Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
July 21, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 7477995

Alina Czekai: Good afternoon. Thank you for joining our July 21st CMS COVID-19 Office Hours. We appreciate you taking time out of your busy schedule to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the Office of CMS Administrator Seema Verma.

Office Hours provide an opportunity for providers on the frontlines 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 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 media inquiries form which can be found online at cms.gov/newsroom. Any non-media COVID-19-related questions for CMS can be directed to covid-19@cms.hhs.gov.

Again, please keep in mind that the questions discussed on this call are general representative questions. Your specific circumstances maybe different, therefore the information provided may not always be applicable to your unique situation. You are welcome to reach out to the COVID-19 mailbox for further assistance.

We'd like to begin our call today with some updates on recent CMS publications and guidance. Last week, CMS announced the agency's targeted approach to provide additional resources to nursing homes in COVID-19 hotspot areas. This includes plans to deploy Quality Improvement Organizations, or QIO, across the country to provide immediate assistance to

nursing homes. Please visit CMS' newsroom page for more information on the recent announcement.

Additionally, the COVID toolkit for statistics to mitigate COVID-19 in nursing homes has been updated and can be found on the current emergencies page under the section Clinical and Technical Guidance for Healthcare Facilities.

Additionally, the document's End-Stage Renal Disease Quality Incentive Program, frequently asked questions, exceptions for dialysis facilities affected by COVID-19 was also updated last week and can be found on CMS' current emergencies page under the section Clinical and Technical Guidance for Healthcare Facilities.

And because we've received a number of recent questions about nursing home testing, we thought we would do a quick review of laboratory testing for skilled nursing patients in Medicare. For a SNF resident who is in a state covered by Medicare Part A, diagnostic laboratory tests along with associated activities like specimen collection are included in Medicare's per diem payment.

This is true regardless of whether the SNF performs the test itself with its own in-house resources or an outside lab performed the test under an arrangement with the SNF. When the beneficiary in a Medicare certified SNF is not entitled to Part A benefit, for example Part A benefits are exhausted, the SNF level of care requirement is not met, et cetera, Medicare Part B may pay for covered diagnostic laboratory tests that are furnished by SNF to their residents.

And there are two ways these services could be billed. First, SNFs that have a CLIA certificate including a certificate of waiver can perform and bill part B for clinical diagnostic laboratory tests under the clinical laboratory fee schedule as permitted by their level of CLIA certification. The other way that these services could be billed for is for SNFs that do not have a CLIA certified laboratory, clinical laboratory testing is performed by independent laboratories that may travel to SNFs to collect specimens for testing.

In those cases, the laboratory may bill Medicare directly, or if the SNF has the arrangement with an independent laboratory, the SNF can bill for the clinical diagnostic tests the laboratory performs on behalf of the SNF. A SNF that is not itself an independent laboratory may not bill for specimen collection under Part B and specimen collection is not included on the list of Part B ancillary services.

Finally on last week's Office Hours Call, we received a question about the SNF benefit period waiver and if the discharge code could be billed or rather should be billed on day 100 or day 101. And a special edition article has been updated to clarify that it's day 101 and we also clarified a few other points. The updates can be found at www.cms.gov/file/document/se20011.pdf. The updates in that document are in red font and the SNF benefit period language starts on page 11.

This concludes today's updates from the agency and now we would like to take questions from folks on the phone. Please do try to keep your questions to one question or one question and a follow up today. Thank you.

Operator, we'll take some questions.

Operator: Thank you. Ladies and gentlemen, we are about to start the question-and-answer session. To ask a question, you will need to press "star" "1" on your telephone. To withdraw your question, press the "pound" key. If your line is not transcribed yet, I'll identify you by the last four digits of your phone number.

Your first question comes from the line of Ronald Hirsch from ACPA. Your line is now open.

Ronald Hirsch: Thank you. So, there had been a lot of questions on past calls about coverage for preoperative testing and the ICD-10 Guidelines for Fiscal Year 2021 were just released. And in it, CMS and the other cooperating parties state that during the pandemic for encounters for COVID-19 testing including preoperative testing, code as exposure to COVID-19 as screening code is not appropriate.

So, that sounds like we should be using the code Z20.828 exposure to COVID-19 and that means it's going to be covered by Medicare. So, my question though is, most of this document is effective as of October 1st but since this refers directly to the pandemic, is it effective now?

Demetrios Kouzoukas: So, the discussion that I think you're referring to really see – really talks about screening, that screening tests are something that CMS doesn't pay for given the historic criteria and differentiates – and speaks to what the screening tests are in at least some circumstances. So I – at the particular scenarios around particular patients and the like, I think I continue to refer you to the MAC as we have in times past.

