able to communicate with Novitas from 3:00 or 4:00 in the afternoon on Friday until Monday and that may make a difference. So, the other question I have about twin beds is, does the patient stay in the same bed?

(Man): Yes, the patient may stay in the same bed and they are using the swing bed waiver. And it's just important that you note that in the record so that it's clear when the patient's – inpatient stay concluded. And when the patient's SNF stay commenced. And there are some – there are some articles and publications available on the MLN website that can provide you some additional information about that.

(Louise Troy): OK. And the other question is, if there's a system and there's one hospital that's got the room to have swing beds and a hospital in the system, can they transfer into swing beds when they can't find other nursing home facilities in the area or does the patient that's in the swing bed have to have come from the same hospital.

(Man): So that – let me see if I'm following the scenario in this case. The patient is in hospital A, which does not have a swing bed agreement in place. There are not any skilled nursing facilities that are available to take the patient. But hospital B, which is in your hospital network does have a swing bed agreement and could take the patient, is that correct?

(Louise Troy): That's what I was wondering. Yes.

(Man): OK. I'll need to go back and talk with some of our technical experts in our enrollment team to determine what occurs in those situations in terms of the enrollment and we can provide an update.

(Louise Troy): Okay, and one last – it follows up on the commentary about Medicare Advantage. If Medicare Advantage, a contractor is involved, whether they cover swing bed in a non – like they're used to covering swing beds in CA, critical access hospitals and rural hospitals, and this is brand new.

And it wasn't contemplated when the agreements were entered into with Medicare Advantage programs be able to refuse to cover swing beds in non-CA – non-critical access hospitals or rural hospitals because that was never covered in the agreement.

Demetrios Kouzoukas: Is this in network or out of network?

(Louise Troy): In network.

Demetrios Kouzoukas: It would be dependent on the agreement there as well in terms of what the plan provides in terms of how to pay for acute care – post acute care coverage in what kinds of facilities or circumstances.

(Louise Troy): I get that but nobody contemplated death when those agreements were entered into.

Demetrios Kouzoukas: Right. I mean, in other words the – I understand your concern. It is that when those agreements were entered into there wasn't as big a proliferation of swing bed, that swing beds are rarely isolated circumstance and now there's a bigger need for them.

And that reflects, ultimately, the underlying market condition that the beneficiaries are confronting, right, in terms of getting access to care. The MA plans are obligated to provide access to needed care including SNF skilled nursing and post acute care.

And in order to meet that requirement, they either use their existing SNF contract network or modify it to add more swing beds or otherwise deal with the situation on the ground. They have that flexibility to adjust to those changing conditions. And we've done a fair amount to sort of provide as much flexibility there as they can – as we can to make it easier for them to be able to do that (mid-year) as well.

(Louise Troy): OK, because it's – most of these hospitals are urban so there never would have been a swing bed issue for them so they never contemplated providing new services at the time. But your point is taken. Thank you.

Demetrios Kouzoukas: Right.

(Louise Troy): Thank you very much. This helps.

Demetrios Kouzoukas: Thank you.

Operator: We have our next question from the line of Amber Rectorfrom University of Utah. Your line is now open. Please ask your question.

(Amber Sector): Yes, thank you for taking my call. So my question is regarding the FAQ that was recently updated last week, under the Section G of the hospital outpatient locations. Question 16 asks about the CR in VR modifiers and condition codes for the waivers.

And it says that it should have them but then under special edition MLN 20011, where you laid out all of the scenarios where the CR or VR is required. I don't see the hospitals without walls or those expansions listed. So I'm just trying to confirm if those really are required when we're expanding the outpatient departments.

Diane Kovach: So, thank you for bringing that to our attention. We'll take a look at the discrepancy between the two and then we will make sure we update the FAQ. I think in general the Special Edition article is the appropriate guidance, but I just want to verify. So, thank you for that and we will definitely look at it.

(Amber Sector): Great and then if you don't mind, I just have one more question also about the expansions. So, if we have – if a hospital creates an off-campus location just for testing, does that need to be – does that address need to go to CMS for the expansion?

Operator: We have our next question from the line of…

Emily Yoder: Operator, we're still looking into that one. Sure. So, if the hospital is creating an off-campus site just for testing purposes and wishes to bill with the PO modifier, then it would go ahead and submit the relocation request assuming that the site that's relocating is moving off or was previously using the PO modifier, meaning that it was accepted from any payment reduction and was not being paid under the Physician Fee Schedule.

But if it's a brand new site that didn't previously exist at all and it's not a relocation then it should be billing with a PN modifier and would be subject to the relativity adjuster under this Physician Fee Schedule. I think we're ready for the next question now. Thank you.

Operator: Thank you. Your next question comes from the line of Ardie Cuezar from Heritage Policies. Your line is now open. Please ask your question.

(Ardie Cuezar): Hi, thank you. This is just asking for some clarification. So, were the telephone only codes 99441 through 3, if during that telephone E&M, the physician ends up ordering the COVID lab tests, is it appropriate to put the CS

modifier on that telephone E&M code? The physician would be in the office, patient's at home.

Ryan: Sure. So, in general, I think we've said that the evaluation management codes would be appropriate for the CS modifier and we will confirm that that's true and that's accurately reflected in the guidance, et cetera.

(Ardie Cuezar): OK. So the answer is yes. I mean, I thought it would be but I was second guessing myself here, but OK. So this is appropriate.

Ryan: It's an important and a good question and we'll make sure that the guidance reflects them.

(Ardie Cuezar): Oh, OK. Thank you very much.

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

Operator: Our final question comes from the line of Jonie Tinsilly from Community Health. Your line is now open. Please ask your question.

(Jonie Tinsilly): Thank you. I have a question regarding the assignment of benefits and there's been any consideration of being able to verbally because we work in the psychiatric population and it is difficult for them to communicate either by e-mail or portal or any other method for signatures for assignment of benefits.

Demetrios Kouzoukas: So you're looking for the signature to be done in some other way that's not electronic, maybe like a verbal or something like that. So, are you asking if it can be done electronically, just – did we lose the caller? We might have lost the caller.

Alina Czekai: Caller, did we lose you? Operator, can you see if we still have our caller connected?

Operator: To the last participant who will ask a question, please press star one again.

Alina Czekai: So I think we did lose that caller, but can we take that one back. And everyone, we appreciate you joining our call this afternoon. As always, you

can continue to direct questions to our COVID-19 mailbox. Again, that email address is COVID-19@cms.hhs.gov.

We appreciate all that you're doing for patients and their families around the country as we continue to address COVID-19 as a nation. This concludes today's call. Have a great rest of your day.

End