Centers for Medicare & Medicaid Services
COVID-19 Office Hours
September 22, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 2409459

Alina Czekai: Good afternoon, and thank you for joining our September 22nd 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 front line to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and health care 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 cms.gov/newsroom. Any non-media COVID-19 related questions can be directed to our COVID mailbox, which is COVID-19@cms.hhs.gov.

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

We'd like to begin today's call with several updates from the agency. Our last office hour's call was held on Tuesday, September 8th. Since then, we have made a number of updates to some CMS publications and guidance. Updates were made to the Frequently Asked Questions to assist Medicare providers. That document was updated on September 11th, which can be found under

waiver and flexibility information, and also under billing and coding guidance on the CMS website.

For telehealth guidance, Medicare telehealth Frequently Asked Questions are now included in all-inclusive FAQs. Key updates have also been made to clinical and technical guidance for health care facilities. We have included information on Medicare payments for COVID-19 viral testing in skilled nursing facilities and nursing facilities.

We have also posted memo number QSO-20-39 on nursing home visitation for COVID-19 outlining reasonable ways a nursing home can safely facilitate in person visitation to address the psychosocial needs of residents. CMS will now approve the use of civil money penalty or CMP funds to purchase tents for outdoor visitation and or clear dividers to create physical barriers to reduce the risk of transmission during in-person visit.

In addition, CMS received the final report on the Coronavirus Commission on safety and quality in nursing homes, which has been included on our website, along with the Trump administration response to commission recommendations that speaks to the actions being taken to address the commission recommendation.

We now will open it up for questions from the lines. Please do keep your questions to one question or one question and a follow up today. Thank you. Operator Charlie, can you please give the instructions?

Operator: Sure, ma'am. Ladies and gentlemen, if you would like to ask a question, please press "star" "1" on your telephone keypad and wait for your name to be announced. If you wish to cancel your request, press the "pound" key. Again, that's "star" "1" to ask a question. Your first question comes from the line of Rick Gawenda with Kinetix Advanced Physical Therapy, your lines now open.

Rick Gawenda: Hi, thank you. The American Medical Association released the new CPT code actually the day of the last office hours 99072, which is for additional supplies, materials and clinical staff time over and above those usually

included in office visit or other non-facility service when performed in a public health emergency.

A couple of questions regarding the CPT code. Number one, has CMS made a decision in whether to pay for the CPT code that became effective per AMA immediately on September 8th?And secondly, all the guidance in (PMA) says again, this code is used for a private practice setting only and a $1,500 claim form. So I guess I know what's going to come next for you.

If CMS does decide to pay for this code, are they going to somehow allow a task to be paid on a facility claim, a UB04, because again, I'm thinking from a physical therapists, occupational therapists, speech therapists perspective, both private practice and non-private practice how this code could be applicable?

Demetrius Kouzoukas: Hi, this is Demetrius. We're aware of the CPT action and are considering or evaluating – and evaluating what might be appropriate in response and how this code fits into many of the others in our overall payment scheme. As of today, we are not – that code hasn't been put into our systems or a payment structure. Obviously, private payers can make their own decisions. And so given that, I won't speculate on the UB question.

Rick Gawenda: OK. I just know what's going to come if CMS does decide to pay for (inaudible) same issue happen with telehealth. If (inaudible) went to their private practice study and then a month or so later, CMS finally approved telehealth for facility settings of this kind of I guess, planting the seed as CMS discusses the CPT code.

Demetrius Kouzoukas: Thank you.

Rick Gawenda: Thank you.

Operator: The next question comes from the line at Jean Russell with Health Solutions. Your line is now open.

Jean Russell: Hello. My question, it pertains to the modifier CS for cost sharing. I know we would use it if we had an outpatient medical visit and there was a need to order a diagnostic COVID-19 test. Would we use the CS modifier also if the

doctor ordered a COVID-19 antibody test? I'm sorry, did you hear my question?

Demetrius Kouzoukas: Yes, sorry, we're figuring out who the best person to answer this.

Jean Russell: All right, sorry.

Sarah Shirey: Hi, this is Sarah Shirey. I think I can answer it. The COVID antibody test, so generally for Medicare, the CS modifier for lab tests, because they do not have co-insurance supply, the CS modifier is not needed for laboratory tests.

Jean Russell: I didn't mean actually to put the CS on the antibody tests. The CS I know goes on the evaluation and management code. But if we ordered an antibody test, would that visit qualify? Does it have to be at COVID test itself or can it be a COVID antibody test?