But I – as to the – and so the basic principle around what Medicare does and doesn't pay for though is something that applies irrespective of October 1 or other times. That's something that is a sort of altruism that doesn't relate to a particular point in time.

Ronald Hirsch: Got it, OK. So my follow-up question actually relates to something that was asked last week which was the social worker asked about billing for counseling services provided to a patient in a Part A SNF stay.

And the correct answer that you gave was that it's part of consolidated billing, so they can't bill separately, but my question is with all of the psychological trauma of these patients, isn't the SNF obligated to provide those services to the patients either under arrangement or with their own staff if the patient or the family requests it? Or are they allowed to say, no, we're not going to get you counseling because we don't want to spend the money on it?

Male: So it – obviously each patient has their own particular needs as it relates to the facility. But if a particular patient believes that their care is not being adequately provided, I believe that they have some ability to request assistance through the QIOs for some assistance in that manner. Particularly, that may be their best approach in the immediate term.

Ronald Hirsch: Perfect. Well, thank you very much.

Operator: Your next question comes from the line of Christopher Shank from Sydney Health. Your line is now open.

Christopher Shank: Hi, thanks for taking my call. I was wondering, we had some communication or there's been some literature talk that the public health emergency is supposed to be ending on July 24th of this month, so basically this Friday. And there's a worry that if that is true and the PHE is going to end, will the telehealth flexibility put out by CMS and central government go back to what they were pre-COVID-19. Do you have any information if the PHE is going to end this Friday, and if so, if the guidance is going to change?

Demetrios Kouzoukas: A number of the flexibilities, a large number of them are dependent on the PHE being in place. The intent is to renew the public health emergency. It hasn't been issued in terms of its renewal but that's the publicly stated intent and plan.

Christopher Shank: So as of right now, technically July 24th, this Friday, it's going to end unless the new notice goes out?

Demetrios Kouzoukas: That – as of this date it's not – it hasn't been renewed yet. The exact date of when the renewal would go hasn't been made available yet but I think you can look forward to seeing it soon.

Christopher Shank: OK, great. Thank you.

Operator: Your next question comes from the line of Jean Russell from Epoch's Health Solutions. Your line is now open.

Jean Russell: Hello. I also have a question about the presurgical testing. I know there's an FAQ specific to outpatient and if it's billed separately, it will be paid separately from an outpatient OPPS claim. Is there any consideration for an inpatient? So if we're doing presurgical testing on a patient that's going to be admitted for surgery, is that still bundled into the 72-hour rule or can it be billed separately?

Ryan: So, I think in those cases the bundling rules would continue to apply.

Jean Russell: OK, there's no exception. OK, that's what I thought, but I was hoping maybe there was. OK, thank you.

Operator: Your next question comes from the line of Sara Hunt from Navan Hospital. Your line is now open.

Sara Hunt: Thank you. I'm reaching out because a number of our members are running into situations regarding patients who are undocumented and this pertains to billing. They have attempted to bill the EMO services for Medicaid and had been denied. And so I'm seeking clarification on what's the right approach that CMS is recommending. Do we bypass EMO and go straight to the HRSA website and bill that way? Clarification would be appreciated.

Demetrios Kouzoukas: Forgive me. Are you thinking about the HRSA program that's available for uncompensated care?

Sara Hunt: Correct. We have – we have individuals who present, who have no insurance and are undocumented. Emergency Medicaid Only services will not pay for the entire stay. It's not considered insurance due to how EMO has been crafted. We have – our hospitals have attempted to bill that only to be – have services denied.

And so we're kind of left seeking, one, are we being inappropriately denied based on your understanding of EMO criteria or is the pathway to use the HRSA uninsured web portal for payment?

Demetrios Kouzoukas: I see. We'll have to take that question to our Medicaid colleagues and then perhaps beyond to HRSA. So, we're not in position to answer it here but we can try to get you to the right place.

Sara Hunt: I would appreciate it. Thank you.

Operator: Your next question comes from the line of Joy Vicker from Bay Ross Medical. Your line is now open.

Joy Vicker: Good afternoon. Thank you for taking my call. I was just curious with the prior authorization for COVID testing, are we able to capture the charge for the pulse oximetry checks or is that an all-inclusive?

Demetrios Kouzoukas: So is this a question around a Medicare Advantage prior authorization or a fee-for-service – Medicare fee-for-service prior authorization?

Joy Vicker: A Medicare fee-for-service.

Demetrios Kouzoukas: And one that you're encountering with regards to COVID testing?

