Centers for Medicare & Medicaid Services
COVID-19 Office Hours
November 03, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 2394789

Alina Czekai: Good afternoon, and thank you for joining our November 3rd 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 frontlines to ask questions of agency officials regarding CMS's temporary actions that empower local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce for patients over paperwork and further promote telehealth in 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 our COVID mailbox, which is covid-19@cms.hhs.gov.

Please keep in mind 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.

And since our last office hours call on Tuesday, October 13th, we have updated a few CMS publications and guidance. We also have follow-ups regarding some questions from our last call.

Some general updates had been made to the frequently asked questions to assist Medicare providers, which includes telehealth FAQs. For healthcare facilities, we have updated the toolkit for states to mitigate COVID-19 in nursing homes. We have also posted the enforcement discretion relating to certain pharmacy billing documents stating that in order to facilitate the efficient administration of COVID-19 vaccines to skilled nursing facility residents CMS will exercise enforcement discretion relating to certain pharmacy billing. In terms of billing and coding guidance, we had provided provider Q&A for patient counseling.

Finally, you can review and download PDFs of the Medicare Accelerated and Advance Payments Program COVID-19 public health emergency payment data. There were also a few questions on our past few weeks of office hours that we followed up with CMS colleagues. And we'd like to share answers to those questions on today's call.

During the last office hours call, a question was raised regarding the editing for claims containing the CS modifier. In late August, CMS released additional guidance regarding with which HCPCS codes, the CS modifier can be used. The policy is effective retroactively. But the edits were implemented prospectively based on the date of claim receipt.

Regardless of the date of service, once the edits were implemented, any code not approved for use with the CS modifier is being rejected or returned to the provider. At this time, CMS does not expect to review claims for the appropriateness of the CS modifier. However, the claim could still be reviewed for other reasons. It is possible the use of the CS modifier could be questioned if there was a possible fraud concern.

Also there were several questions regarding COVID -19 vaccines. And we confirm that orders will not be required for COVID-19 vaccines.

Also last week, there was an outstanding question on the vaccine stakeholder call that we held regarding critical access hospital's ability to request a change to their interim payments for vaccine administration costs. The response to that question is there is an existing process for established costs already in

place for (Max) to evaluate these types of requests to adjustments to call per diem rate.

CMS will need to meet internally and with the (Max) to figure out how to (fold) these new not yet known/established costs into the process. So they are built into their per diem from day one, which does slightly differ from the way the (Max) generally handled changes to existing rates by evaluating historical data.

However, CMS will work with the (Max) to implement this on a consistent basis nationwide to address the call provider community concerns. That concludes our updates at the top of today's call. We will now open it up to live questions. Please keep in mind to keep your questions to one question today or one question and a follow up. Operator, (Charlie), over to you.

Operator: Sure, ma'am. Ladies and gentlemen, if you would like to ask a question at this time, please press "star" "1" on your telephone keypad and wait for your name to be announced. Again, that's "star" "1" to ask a question.

Your first question comes from the line of (Rosy Suasel) with AdventHealth Orlando. Your line is now open.

(Rosy Suasel): Thank you so much for these calls. I have a question about the new recent ruling CMS-2020-1-R2. And it's in regards to laboratory turnaround times for COVID-19 high throughput testings. My question is how is two calendar days from specimen collection to be measured. There is many different ways you can count calendar days like the collection date is day-zero or is the collection date day one or is it 48 hours exactly or is it at midnight on day two. If – in order to program our systems properly, I need a really definite definition of two calendar days.

CMS - Male: So that is a great question. And certainly appreciate it. I'd – that the interpretation will be that generally, I think you – the way you termed it was day zero would be the first day. So the intention is that on the second day following that specimen collection, that would – that would meet the – meet the threshold requirement for the two calendar days. But we will endeavor to

take a look at that and issue something in writing that will – that will help you in all of sort of implementing details for that.

(Rosy Suasel): That would be really wonderful. I would sure appreciate a definition in FAQs. And as a follow up question, as you know, our supply chain issues for clinical laboratory testing are still issues. So are – when you count – when you measure your turnaround time are you measuring only high throughput tests done in house? Or is it high throughput testings done in house and the high throughput testing that you have to send out to a reference laboratory because no laboratory has enough supplies to meet the demand?