Demetrius Kouzoukas: There is a statutory definition of COVID-19 tests. We have to take that one back or if we've thought about that one before.

CMS - (Ryan): Yes.

Jean Russell: You want me to submit it to the COVID-19 mailbox?

Demetrius Kouzoukas: What do you think, Ryan? I think I heard you starting to talk.

CMS - Ryan: Yes. No, I think if you could that would be helpful. In the meantime, we'll try to find – I think it's just a matter of is that the folks who are on the call don't recall and so, we'll we can – I think that's one that we've answered before. So we will – I will take a look while we're answering other questions, and if not, we'll get back to you for the next call.

Jean Russell: OK, thank you.

Operator: Your next question comes from the line of Jen Stevens with Jamaica Hospital. Your line is now open.

Jen Stevens: Hi. Can you clarify again the difference between billing for G0463 and Q3014? And just tell me if this scenario is correct. If when a Medicare

enrolled and billable provider such as an LCSW, does a site counseling CPT 90832, and that social worker is located on site at a hospital-based clinic providing the service to where patient to who's at home, there would be two separate billing component.

A professional billing component for that LCSW on a 1500 claim form. They would bill CPT 90832 with no modifier. And on the hospital side, if the hospital can send a UB04 with G0463. Is that correct?

CMS - Ryan: So, in the case where there is a professional bill for the service that's furnished in the hospital where there isn't a telehealth service, so that the 95 modifier wouldn't be appropriate. In those cases, then the Q code would also not be used. And instead, a code like this, an (explicit) code would be appropriate. Alternatively...

Jen Stevens: (Inaudible) with bill G0463, when the professional is billing 90832 on the professional side?

CMS - Ryan: I don't know offhand if those are the two codes that go together, but in the case where there's not a telehealth claim submitted on the professional side, then the code that would be submitted under the OPPS would be the same for an in-person service.

So, if under ordinary circumstances for an in-person service in the hospital outpatient setting, under those circumstances, the 908 code would be submitted on the professional claim and the clinic visit code would be the appropriate claim under the – for the clinic that's billing, then that would also be the case under the scenario where the hospital's using the temporary location flexibilities.

If, again, if the professional isn't submitting a telehealth claim, but if there's a separate – if that service would be reported using 908 code by the hospital under ordinary circumstances, then that would – then that code would also be reported under the circumstances as well.

Jen Stevens: That's my question. Would the hospital normally report the same code as the professional billing code if this was in regular face-to-face encounter who are on the site?

CMS - Ryan: I think it depends on the particular service. For example, for the office outpatient E&M, the clinic visit code would apply. And I think it would depend on the particular the particular service, what the rules should be, and I don't think we'd give guidance on that particular coding.

Jen Stevens: So how could I get that guidance? It's CPT. Is psych services, CPT 90832 site counseling?

CMS - Ryan: Right.

Jen Stevens: It's location.

CMS - Ryan: So, I think you would look at the guidance for CPT and look at this specific guidance for the hospital outpatient setting for those kinds of services. And I don't know if anybody else is on the call that that might be helpful in that regard. Feel free to join in. But there wouldn't be any special rules relative to the circumstance for the temporary location flexibilities.

Jen Stevens: Yes. And determine what would be the correct code to use on the hospital claim (inaudible).

CMS - Ryan: I think – I think we need to know more about your specific circumstance, but you can certainly submit that question and somebody will get back to you.

Jen Stevens: OK, thank you.

Operator: Your next question comes from the lines of Eileen Lyons with Boston Medical Center. Your line is now open.

Eileen Lyons: Good evening. Thank you so much for taking my call and thank you for having these call. They're extremely helpful. So our question is for a physician group doing home visits. If an RN goes to the home under the physician's direction to give a flu or other immunization vaccines, is it enough if the physician is available by audio and video when needed or does a physician

need to be on an audio, video call with the patient while the RN provides the immunization?

CMS - Ryan: So, for the – to meet the direct supervision requirements, the change that we made would allow for the availability for audio and video presence, much like the physician in this case would be available in the – in-office situation would be in the suite to be available if necessary, and not necessarily in in the room. And so in the same way the audio, video presence needs to be an availability and not necessarily a continuous presence if that's not necessary.

Eileen Lyons: Excellent. Thank you so much.

Operator: Your next question comes from the line of Slevka Partolova. Please state your organization before your question.