Joy Vicker: Correct.

Demetrios Kouzoukas: OK. I don't know that we're familiar with the prior authorization for Medicare fee-for-service for COVID testing.

Joy Vicker: OK. Well will – so then the other piece is, would it be covered as a service for screening prior to surgical procedures?

Demetrios Kouzoukas: Pulse oximetry reading or COVID testing?

Joy Vicker: Yes, pulse oximetry reading to assess for potential COVID.

Demetrios Kouzoukas: I would direct you to the MAC for coverage questions like that.

Joy Vicker: OK.

Demetrios Kouzoukas: As we have – for the COVID testing too.

Joy Vicker: OK. Thank you very much.

Operator: Your next question comes from the line of Nancy Reed from University of Virginia. Your line is now open.

Nancy Reed: Hi. Thank you for taking my call. We are trying to clarify some specifics relative to the CS modifier that's billing as a hospital and we had a patient who's seen – is seen for outpatient services and does a high throughput

COVID test, the U0003. Would we append the CS modifier to that E&M visit?

Female: Hi, thanks for the question. We're not offering specific coding information relative to use of the CS modifier outside of some guidance that we expect to be issued very soon. But, I would just kind of reiterate on – several weeks ago we had some conversations about when it was appropriate to use the CS modifier and so when – as it relates to hospital, the CS modifier – it's for testing-related services where there's an order for or administration of the clinical diagnostic lab test that relates to the furnishing of the test or the evaluation of the patient and their E&M codes and so it sounds like you're asking if the CS modifier would apply to the lab test code itself and there's – I'm not aware that there's any cost sharing associated with the lab test. But if there – if it meets all the other requirements, then that would be an appropriate use of the CS modifier.

Nancy Reed: OK, so to follow up, let me clarify, we are paid on the lab fee schedule, so we're aware that the CS modifier is not required on the actual COVID test. However, all the literature that we've seen thus far only states that the CS use with a U0001, 02 or the 87635. The high throughput test, the U0003 and U0004 assumedly would be included but has not been explicitly stated that way and that's where we're questioning, if we treat them the same as the U0001 and U0002 or not?

Female: I do ...

Ryan: So I think – I think ...

Female: Oh go ahead.

Ryan: .. I think we can take that back. I was just going to say I think we can take that back for – to make sure that the guidance is clear and updated to include the – which lab test codes are applicable. But, I think what you're hearing too is that the – as you're assuming that the – that the provision applies to the COVID testing and so – and as you know, the COVID testing from a coding perspective and the specificity of the test continues to evolve and so we'll make sure that the guidance is updated.

Nancy Reed: Great. Thank you so much.

Operator: Your next question comes from the line of Sara Hednesky from UVA. Your line is now open.

Sara Hednesky: Hi, thanks for taking my call. I actually had the exact same question that you just covered with Nancy. So, let me just say what I think I heard you say that applying the CS modifier to the evaluation and management code is appropriate, assuming that all of the other guidance that you published is true.

And that is true for the lab test that you published, the other U-codes and that you will be providing more specific guidance on the U0003 and 4 soon. Assuming I stated all that correctly, do you have any sense of what soon is, is that a day, is that a week, is that four weeks?

Ryan: I understand the question. I think – I wish I can get – I could be more detailed about what soon means but in this case, we'll – we will at a minimum we can give an update on next week's Office Hours Calls but we'll try to make sure that the guidance is updated as soon as we can.

And again, I think the policy is for the E&M visits that lead to COVID testing and so I think that's the – that's the key point there and we will update as soon as we can and again, we can get back to you with the more formal for next week's Office Hours Calls.

Sara Hednesky: OK, thank you.

Ryan: Sure.

Operator: Your next question comes from the line of Cathy Lafrei from UCI Health. Your line is now open.

Cathy Lafrei: Thank you for taking my call. I'm going to take us back to the preop testing. Our institution does preop COVID testing for all procedures since the PHE. This is a research study question. Would we consider a procedure that is part of the research study? Would that be considered something that we should be

billing to the study or because we do it overall for all procedures, would we be able to consider that standard of care and bill to the insurance company?

Female: So, it sounds like we might not have the right people on the call for these questions. So if you have not already submitted to the COVID mailbox, that would be great. So, I'll have to get back to you on that.

Cathy Lafrei: Great. Thank you very much.

Operator: Your next question comes from the line of Sandy Donovan From Columbus Regional. Your line is now open.