CMS - Male: I don't know if anybody else is on who can answer that definitively. But we can certainly take that back and address that as well.

(Rosy Suasel): OK because sending it to your reference lab is going to take a little longer than being able to do it in house. But we can't always – we just don't have the materials to do everything we want to do in house.

So thank you very much for your clarification. I really appreciate it.

CMS - Male: Sure. Thank you.

Operator: Your next question comes from the line of Sandy Sage with HomeTown Health. Your line is now open.

Sandy Sage: Hi. Thank you for taking my call. We were wondering if a patient is in an – a skilled nursing facility bed and receives either plasma or the antibodies and when they're available as an outpatient if they're excluded from the SNF consolidated billings that – so that the hospital could build those directly to Medicare as an outpatient or is it included and shall we bill the SNF for the payment.

CMS - Female: Sorry can you just repeat the scenario again from the beginning. I know there's ...

Sandy Sage: Sure.

CMS - Female: ... part of the part now whether or not you wanted to exclude it from consolidated billing. But wasn't sure I captured ...

Sandy Sage: Right.

CMS - Female: ... all of those details on the scenario.

Sandy Sage: That's OK. So when Medicare patient is in a skilled nursing bed ...

CMS - Female: Yes.

Sandy Sage: ... in the nursing home and these – the plasma or antibodies – and they have to come to the hospital for outpatient, do we bill that to the nursing home or do we bill that directly to Medicare? Where's the part of the nursing home payment?

CMS - Female: If then – if the nursing home patient is in – is in the middle of their part A stay, the SNF would be ...

Sandy Sage: Right.

CMS - Female: ... billing Medicare. So the hospital would need to work with the SNF in terms of payment to the hospital.

Sandy Sage: OK. So it's not excluded from their payment, it's –part of it.

CMS - Female: It's not excluded from consolidated billing? Then I was at ...

Sandy Sage: Did you know – OK. Thank you so much. Yes.

CMS - Female: Sure.

Sandy Sage: Go ahead.

CMS - Female: No. I was just going to say you'd handle it the same way you would handle anything you would typically work with that SNF on in terms of the consolidated billing services you already provide.

Sandy Sage: OK. Excellent. Thank you.

CMS - Female: Sure.

Operator: Your next question comes from the line of (Christa Barnes) with University of Texas. Your line is now open.

(Christa Barnes): It's (Christa). So my question has to do with telehealth billing and it focuses on video visits where the provider is billing on the basis of time. And I'm going to walk through the scenario. And then if you could tell me what – if you think I've got it right, please do.

OK. So say the provider is at home and the patient is also at their homes. And let's say the patient's home has been made a temporary expansion location of a hospital outpatient department. But in this case, the provider would bill a telehealth visit with an originating site code because the provider is off campus when the visit occurred. Is that correct?

CMS - (Emily): This is (Emily). And others should weigh in here. But I do believe that that is correct.

(Christa Barnes): OK. So when they are billing on the basis of time, because they're billing a telehealth code, they get to count all the time spent that day, not just the time spent face to face on the video.

Now, say instead the provider had been on campus maybe in their office in the instance that occurred and the patient was in their home, which has been made a temporary expansion site. This time, we would select normal codes that would not be considered telehealth because the provider and the patient are "in the same location."

So this time, the provider could only count the time spent face to face on the video with the patient even if it was the exact same everything, same amount of time spent prepping same amount everything. They'd – they would count different amounts of time depending on where the provider is sitting when the visit occurred. Is that a correct interpretation? It feels illogical. But it seems technically what you guys are saying.

CMS - (Emily): So is the servicing performed just like an office outpatient evaluation management visit? Is that correct?

(Christa Barnes): Sure. Let's say it is.

CMS - (Emily): OK. So I can confirm – and others will have to speak to how they would help potentially bill in a hospital. But on – for that – in the first scenario, yes, they can bill – they can consider all time on the day of the visit as part in – when it comes to selecting the level of off-site patient in them.

(Christa Barnes): OK. But then if the provider's on campus, when does it – same exact visit occurred, they couldn't because they're billing normal codes and not telehealth codes.

CMS - (Emily): I would need to defer to my colleagues on the hospital side.

CMS - Male: So I think – I think in that case you're – it – you're pointing out at what may be a disconnect. But in part, I think that that's because of the (Fritela) health services. We accelerated some of the changes that are slated to be effective for 2021 specifically for telehealth services ...