Slevka Partolova: Good afternoon everyone. Thank you for taking my question. I am from Healthcare Resources. I have a question regarding the skilled nursing facilities under the waiver we are allowed to extend benefit period. There has been a great publishing done how to go about it, but with the Public Health Emergency expiring on October 24th, I have a question how are we supposed to treat ongoing benefit period that was assigned under the waiver? Is that meant to be a full 100 days or is that benefit period going to be ending exactly when the Public Health Emergency expires?

Demetrius Kouzoukas: Ing Jye, I don't know if we have the right folks with CCPG on to speak to that.

Ing Jye Cheng: Would you repeat the question please?

Slevka Partolova: My question is regarding the extended benefits period. Under the waiver that allows us to give beneficiary new 100 days without completing previous benefits period, meaning without really 60 days with break and following by the three-day qualifying hospital stay.

When the Public Health Emergency expires on 10/24, if we have residents that have been given these new extended benefit period under the waiver, is that benefit period considered 400 days and we just go about it like we would

normally go about the benefits period or is that going to end exactly on 10/24 if the Public Health Emergency expires?

Ing Jye Cheng: I understand the question now. Unfortunately, I don't have an answer at this time. I think your question just to repeat it to make sure I've got the right folks taking a look at it, is should the Public Health Emergency End and not be extended on October 24th. If somebody is in the middle of an extended benefit period that was granted under a waiver, would that extended benefit period end as of the end date of the Public Health Emergency or would it end as is the normal 100 day?

And unfortunately, I don't have the answer right now, but we will look into that and respond next week at the open door call or at the next open door call.

Slevka Partolova: OK, great. Thank you so much.

Alina Czekai: Sure.

Operator: Once again, if you would like to ask a question, please press "star" "1" on your telephone keypad. Your next question comes from the line of Maria with Jamaica Hospital (inaudible). Your line is now open. Excuse me, Maria from Jamaica Hospital, your line is now open.

Maria: Yes, I'm sorry I was on mute on my phone. How are you everybody? My question is about this CS modifier. If we use CS modifier on CPT codes that they not – we're not supposed to use, is that a problem?

Demetrius Kouzoukas: Diane, I think the issues really around the cost sharing and the collection, the proper administration of the benefit with the bene...

Diane Kovach: Right. And there has been some – sure. There has been education that's been going on when it's appropriate to use the CS modifier so you should only be using it in those cases. You should not be putting the CS modifier on the claim if it's not appropriate to put it on the claim.

Maria: No, I mean, if it's appropriate to be added on the E&M code and we use it on the E&M code, however, we use it on the lab code that is in that same visit or

we use it with the CT scan that is done in the same visit? And it's not supposed to be on the CT scan or the lab code. Is that inappropriate, if I am correct, do we need to correct the claim – the claim right now? That's what I'm asking.

Diane Kovach: Right, so it – you would not need to use the CS modifier for lab codes, so that is inappropriate. You don't have to resubmit the claim that is, excuse me, already been processed. However, if the claim has been processed appropriately, if the claim has not been processed appropriately or do you have specific questions, you should contact your MAC.

Maria: OK, all right, thank you.

Diana Kovach: You're welcome.

Operator: Once again if you would like to ask a question, please press "star" "1" on your telephone keypad. Your next question comes from the line of Nolte Napolitano with Medisys Health Metric. Your line is now open.

Penelope: Yes, hi. My name is Penelope and I have a question regarding the 90832 along with Jennifer. When I look at page 128 of your frequently asked questions, this is like provider and we're not putting out a 1500 and I heard you just say that. If we're always billed on the UB and only the UB and I saw down the right side, can I still – can I bill it on the UB with no professional services and I have the waiver?

CMS - Ryan: So if there's no professional services, then you would bill – you would bill in the institutional claim on the UB.

Penelope: So – yes, so we would use that 90832, 90834, all the psychotherapy fully employed, so LCSW societies and Ph.D.s. We're going to go down the right side. Could you have left it in the right side, you know what I'm saying, of your – of your like a decision tree. So, we can actually put that out on the UB scene, that we're not putting out any professional component.

CMS - Ryan: And you're looking at – is it page 132?

Penelope: Page 128, you know 128 ...

CMS - Ryan: OK.

Penelope: ... in the frequently asked questions.

CMS - Ryan: Right, right. That's right, so that's for – that's for PT/OT and SOP and that's where you're asking about it, are you asking about psychotherapy?

Penelope: I'm asking about the psychotherapy. Once, you know, because if I use that same logic, this is psych, and I go down, and I'm not going to be putting out any physician's chart, it's certainly going to be ...

CMS - Ryan: Right.

Penelope: ... fully employed and ...