Sandy Donovan: Yes, I need some clarification on the HCPCS code C9803, the collection of the test that was created specifically I thought for outpatient department labs within a hospital. I'm hearing some conflicting information, I'm being told that we're not supposed to be billing with that code and – but I thought they were specific to the outpatient labs within a hospital. And also, that my other – my second question to that is, are we only to use that if we're – if we're drawing that – for that test within our hospital or collecting with that test?

Female: Yes, so I can start. HCPCS code C9803 is for the hospital outpatient billing itself, so it's hospital outpatient clinic visit specimen collection for COVID, any specimen source is the long descriptor. And so if there's a hospital-based lab billing, there are other codes that labs, if in that instance, if the hospital is billing as a lab, there are other codes that would be billed for that. But if it's the hospital billing directly, the C9803 would be the appropriate code.

Sandy Donovan: And so if they were – if we have practices that we owned, we would – it would not be appropriate for us to bill for them, is that correct or not correct?

Female: What sort of practices are you referring to?

Sandy Donovan: Well, physician practices that we owned. If they – if they should collect at a practice, then they send it to the hospital and we bill for the test, can we bill for the collection of it as well or not?

Female: So, it might be good to talk to your MAC because it really depends on how the entities are enrolled. And so if the service is furnished by a physician practice and it's billing under the physician fee schedule, their – this code would not be appropriate. This code is only appropriate for hospital outpatient departments who are billing as the hospital outpatient department.

Sandy Donovan: Yes and I get that but I think they're in – in some people's head, they think that if it's collected at the practice, that the hospital can go ahead and bill for that collection piece.

Female: Yes, so the – I think the important point there is to recognize how the collecting entity is enrolled and recognized in Medicare before determining which code is appropriate.

Sandy Donovan: OK, thank you.

Female: Sure.

Operator: Your next question comes from the line of Rhonda Carr from Johns Hopkins Health. Your line is now open.

Rhonda Carr: Hi, good afternoon. My question is related to hospital outpatient cardiac rehab program that were impacted by COVID-19 health emergency. The program, the Medicare program coverage benefit requires the patient to complete 36 sessions over a 36-week period or for peripheral artery disease, a total of 36 sessions over 12 weeks. And we have patients that are approaching those timeframes who've experienced an interruption in their program due to COVID.

And so what I'm trying to seek additional guidance around is whether there are any flexibilities that were established for those patients who were prescribed and started with the hospital outpatient cardiac rehab program pre-pandemic that were unable to continue in the hospital outpatient setting for significant period of time because of COVID?

Female: So, I'm not sure if we had this question before but again I do not believe we have the right people on the phone to answer it. So if you can send that into the COVID mailbox and we'll make sure that we did manage it for you.

Rhonda Carr: Awesome. Thank you. I appreciate your assistance.

Female: Sure. Thank you.

Operator: The next question comes from the line of Sedona Kirby from Conifer Health. Your line is now open.

Sedona Kirby: Hi, thank you for taking my call. I appreciate it. So, my question is around convalescent plasma therapy and the requirements around claim reporting and submission. We understand that there is no reimbursement impact for patients being treated with the plasma but we would like to confirm that we can assign a penny charge to a plasma charge code for reporting purposes. So, that's the first part of my question.

The second part is from a claims perspective, what reporting process should be followed regarding convalescent plasma therapy reporting for COVID patients? We want to confirm that our facilities are not required to follow Medicare clinical trial policy as convalescent therapy treatment for COVID patient is part of the expanded access program and not a clinical trial. So, can we assign the penny charge and is – are we interpreting the rule correctly?

Female: So in terms of submitting with the penny charge, I believe that you could do that and then it would be denied, if it's a non-covered service. In terms of the correct interpretation, I would have to defer to my colleagues on that. I'm not sure if there's anyone on the call that can address that issue.

Sedona Kirby: And just for clarification, we're really – if we follow that clinical trial policy, then we have to assign the research codes and that's not the process that we want to take but we want to make sure that's appropriate.

Female: OK. And I don't think our colleagues and our coverage and analysis group are here on the call today and I believe they're the right folks to answer the rest of

your questions. So again, if you could submit that to the COVID mailbox, that would be helpful and then we'll make sure you get an answer to that.

Sedona Kirby: OK, thank you. I really appreciate your time today.

Operator: Your next question comes from the line of Jim Collins from CardiologyCoder. Your line is now open.

Jim Collins: Hi, there. Yes, I'm trying to follow up on a question that I asked several weeks ago about how physicians should differentiate between the four different levels of medical decision making.

As it stands now, all of these telehealth services, the ones that are audio and video are supposed to be coded based on either time or medical decision making and there's just no standard for medical decision making. So, I'm kind of following around to see if maybe those 2021 guidelines could be used as an alternative to kind of like the mystery standard that's out there now.