(Christa Barnes): Right.

CMS - Male: ... during the PHE. And so I think the expectation would be that those – that there would be more uniformity once the changes are implemented in January. I think ...

(Christa Barnes): Yes.

CMS - Male: ... we can – we can take that back and take a look at this any other way to kind of rectify it. But I would point out that the – that these are – these are overlapping policies that are – that are intended during the health emergency. And so sometimes, they don't fit together perfectly necessarily. But looking forward, they are slated to sort of reconcile.

(Christa Barnes): Right. Yes – no. I know that come in. And I think it's just super confusing for a provider who says, "I'm doing a video visit. I get to count all the time spent

that day" except that the technical answer is not if you're on campus when you do that video visit.

It – it's so hard for those guys who are trying so hard to do everything a new way to keep track of some weird little illogical glitch like that. You know what I mean? And I wondered if when you all expanded that policy it was earlier – it was earlier in the pandemic. And we were wondering if maybe what you really intended was to allow people to (move) video visits to count all the time spent that day.

You know when the patient's in their home, you can count all the time spent that day. And that this interpretation about being in the same location sort of came afterwards and layered upon it and make things a little more confusing. I mean, do you – was that the original intent, that video visits you'd get to accelerate to that 2021 time counting rule?

CMS - Male: Right. I think that the intent really was around that, the telehealth services and how that applies to the services that aren't from a billing perspective subject to the telehealth rules. I think may not had been fully considered. So we certainly appreciate the question and how confusing it is. And that while it's certainly not the intent for it to be confusing, I think we'd need to go back then and take a look at that but of course understanding again that hopefully it will be clear in the future regardless.

(Christa Barnes): OK. And forgive me I have one last little queued to it. OK.

What if the provider's on campus and the patient is in a public area? Maybe, they're in a restaurant on – in your hospital campus. Maybe, they're sitting outside on a bench that's still on the campus.

They are in the same location. They'd be connecting by video. Would we do normally in that circumstance as well? The patient is not roomed in a clinic. They are somewhere public. But they are technically "in the same location." Would it be OK to bill for example the originating – the facility fee – the facility E&M, the G0463 in a situation where the patient's sitting on a bench right outside that door of the hospital?

CMS - Male: So I think that the policy with regards to the billing the telehealth originating site facility fee is specific to the temporary location under the hospital without walls. And so I think that the – when that – when that's not being used but rather that the video is used for purposes of connecting two places within the same location, then the telehealth originating site facility fee bill wouldn't apply.

(Christa Barnes): Right. I mean like if the facility E&M like our normal facility E&M charge that we charge when a patient comes in the clinic ...

CMS - Male: I understand the ...

(Christa Barnes): ... and – so we would or would not be able to charge that if patient was on campus in our location. Maybe they're in between visits with different specialists and they have a consult with a third specialist while they're sitting somewhere. They're not roomed. They're not getting in a room like you would when you go the doctor. But they are "in the same location." So do we bill that normally or do you bill that telehealth?

CMS - Male: So I think – I think you wouldn't bill it as a telehealth service because they're in the same location. And so you would bill the same way that you would as if the video weren't being used.

(Christa Barnes): OK. Including the facility evaluation and management charge, the G0463 even though they're not in a clinic room.

CMS - Male: Assuming that all of the other rules from that and that – et cetera. So that, yes, that the – to the extent that you would bill the in person visit not as a telehealth visit on both the professional and the facility side, then you would do so there as well.

(Christa Barnes): OK. So in that regard, it's sort of like when the patient's in their home and has been made an expansion location, it's the same as in the providers on campus, would be the same as if that the patient was sitting somewhere oncampus, not in a room but is "in the same location" from the technical standpoint. Yes. OK. Thank you.

CMS - Male: Sure.

Operator: Your next question comes from the line of Maria Tiberend. Please state your organization then your question.

Maria Tiberend: Hi. My name is Maria Tiberend. And I'm with BJC HealthCare in St. Louis. My question today is regarding the e-visits for those professionals who aren't eligible to submit claims on their own picking – or evaluation of management on their own so for physical therapists and occupational therapists.