CMS - Ryan: That's right, it's a ...

Penelope: ... on the UB.

CMS - Ryan: And if under the – under the rules that you would bill under those employment relationships for regular in-person care would apply the same way for the expanded site flexibilities. In which case ...

Penelope: OK, thank you very, very much.

CMS - Ryan: Yes.

Penelope: In which case what?

CMS - Ryan: In which case you would be with – you would bill on the UB, if that's what you would do with the in-person service.

Penelope: OK, thank you.

Operator: Your next question comes from the line of Derek Parris with Life Care Centers of America. Your line is now open.

Derek Parris: Hi, this is Derek Parris and I have a question as it relates to nursing home positivity testing. CMS and CDC recently modified its – the way it's calculating this and are now looking at different classifications based on the volume of testing. So, are facilities obligated to test under the percentage that is shown on the spreadsheet that is from the CMS dataset or are they obligated to test under the color associated to that spreadsheet?

And if so, if we're – if facilities are required to test based off of the colors, is there going to be supplemental guidance that will come out in addition to what is previously been posted related to percentages?

Evan Shulman: Hi, good afternoon, this is ...

Demetrius Kouzoukas: Go ahead – go ahead, you can answer.

Evan Shulman: Thanks. This is Evan Shulman from the Division of Nursing Homes. Thank you for your question and yes, at the top of the document where we post the positivity rates, we described the methodology. And this is really intended to ensure that we're basing testing decisions off of – enough of a volume of testing, so that counties where there are small numbers of testing conducted aren't artificially thrown into higher testing category just based on pure low numbers.

You can test this on a classification. So you know, whether you're red, yellow or green, that's fine. And we're looking at seeing where we can put out that to also speak to this but again, I think what's stated at the top of the – of that document give some of the methodology and you can go ahead test by the classification color.

Derek Parris: OK, so classification color is an acceptable testing process then?

Evan Shulman: Yes. Yes, just document that ...

Derek Parris: All right.

Evan Shulman: ...when you're – when you're documenting your testing trigger, just document what you're basing it off of.

Derek Parris: Fair enough. So, we would just need to document we're at 18 percent on this dataset but it reflects yellow on the classification?

Evan Shulman: That's correct.

Derek Parris: OK, we can do it. I appreciate it sir. Thank you very much for the clarification.

Evan Shulman: Sure.

Operator: Your next question comes from the line of Gwen Dishwoke with UW Medicine. Your line is now open.

Gwen Dishwoke: Hi there, thank you so very much for taking my call. I really truly appreciate it. I have a facility outpatient hospital billing question, not professional but facility. For the transitional care management codes, the 99495 and 99496, during the public health emergency when they're performed via audiovisual we are to bill 99495, 99496 on the facility side, correct?

There's been guidance on the professional side but not the facility side, so I want to make sure I'm clear that pre-PHE we would bill the 99495, 99496. COVID hits, public health emergency happens, these are now being performed via audiovisual. It – I'm needing confirmation from CMS that we bill the 99495 and 99496 from the facility outpatient claim.

CMS - Ryan: So under the – I think I understand your question but I want to make sure that I have the details right.

Gwen Dishwoke: Sure.

CMS - Ryan: So, under the pre-PHE scenario, the visit that takes place in-person and the hospital outpatient department setting happens. The professional bills the transitional care management code and the facility as well as under the OPPS, you're billing the transitional care management code. And then, under the PHE the required visit portion of the transitional care management service is happening and is the professional billing ...

Gwen Dishwoke: No, I don't care about pro. I don't care about professional, like they ...

CMS - Ryan: Right.

Gwen Dishwoke: It's literally for the nurses who are doing the – making sure everything is followed up. I's are dotted, T's are crossed ...

CMS - Ryan: Understood.

Gwen Dishwoke: ... et cetera.

CMS - (Ryan): Understood, so the general – the general policy has been that the facility billing should – whether or not the individual service or the Q3014 code would be appropriate would be determined based on how the professional is billing. So that's ...

Gwen Dishwoke: Well isn't – but I actually – with all due respect, I would challenge you on that.

CMS - Ryan: Sure.

Gwen Dishwoke: Because, it's my understanding, and you guys can correct me if I'm wrong, but the number one question is that you need to ask as an organization is, are you going to follow telemedicine rules or are you going to follow hospital without walls rules?

CMS - Ryan: Right.

Gwen Dishwoke: And that determines how you actually bill, right. If it's telemedicine, it's not – E&M gets billed with the – where the place of service would normally be happening with the modifier 95, and there's no way around it. The facility code gets Q3014 period, end of story. On the hospital without walls ...