Ryan: So again, we certainly appreciate the question. I think for – in terms of what would be the appropriate documentation for code selection using the medical decision making, I think the best advice we could give is to talk directly with your MAC about what would be – what would be the best approach, given the – given that the 2021 definitions are not effective yet.

And the – as you're pointing out, the definitions that are part of the 2020 coding guidance aren't themselves design to be used in that way. And so I would recommend talking with your MAC directly about how they would – how they would do that.

Jim Collins: Yes, OK, well we – OK. We'll try then. They will not give an answer on some of them but it's just kind of a – it's like a catch-22, a lot of physicians because there's a lot of money being dedicated to auditing and constituting fraud. But, we don't know what the standard is, so it's hard to be compliant, so I get it. There's no definitive answer now but I'm telling you the MACs are not helpful in this endeavor.

Ryan: OK. OK, we appreciate hearing that and we'll continue to look at it and see if there's a better answer that we can get to.

Jim Collins: All right, thank you.

Operator: Your next question comes from the line of Barbara Cobuzzi from CRN Healthcare. Your line is now open.

Barbara Cobuzzi: Hi, good afternoon. I talked to you about this some weeks ago and then last week a colleague brought this up and I'm going to – you had said you were going to bring it back. When a physician does a phone call telehealth service, so it's 99441 through 443, it has that seven-day limitation on it.

NGS has removed that seven-day limitation, realizing that physicians will do follow up with those – with patients within that seven-day window and therefore allowing them to do another phone call service sooner than eight days since the prior one. But other MACs are not eliminating that seven-day window and you guys had said you were going to look into that because it's really putting a cramp on physician's ability to charter real services they're providing to their patients that are medically necessary.

Ryan: No, thank you for – thank you for bringing that up again and we certainly appreciate the importance. Unfortunately, that's something that we're still looking into and determining whether or not there can be national guidance in that regard. But in the – at present, I think following the guidance for your individual MAC is the best approach.

Barbara Cobuzzi: OK, thank you.

Operator: Your next question comes from the line of Gina Ruiz. Please state your organization name. Your line is now open.

Gina Ruiz: Hi, thank you. I'm calling from Casa Colina Hospital and my question is with regards to billing the Q3014 versus G0463. So along the same lines with the unhelpful MAC, our MAC has been doing several telehealth webinars and through these calls we thought we were pretty clear that we could not bill a G0463. When the physician in our HOPD is providing a telehealth E&M

service to a patient in their home, we were told that we should be billing Q3014 just during this PHE.

So, that's what we were doing but then our MAC told us that we should be billing a G0463 and they handed out the FAQs, the most recent FAQ and they directed us to section G, question 1 the direction for billing G0463. So, I just wanted to call you all and confirm, are we allowed to bill the G0463? Because, the payment differential is huge but we don't want to do anything inappropriate either.

Female: Hi. What you stated is correct. If there's a telehealth visit by a professional in the hospital serving as the originating site, the originating site fee would be appropriate which – well, you don't have to put them on the spot, if you don't want to, but we would be happy to follow up with the MAC. And we also do have some guidance that's in the Q based on some of the calls that we had recently which highlighted the need for further clarity on this issue.

So, we are hoping that will be out soon but in the meantime, if you want to just let us know by submitting an e-mail which MAC is giving you that guidance, so we can do some appropriate follow up. That would be appreciated.

Gina Ruiz: OK and that's the covid-19 ...

Female: Yes.

Gina Ruiz: ... e-mail?

Female: Yes.

Gina Ruiz: OK, thank you. Thank you very much.

Operator: Your next question comes from the line of Sharon. Please state your last name and your organization name. Your line is now open.

Shayvon: Hi my name is Shayvon and I'm with Allscripts. I wanted to ask a question regarding recoupment of Medicare Accelerated and Advance Payment. Since the public health emergency is expected to be extended, does that mean that

the recoupment of those payments, advance payments will also be extended or is the 120-day recoupment going to stand?

Female: So, that's a question for our colleagues in the Office of Financial Management and I don't believe they are on this call today. I do believe that there is some guidance that's being developed on the recoupment but we don't have any additional information that we can share right now. We will though take the question back and let our colleagues know that it came up on the call today.

Shayvon: OK, thank you.

Operator: Your next question comes from the line of Regan Pennypacker. Please state your organization name. Your line is now open.