The HCPCS codes are G2061 and G2063. And I'm curious are these – with the update, should the (OPPS) payment system back in July – did the changes in that indicate that the services, these e-visits are eligible for hospital outpatient therapy departments for the institution to bill for those e-visits by their employee therapist. Can I clarify that?

CMS - Male: Yes. That I think that will be helpful if you could clarify that?

Maria Tiberend: OK. So the e-visits – the HCPCS codes are G2061, G2062 and G2063 and although they're not considered telehealth. But they're – that's the electronic visits via a secure patient portal. And specific they were on the Medicare physician fee schedule. But a question has arisen from our organization that per the July outpatient perspective payment system changes that the indicator, the payment indicator changed to – from an M to an A for active code.

And so the question is we have therapists who – whose patients reach out and contact them through – they're conducting e-visits in every sense of the word. But we weren't sure if the hospital was eligible to bill for those services for their employed therapists as that institution billing.

We know that the independent therapist that these codes are out – that they're eligible to performance and bill these. But we weren't sure about at – whether this was applicable to the hospitals for their employed – for the services of their employed therapist.

CMS - Male: Yes. Thank you for the question. I think that ...

Maria Tiberend: Does that – does that help?

CMS - Male: That certainly does help. Now, that that question was very clear. I appreciate that on a clarification. That I think that's the case. But unless there's somebody else on that call to confirm, we can – we can to – I'll take that back and to confirm that either in the call in it and then at the ...

Maria Tiberend: I would – I would certainly appreciate it. Thank you.

CMS - Male: Sure.

Operator: Your next question comes from the line of Arlene Wivell-Kozar with Heritage Valley Medical Group. Your line is now open.

Arlene Wivell-Kozar: Hi. Thank you for the taking my question. So this question is about annual wellness visits being performed via telehealth or audio only. In your wellness visits, they require certain exam requirements such as a blood pressure and weight. So during the PHE, CMS allows beneficiary self-reported vital signs to satisfy the exam requirements.

So what if the patient cannot self-report a blood pressure or weight but all other component of the annual wellness visit are met? Will CMS cover the annual wellness visit in this case?

CMS - (Emily): Hi. This is (Emily). Thank you so much for that question. And this is certainly something that we've been – that we've been hearing about.

So right now, the rules are that if the patient can self-report those components of the visit, then you could certainly bill for the annual bonuses that you articulated. Unfortunately, we haven't issued any further guidance that would suggest that if the patient cannot self-report that there would be some sort of a waiver, something that would allow you to bill for the annual wellness visit.

I – and so I – we've definitely gotten this question a lot. And I think that we're still sort of considering how best we can extend any sort of possibilities here. But as it stands right now, no, if the patient cannot self-report, then you would not be able to bill for the annual wellness visits.

Arlene Wivell-Kozar: OK. I just – I was trying to think outside of the box. And let's just say the patient had gone to (CVS) the day before they pick up medication, they got their blood pressure checked and they wrote it down. So the next day, they did their telehealth annual wellness visit and they gave that blood pressure from the day before. Is that something that would be acceptable? Or does it have to be on that day?

CMS - (Emily): Speaking just sort of – I think that that – I think that that would be fine. I don't know if there are others on the – on the call who would have in it more information there. But I think from out of – from a payment policy perspective, you don't have any sort of stipulations about when that blood pressure needed to be measured.

CMS - Male: I would just add I think in those cases obviously, what would be – that that sort of information would probably – it would probably be wise to document the information about the clinical utility of that when the information was taken and et cetera. So that I think that intentions behind the flexibilities are to allow for greater access to the service. And so I don't know that we have specific timing requirements. But I do think that how the requirements of the billing code are met would need to be explained.

Arlene Wivell-Kozar: OK. I appreciate it. Yes. It would be – it would be so helpful if we really could get answers on my original question because we're running in – running into a wall with patients not being able to self-report and they don't want to come in. So it would be really helpful. Thank you.

CMS - Male: OK. Thank you.

Operator: Your next question comes from the line of (Kimberly Jumaro) with Viewmont Health. Your line is now open.

(Kimberly Jumaro): Hi. (Kimberly Jumaro)VermontHealth. We are watching COVID rates go up in Southeastern Michigan.

CMS - Female: Yes.

(Kimberly Jumaro): And we have a couple of centers that the data may be indicating they may be needing to switch to biweekly testing for employees.