CMS - Ryan: Right.

Gwen Dishwoke: ... it's a different series of E&M components of how you get to bill which time-based versus three-key components and they don't put a modifier 95. The place of services were – was going to take place and then the hospital gets to bill the G0463. So ...

CMS - Ryan: That's right.

Gwen Dishwoke: ... that's the first – right, either A or B, that's the – where you have to start from. But in this situation, the 99495, 99496 is the code that we actually get to bill as a facility pre-PHE, so it's not a G0463. So I don't feel like following the Q3014 code or following the G0463 code is appropriate and/or correct, given the fact that pre-PHE they're billing the CPT code, you know, the 495 and 496. Does that make sense?

CMS - Ryan: It does. It does make sense and the payment to the facility in that case is reflective of the cost for the – for that ...

Gwen Dishwoke: Services that's been provided. Yes.

CMS - Ryan: Understood. I certainly understand your point and I think – I think it's a good one. I think it's a good one. I think it might be helpful for us to take that back and issue something ...

Gwen Dishwoke: OK.

CMS - Ryan: ... in writing ...

Gwen Dishwoke: I actually asked ...

CMS - Ryan: ... on that particular issue.

Gwen Dishwoke: That you – absolutely fantastic. I've asked that and CMS did respond to the COVID-19 helpdesk e-mail. You guys responded but you didn't understand my question. That's why I wanted to make sure I did respond last Friday. I can give you a case number, if that would be helpful because we're just trying to get to the bottom of it, right, because ...

CMS - Ryan: Sure.

Gwen Dishwoke: ... we are performing these services and it doesn't really flow into the is this then that, right, telemedicine versus hospital without wall scenario.

CMS - Ryan: Understood. Yes – no, I think you're brining up a good point and it's – in the – in the – in this quick way that we're constructing ...

Gwen Dishwoke: Oh totally get it, no ...

CMS - Ryan: ... (inaudible) in response to the pandemic with the – an interesting and a good and an important question, so I really appreciate it, Gwen.

Gwen Dishwoke: Absolutely, no problem. I appreciate you taking it back.

CMS - Ryan: OK, thank you.

Gwen Dishwoke: Thank you.

Operator: Once again if you would like to ask a question, please press "star" "1" on your telephone keypad. Your next question comes from the line of Jen Stevens, Jamaica Hospital. Your line is now open.

Jen Stevens: Hi, I just wanted to clarify when a fully employed staff of the hospital say a licensed – say a clinical social worker who's fully employed by the hospital for whom there is no separate professional billing being done. When that social worker is located on site at the hospital providing services to a patient at home, the facility can bill on the UB-04 hospital claim form for, say, CPT 90832, when that provider is on site.

If that provider is not on site, can we utilize that billing scenario for a fully employed clinical social worker? We are doing no separate professional billing for the social worker.

CMS - Ryan: That is correct. Just pausing to make sure, Dave, I don't know if you want to take that one.

Yes, maybe he's not on, so that is correct. So for the kinds of services where the hospital is billing for them directly and using that – those location flexibilities, then the hospital would bill just like they would for the in-person service.

Jen Stevens: So if that provider needs to be on site in order to bill for that service on the UB-04, if they were off – if they were not on site, it becomes the telemedicine scenario?

CMS - Ryan: Generally, that's right.

Jen Stevens: And the – would then bill a Q code?

CMS - Ryan: Right. So in the cases where the professional would be separately billing and they were off-site, then it would – then the telehealth rules would apply and the telehealth billing instructions would apply and the hospital would bill a Q code in that scenario.

Jen Stevens: OK, so if the – if this fully employed clinical staff is not a Medicare enrolled biller, they technically can't be off-site providing services? Unless, they're billing incident to somebody else.

CMS - Ryan: That is a good question and if nobody – if Dave is not on, I think we'll take that one back to be sure that we get the right answer. In cases where they're in the – where both the patient by virtue of the site flexibilities and the staff are located within the hospital setting, then indeed they would bill as if they work for in-person service on the institutional claim. But, I will take back for that scenario where the staff would be off-site.

Jen Stevens: To be off-site because I think in the vicinity of ...

CMS - Ryan: Whether those flexibilities would apply.

Jen Stevens: You implied that they could be off-site but they would need to bill incident to somebody else under telemedicine.