Regan Pennypacker: Hi, thank you. I'm Regan Pennypacker from Ancorat Consulting. I have two questions as they relate to Medicare Advantage organization flexibilities. So, the first question is regarding the May 22nd memo to all MAOs, it exercised – it notes that CMS is exercising its enforcement discretion to adopt the temporary policy of relaxed enforcement in connection with the prohibition on mid-year benefit enhancements such as expanded or additional benefits or more generous cost sharing under the conditions outlined in the memo.

Of course – so that they are beneficial to enrollees and of course provided uniformly to all similarly situated enrollees. Now, mid-year benefit enhancements prior to their prohibition were typically put in effect for the remainder of a contract year. So, I understand from last week's call that HHS expects to renew the public health emergency before it expires.

Therefore, even if the public health emergency is not renewed after October, do you think CMS would still exercise enforcement discretion relative to a mid-year benefit enhancement that is put in place to the end of a contract year?

Demetrios Kouzoukas: Hi, this is Demetrios. That's a question that I know we've gotten and are working to develop an answer through in the interest of more certainty. Obviously, to the extent of public health emergency is still in place

and it's not as much of a question or an issue and – but we are looking to see if we can provide some greater clarity about what would happen in the absence of a public health emergency and we're working through that option.

I don't have any particular news at this point, one way or the other, except to just reiterate that to the extent of public health emergency is in place, then that's clear.

Regan Pennypacker: Super, Demetrios. Thank you for that. And my second question is related to the July 10th memo. CMS released a memo of questions and answers relative to MLR. And of these 10 questions, question 9 asked if an MA organization waives or reduces Part C premiums as a COVID-19 permissive action, should that be reflected in the MLR calculation?

And basically the answer is that of course waived premiums wouldn't be considered unpaid premiums in the denominator because the plan didn't require the member to pay them. So that said, the question posed in question 9 asked if an MAO waives or reduces premiums. So, my question is would a partial refund of premiums already paid be considered a reduction of premiums as it applies in this scenario, of course applying the same policy consistently for all enrollees of an applicable plan?

Demetrios Kouzoukas: I don't know that we've see the partial refund question before, so this would be a refund of – rather than a premium reduction that you'd go back in time to another point in the year and refund premiums would be the notion.

Regan Pennypacker: Yes sir.

Demetrios Kouzoukas: And the question is how to treat that under MLR?

Regan Pennypacker: We wondered if – since refund wasn't part of that question, it really spoke to waiver or reduction. We wanted to understand if reduction could be considered also a partial refund, say like you said, a refund of maybe second quarter premiums already paid.

Demetrios Kouzoukas: That's a new one for us. I got to take a look at that. I'm just hesitant to venture out on the MLR because some of that can be kind technical

around the terms of the – sort of the ins and outs of the statute. So, if you could direct that to the e-mail address, I'll give Alina a heads up about where to send the question and we'll make sure we get back to you.

Regan Pennypacker: Certainly. Thank you so much.

Operator: Your next question comes from the line of Dr. Taurus. Please state your organization name. Your line is now open.

Dr. Tordoff: Is that me?

Alina Czekai: Yes, thank you.

Dr. Tordoff: OK, Dr. Tordoff, like tord off running, private practice. I, first off, the person that asked the question about medical decision making, I have like a really good table that helps you be able to tell like complexity, diagnosis and risk that I can send to you. If you want to text me at 850-867-4963 and I can send that to you. But, my question that I had was I'm having a lot of patients recently who are being – not being able to see specialist because insurances don't have specialists in their network.

What can these patients do? Because, their insurance website say, the specialist is in their network, the patient calls and then they're saying that no, they don't take that insurance. And so like, they don't have a – there's some insurances have no neurologist, no pain management, no cardiologist in their entire network.

Demetrios Kouzoukas: None available or they don't have any listed in their network?

Dr. Tordoff: Well, there's none listed like the ones listed on their website, everyone they – the patient calls, they say they don't accept that insurance.

Demetrios Kouzoukas: And is it Medicare Advantage, do you know?

Dr. Tordoff: It's a lot – it’s the marketplace insurances and then there are some Medicaid insurances.

Demetrios Kouzoukas: OK, so the marketplace and the Medicaid plans have different network requirements than Medicare Advantage. I think we can – we, you know, pass on your concerns to our Medicaid team and the marketplace team and then if you have – if you find this MA plan in particular, we can – I think we should – they'll be particularly interested to know about that but ...

Dr. Tordoff: OK. So, you want me to e-mail?

Demetrios Kouzoukas: Yes and we can convey that concerns to the – the more details you can provide, the more we can likely provide to our colleagues who are in the Medicaid in ...