CMS - Ryan: Right and under – in the scenarios where they could enroll separately or meet the incident to requirements, they certainly could bill under the telehealth provisions on a professional claim. But, I guess if your question is they are fully employed by the hospital, are there any flexibilities in it? I don't know offhand and I'm not sure we have anybody on the call can answer that and we can take that part back.

But yes, if they – if they were working – if they were in employment relationship with, for example, a physician, who could then bill that services of telehealth service that back – that service could be billed that way as well.

Jen Stevens: And that – then we wouldn't be billing that code on the UB-04, we'll be billing ...

CMS - Ryan: Correct.

Jen Stevens: A Q code on the hospital billing side and a telemedicine professional bill.

CMS - Ryan: That's right.

Jen Stevens: OK. Thank you.

Demetrius Kouzoukas: Thank you.

Operator: Your next question comes from the line of (Paul Johnson) with (N-Services). Your line is now open.

Paul Johnson: Thank you for taking my call. My question is related to SNF Part A patient who is tested for COVID-19 per the new rules and the facility is incurring additional cost. However, because the Part A patient falls under SNF consolidated billing rules, no additional revenue is going to be recorded for that patient. Can these additional cost be covered with the infection control cares funding?

Demetrius Kouzoukas: This is the funding that is coming out of the provider relief fund?

Paul Johnson: Yes, sir.

Demetrius Kouzoukas: That is a question for our provider relief fund colleagues in HRSA. We can take that answer to them. I am – I'm thinking about – and also there might be some relation back I supposed to the way that they structured those, that funding and whether or not it relates back to Medicare policies. So, we'll take that over to our PRF colleagues and see if we can get your answer and work with them.

Paul Johnson: OK. Would that also apply to managed care as when their per diem contracts generally and fall under the consolidated billing as well. It would – that would question would also needing to be answered as well.

Demetrius Kouzoukas: I think there, you really be looking to the contracts since we – and the way that they're worded since those are contractual arrangements is made between facilities and managed care plans. They sometimes reference fee-for-service rules in terms of how they're written but that is a matter of ultimately of contractual interpretation.

Paul Johnson: OK. Just finally then, I mean under consolidated billing, we are – the facilities incur all the cost for Part A patients and there's no increase in the PDPM rates to account for any of these costs, hence the question. So, I don't know if you have any further guidance on that. Will the PDPM rates be increased to account for any further cost if we can't allocate that through the cares funding?

Demetrius Kouzoukas: The PDPM rates are set in accordance with the annual process. There are – the circumstances – the rate that applies to any particular COVID case is going to vary quite a bit, depending on some other factors and the – in terms of the room and the patient and so on. And so, there's sort of a broad-range of potentially applicable PDPM rates for COVID patients.

We have not undertaken any rule making to change those rates. Obviously, if you think that they're insufficient in some manner or need to be revisited, that's something we can always take under advisement. But it's not something that we're currently have discussed doing in any external fashion.

And we would – I think we would want to know some more information about the depths and breadth of the issues if we were to undertake something like that and it would almost certainly involve rule making.

Paul Johnson: All right. Well, thank you for the consideration there SNFs bearing the cost of those patients that are otherwise bundled which hadn't contemplated these costs before. So, thank you.

Demetrius Kouzoukas: Thank you.

CMS - Ryan: Hi. And I just wanted to add something. I saw something come across this morning. And the Department of Health and Human Services did – it's not a CMS thing – but they did post some information on reporting requirements for the Provider Relief Funds from the HHS website under post payment notice of reporting requirement.

So, you could probably Google it. I think it was also in McKnight's (inaudible) that helps. But there's some information in there that you may find helpful about the use of the Provider Relief Funds.

Paul Johnson: OK. Thank you very much.

Operator: Once again, if you would like to ask a question, please press "star" "1" on your telephone keypad.

Alina Czekai: We'll take our next question please.

Operator: Your next question comes from the line of Nolte Napoliccino from Medicines Health Networks. Your line is now open.

Nolte Napoliccino: Sorry. (Inaudible). Is it Penelope that you want?

Alina Czekai: Yes. We can hear you. Yes. What is your question please?

Penelope: OK. It actually goes back to the 90832 and the (inaudible) practitioner and if we've never put out 1500. If the provider is at home and the patient – we have the waiver – the 1135 waiver – and we've never put out a physician's bill, can I put that on UB? I mean because you have allowed a lot flexibilities for the providers and you have a lot of flexibilities of the – obviously, of adding the patient's home addresses, and you've never asked for us to add the provider's addresses. I mean, so these are the therapists at home that we only ever billed on UB. They're fully employed.

So, when I look at your graph, again, I still go down the right side. Nobody's putting out a HCFA with a 95. So, if I say – if I hit – if I go then no, can hospital service be (inaudible) remotely to a patient in north campus provided base apartment including the basements home when servicing as a PBT?

Then they go down. When hospital staff furnishes the remote hospital services using telecommunication technology, the hospital may bill all the UBL4 if the care was furnished in the hospital. And if you (inaudible) before, it's talking about all the flexibilities that you're given.

CMS - Male: So, the issue with the practitioner has to be at the hospital department in order to bill as if the service was provided at the hospital because – in this case, the patient's home is a remote location of the hospital. But if the person providing the service is neither at the patient's home nor at the hospital, then it's not a situation where it's equivalent to providing the service at the hospital location we've now sort of made the patient's home a remote location of that hospital department. Instead, it would be a telehealth service under PFS.

Penelope: OK. So, in the beginning of the pandemic though, when you were allowing providers who actually (inaudible), you expect that also to be a telehealth as well when you are asking the providers to add their addresses as locations?

CMS - Male: When we were asking the – for the patients' homes to be provided as a remote location of the hospital?

Penelope: Yes. But you never asked that the providers' location to be – if the provider was sitting home providing the service, you never asked for that to be added as an address as well.

CMS - Male: Correct. We don't need the provider's address provided when they're providing a telehealth service.

Penelope: OK.

CMS - Ryan: And so, I think we understand the question here. I appreciate folks pointing out that where you're looking in the frequently asked questions document and we'll take that back and see whether we can clarify so that you know what the rules are for that scenario particular and that it might be helpful to know.

So, you have circumstances where staff not – who wouldn't be billing professionally on the professional claim but staff are located outside of the hospital but furnishing services remotely to patients where the patient is at

home under the hospital without wall flexibility. That's sort of the heart of the question, do I have that right?

Penelope: Yes. So, where is – do those flexibilities start and stop? Because if you look, you're saying the (inaudible) shows flexibilities.

CMS - Ryan: OK.

Penelope: So, if you're allowing those flexibilities, I'm sitting here and I'm looking, I'm saying, OK, I'm not going down the left side of the graph. I'm going down the right side of the graph.

CMS - Ryan: Understood. OK. We'll...

Penelope: And to me that will be my flexibility.

CMS – Ryan: OK. We will take that back and clarify. Thank you.

Operator: Your next question comes from the line of Teresa Anderson of University of Washington Department of Laboratory Medicine and Pathology. Your line is now open.

Theresa Anderson: Hello. Thank you so much for taking my call. Can you confirm whether CMS will reimburse laboratories for COVID-19 testing that has been performed by the pool testing strategy?

CMS - Ryan: Could you ask that one more time? I missed the end of your question.

Theresa Anderson: Sure. Can you confirm whether CMS will reimburse laboratories for COVID-19 testing performed by the pooled testing strategy?

CMS - Female: So, this is (Inaudible) from CCSQ. We don't have a national Medicare policy on that. So that would be decided by our local Medicare Administrative Contractors on what they're going to cover under pool testing because they would pay for individual by individual, claim by claim. But we are leaving it up to our Medicare Administrative Contractors. So, they're the ones who would be able to answer that question.

Theresa Anderson: Thank you very much.

Operator: We have caller on the line. Kindly state your first and last name. Your line is now open.

Alina Czekai: And the last four digits are 4192.

Joana: Hi. My name is Joana. I'm with New York Presbyterian. I was wondering if CMS will be considering the newly allowed CPT code 99072 for extra time, supplies, et cetera, incurred fees.

Demetrios Kouzoukas: We are taking a look at that code although – but at this time, we have not changed our systems or payment in order to recognize that code.

Joana: OK. Thank you.

Demetrios Kouzoukas: Thank you.

Operator: Once again, in order to ask a question, please press "star" "1" on your telephone. There are no questions from participants online. We have – one moment. Kindly state your first and last name. Your line is now open.

Alina Czekai: And the last four digits are 4436.

Lisa Bell: Yes. This is Lisa Bell with Sun Medical. I was calling – I wanted to ask back about the Provider Relief Funds for the infection prevention targeted funds. I saw that there's an education requirement referring to the CDC.

Where can I find more information about what that education requirement is? Is it for all employees? Is it for a certain subset? I'm just not able to find the specifics of what's required for the infection prevention training to qualify for the fund.

Demetrios Kouzoukas: (Inaudible), I don't know if you happen to know if this flows from HRSA.

CMS - Ryan: Yes. It's not from CM – the funding part, it does not from CMS. So, I'm sorry. I do not know.