Dr. Tordoff: Yes, I can give you lots of details because me and this patient for the past five months had been calling everyone, trying to find them and nobody – so – and it's the – what was the e-mail address again?

Alina Czekai: Sure. I can provide that, it's covid-19@cms.hhs.gov.

Dr. Tordoff: Thank you.

Alina Czekai: Thank you. And we'll take our next question please.

Operator: Your next question comes from the line of Gretchen Case. Please state your organization name. Your line is now open.

Gretchen Case: Good afternoon. I'm calling from Cedars-Sinai in Los Angeles. I just wanted to – a caller, a few back, did ask a question that we have a very strong interest in understanding explicitly the difference between use of the G0463 and Q3014. So, any guidance that you have coming on that would be extremely important to us and very timely.

As she noted, there is a very different price differential or reimbursement differential and there hasn't been sort of the clarity that we need. I think you're hearing that from the other providers with regard to the actual codes to the billing compliance. Thank you.

Female: Thank you. We appreciate that and certainly we heard that on several of these calls and have addressed it there but we understand that having something in

writing that's super clear is also very helpful. So, we are working as quickly as we can on that. Thank you.

Gretchen Case: Perfect. Thank you.

Operator: Your next question comes from the line of Ina Bender. Please state your organization name. Your line is now open.

Ina Bender: Yes, good morning. This is – this is Ina Bender. Thank you for taking my call. I'm just trying to follow up on the status of the publication of clarifications for the use of CS modifier. On the last week's call, there was a mention there were some Q&A coming out about the use of the modifier in general. And as a follow-up question, are there any specific requirements for the diagnosis to be used with CS modifier?

We seem to have gotten recent OC editors and one of the edits seems to be looking for, if you have a CS modifier, is looking for specific – the COVID diagnosis. But, they're only mentioning two diagnosis codes, the D-codes and the U-codes, none of the Z-codes were mentioned in the editor. So, I wasn't sure if it's customized edits from our company or is that something that CMS published?

Female: So in terms of the question on the outpatient code editor, I am not aware of anything that requires diagnosis codes for that. So if you have any specific information that you can send in to us, that would be helpful and we can look into it. As far as the timing of the additional information on the CS modifier, I believe that is still in development.

Ina Bender: OK, thank you very much.

Operator: Your next question comes from the line of Lori Diggle. Please state your organization name. Your line is now open.

Lori Diggle: Yes, thank you. I'm calling from Warbird Consulting Partners. This is a follow up to a call from a few weeks ago and I also put a question on the COVID-19 e-mail. I was asking about rural health centers performing routine exam. This should have the cost sharing waived but with the G2025, we have

no mechanism to report that it is a physical. So, how should these be reported to waive the cost sharing?

Ryan: I think that there is – that we recently released – so – let me just make sure I'm understanding, so you're talking about a preventive service that sort of (inaudible) rural health clinic via telehealth, is that the question?

Lori Diggle: Yes, yes.

Ryan: So in that case, I believe the answer is that you should use the CS modifier for those claims. It's a secondary use of the CS modifier and I don't have the guidance directly in front of me but I believe that guidance has been released.

Lori Diggle: Thank you. I'll go out and find it. I haven't seen it. Thank you.

Operator: Your next question comes from the line of Susan Tifani. Please state your organization name. Your line is now open.

Susan Tifani: Yes, this is Susan Tifani from Brighton Consultants and we too had some questions regarding the use of the G0463 versus the Q3014. So, we're looking forward to having some clarification and being able to make sure that we're billing compliantly.

Female: Sure. Thank you for communicating that. It maybe helpful just to give another quick reminder on this call, nothing that we haven't said before, but while we're waiting on the guidance to come out. So in general when a hospital outpatient department has registered an outpatient and regardless of, if that patient is in the physical location of the hospital or is in provider-based department of the hospital which could include during the public health emergency the patient's home, if the home location is made provider-based to the hospital.

In that scenario, if the patient is receiving an eligible telehealth service on the telehealth list from an eligible professional whose paid under the physician fee schedule, and the hospital has registered them as an outpatient, the hospital would be permitted to bill the originating site fee in that scenario and not the G0463.

When there's not a corresponding telehealth service being furnished and the hospital, you know, both the patient and the physician are in the same location in the hospital, then the hospital should bill for the appropriate service being furnished which in some cases may be G0463 and other cases may be other services.

And then the last sort of that scenario is when the hospital is furnishing itself is furnishing a remote service as described in the interim final rule that was issued in early May, again in that scenario the hospital – it's not telehealth service, but the hospital is furnishing a remote service which has allowed during the public health emergency and the hospital would just bill for the service that was furnished to the patient.