Demetrios Kouzoukas: Well, we can – go ahead.

CMS - Ryan: Probably HRSA.

Demetrios Kouzoukas: Yes. I think we can pass the question along to the PRF people.

Lisa Bell: Thank you.

Operator: Once again, if you would like to ask a question, please press "star" "1" on your telephone keypad. And we have no further question. We have a follow up question from Jen Stevens with Jamaica Hospital. Your line is now open.

Jen Stevens: Hi. Thank you. I have a question about billing to Medicare manage care plans with modifier PO or PN. Should those modifiers be used with the Medicare HMOs? And is there any requirement for addresses for the Medicare HMOs? Or is it only for traditional Medicare?

Demetrios Kouzoukas: So, you're billing in network or out of network?

Jen Stevens: Can you give me both scenarios?

Demetrios Kouzoukas: So, in network, it would depend on your contractual arrangement with the plan about what kind of billing protocols the plan the provider have agreed to. Out of network, the out of network providers are obligated to accept as payment in full the fee-for-service rate for the same item or service.

And so, the best way to signal that the service is the same item or service that Medicare fee-for-service would have paid for certain ways to use the same billing protocol for out of network. But the particulars of that might also rely on Medicare Advantage Plans billing guidelines.

I think for the most part though, for out of network, you're going to generally be looking to the way that the fee-for-service program operates; and for in network, depending on the contract.

Jen Stevens: But are the addresses for the manage care is also being transmitted to CMS, the patient's home addresses, the relocated addresses? Do those...

Demetrios Kouzoukas: I see. So, you're wondering whether or not in an out-of-network situation where you're doing a hospital without walls item or service in the patient address and there's a billing mechanism – and if you were billing fee-for-service you would need to be providing us with the patient address as part of the definition of the hospital location whether or not somehow comparable procedures need to be done for a managed care?

Jen Stevens: Yes, that's my question. I mean, I can't imagine that there would be. But I'm just asking if we are to basically follow the same guideline as if we were furnishing the addresses for the managed cares?

Demetrios Kouzoukas: I see. I don't know that we have that particular question before. In general, the way that we view out-of-network rates in Medicare is that it's really that the focus of our guidance has been around the actual rate, not necessarily the billing mechanism.

We should go back and double check to see that there isn't anything particular here. But I think for one, obviously, checking with the plan could be helpful but we can go back and just double check and maybe take a look to see if there's some reason that the address need to be appended. We'll take that back.

Jen Stevens: OK. Thank you.

Operator: Your next question comes from the line of Cindy Pfister with University of Kansas Health System. Your line is now open.

Cindy Pfister: Yes. So, I have a situation where we have a telehealth visit within 72 hours of an inpatient admission. And I'm getting an RTP or denial for that revenue code for the inpatient claim. Should those telehealth visits be rolled up into that inpatient claim or should they be billed separately?

Ing Jye Cheng: So, this is Ing Jye. I guess one question we would have is – when you say telehealth, are they professional claims or are these remote services provided by the hospital?

Cindy Pfister: Remote services provided by the hospital.

Ing Jye Cheng: Ryan I'm sorry. We were about to speak.

CMS - Ryan: Yes. No, that's OK. So, are you billing the Q code?

Cindy Pfister: No. We're billing the...

CMS - Ryan: The telehealth services?

Cindy Pfister: The telehealth code, yes.

CMS - Ryan So, if the hospital is reporting the Q3014, which is on the – under the OPPS or I should say on the institutional claim on the UB claim, then those Q codes I think you will continue to report and they should be separately paid.

But the – is it on the professional claim that you're having an issue or the hospital claim?

Cindy Pfister: The hospital claim.

CMS - Ryan: And is the telehealth originating site code?

Cindy Pfister: 9921 through 15.

CMS - Ryan: So those – the – those office or outpatient E&M codes would be for under the OPPS would be reported the clinic visit code, right, the 30463?

Cindy Pfister: So, their telehealth because of the CARES Act and the patient's at home, the physician's in his office.

CMS - Ryan: In which case, they will be billed on the professional. If they're professional services then they're – then they'd be billed on the professional claim with the telehealth rules that would apply.

Cindy Pfister: OK. All right. Thank you very much. Appreciate it.

CMS - Ryan: Yes.

Alina Czekai: Thank you. And thanks everyone for joining our call today. You can continue to submit questions to our COVID mailbox which is covid-19@cms.hhs.gov. This concludes today's call. Have a great rest of your day.

End