So, I do hope that provides some helpful clarification of what the policy is but we understand that there are a lots of moving parts and that can make things very confusing. So, I appreciate all the questions on this today.

Operator: Your next question comes from the line of Linda Clark. Please state your organization name. Your line is now open.

Linda Clark: Hi, my name is Linda Clark and I'm with Anova Health Care Services. And my question is about the list of the examples of hospital outpatient therapy counseling and education services that could be furnished to Medicare beneficiaries by hospital outpatient remote clinical staff via telecommunication. The list stipulates that it's not an all-inclusive list and of course it's definitely not all of the – it doesn't include all of the codes for telemedicine.

And so my question is, are hospital outpatient departments limited to what CMS has on this list? And if they are, is there a way that we can have additional codes added to the list? For instance, there's a whole set of speech pathology codes that are included in the telemedicine service but they're not included on the list for hospital outpatient department.

Female: Hi, thank you for that question. You are correct in your description that those are example services. It is not an exhaustive list, so hospitals are not

precluded from billing for a service as a remote hospital service that is not on that list, if they believe that they have furnished that service.

Linda Clark: OK, great. Thank you very much.

Female: Sure.

Operator: Your next question comes from the line of Denise Webber. Please state your organization name. Your line is now open.

Denise Webber: Hi calling from United Health Services in New York and I'm going to go back to the G0463 versus the Q-code. We had posed that question on numerous calls and the clarification you provides us was an exception to what you just stated. And that is if we are a hospital outpatient department rendering care to a patient via through telehealth and that patient's home is registered as part of the hospital outpatient department, we would bill the G0463.

The Q directive, the directive for use of the Q-code was if we were doing any service that was not related to the patient's home being part of the hospital outpatient department designation in which we file for the address to get that qualified. Can you please restate that again? Did we misunderstand it because that was the clarification we received several weeks in a row?

Female: Sure, happy to clarify. So, just as a reminder hospitals are not generally eligible to furnish telehealth services and we understand that can be very confusing, in that hospitals now are able to offer remote services, even though they're not considered telehealth services. So, I do think that may be a source of some confusion but just to reiterate.

So if the hospital is serving as an originating site for a physician or eligible practitioner who's furnishing a telehealth service that is on the telehealth list, the hospital could bill the originating site fee in that instance. It would not be appropriate to bill the G0463 in that case and this is one way to think about it that I think maybe helpful is what would have occurred prior to the pandemic.

And so when the hospital was serving as an originating site fee prior to the pandemic, the only code that would be permitted for a telehealth visit would

be the originating site fee. I recognized that right now with the public health emergency and with care being furnished a lot differently that raises a lot of questions. So, we will be issuing some clarifying guidance on this that I hope will be helpful but it is just the originating site fee if a professional is located outside of the hospital furnishing a telehealth service.

Denise Webber: OK, so let me second – add a secondary situation. So, our physician practices, our hospital outpatient-based departments, so you're stating now in that instance a hospital outpatient-based department, physician practice, the facility with a hospital pre-COVID, we would bill the G0463 if the patient was in the clinic.

The patient is now home-based, the physician practice hospital outpatient department is rendering the service and we have registered that patient home as an extension of a hospital outpatient department.

Ryan: So let me – let me try to help, so in that scenario, then the professional on the – the billing on the professional claim would be via telehealth. So, under the previous circumstances where the patient is seen in person, I'm assuming there – in that scenario let's say that they were – on the professional claim there would be an E&M code reported. And then on the facility claim there would be the G-code for the clinic visit.

Denise Webber: That's correct.

Ryan: And then under the circumstances where the service is furnished the telehealth, the professional claim would be billed and paid the same way with the exception of the – under the – under the PHE would be billed and paid the same way with the exception of the 95-modifier for telehealth being applied to the professional service.

And then rather than reporting the G-code for the clinic visit in that case because it's a Medicare telehealth service, the appropriate code for the facility to bill would be the Q-code, the originating site facility fee.

Denise Webber: OK, I will second the motion of all the previous speakers that it's not what was stated on previous calls. We just revamped our billing according to the

directive we received that we could use the G0463. So, we really need to get that in writing.

Ryan: OK. We certainly appreciate that and we'll get that out as soon as we can.

Alina Czekai: Thank you and thanks everyone for joining our Office Hours today. Our next Office Hours will take place next Tuesday at 5:00 p.m. Eastern. In the meantime, you can continue to submit questions to our COVID-19 mailbox. Again, that e-mail address is covid-19@cms.hhs.gov.

This concludes today's call. Have a great rest of your day.

End