The question at the sites is how do they handle employees that are not scheduled during the week. Do they need to pay them, to have them come back in to be tested? Or do they just need to make sure they're tested the next time they are scheduled in onsite?

CMS - (Holly Nureli):Hi. This is (Holly Nureli). Can you hear me?

(Kimberly Jumaro): Yes, I can.

CMS - (Holly Nureli):Is this for skilled nursing facility?

(Kimberly Jumaro): Yes, it is.

CMS - (Holly Nureli):OK. No, we would not expect folks who are out to be brought back into the facility for testing. Our guidance that we've given previously to folks with this question is that we would just insert them into the next regularly scheduled testing gate, so in other words, the next time that the individual would be back into the facility. Let's say they were on vacation that week but that you were – you would be conducting testing at a later date. You would just insert that employee into that next scheduled testing time.

(Kimberly Jumaro): All right. Thank you very much.

CMS - (Holly Nureli):Sure thing.

Operator: Your next question comes from the line of (Christina Fersey) with (PPS). Your line is now open.

(Christina Fersey): Hello. Thank you. I was wondering is CMS collecting data with regards to the number and percentages of patients being provided physical therapy services by physical therapists via telehealth. And then secondly, will CMS encourage and work with Congress to extend the payment for physical therapist providing physical therapy services via telehealth beyond the index of public health emergency?

CMS - (Emily): Yes. So this is (Emily). And I can – I can go ahead and take a stab at this.

So for therapists billing on professional claims, that specialty would be – that provider specialty would be a piece of information that would be on the claim. And so in that instance, this states purely on claimed (face) reporting, we would be able to sort of monitor or not monitor but collect information on the volume of therapy services being provided via telehealth by therapists during the public health emergency.

And in terms of making some of these flexibilities permanent, we certainly hear you. We are not able to sort of speak to Congress directly on some of these things. So we would encourage you to take those concerns to Congress directly.

(Christina Fersey): OK. Thank you.

CMS - Male: Just to – just to add to that, I would just say that we're actively taking a look at all of those flexibilities. And while we wouldn't opine on what Congress should do, we are taking a look at all of those. And we saw it coming on a – on a range of services in the physician fee schedule rule. And we're taking with those comments now. So thank you. I – and we'd certainly appreciate it.

Operator: Your next question comes from the line of Nathan Baugh with National Association of Rural Health Clinics. Your line is now open.

Nathan Baugh: Yes. I want to thank you for taking my call. I had a question. Can CMS confirm that they are working on a way for RHCs and FQHCs to bill for COVID vaccine administration? As you may know, we bill flu and pneumococcal a little differently than our fee schedule peers would. And so we are wondering if the COVID vaccine would be billed the same – a similar way or if some special reimbursement codes would be created for RHCs and FQHCs.

CMS - (Sarah Shirey): Hey, Nathan. This is (Sarah Shirey). We are not envisioning anything different for COVID-19 vaccines as RHCs are currently in the method that you're reimbursed today for flu and pneumococcal vaccines. So we're envisioning that that would work the same way.

Nathan Baugh: OK. So they would essentially be reimbursed cost, a lump sum at the end of the year.

CMS - (Sarah Shirey): That's correct.

Nathan Baugh: OK. Thank you very much.

CMS - (Sarah Shirey): You're welcome.

Operator: Your next question comes from the line of (Brenda Sholky) with UW Medicine. Your line is now open.

(Brenda Sholky): Hi. Thank you so very much for taking my call. Can you hear me? I just want to confirm. Hello. Can you hear me?

CMS - Female: Hello.

CMS - Female: Yes, we can.

(Brenda Sholky): OK. Sorry. Apologize. My question is in regards to the relocating of HO, hospital outpatient departments during the pandemic of PHE. Let me be clear. It's only during the PHE.

So I would start to our CMS regional office in regards to email that we received back from them stating that we actually have to provide the list of departments that we are asking to be relocated. And I guess I'm confused and I need some help so because in the actual FAQs on page 35 it does not actually say specifically the department. And what the person tried to tell me was it – the department on the claim.

Well, as you know, per CMS Claims Processing Manual, 100-04 Chapter 25, Completing of the CMS-1450 Data Set, there's only two actual items that are listed under Form Locator 1, which is the billing providers name and address and (Bill Locator 2), which is the billing provider designated pay to name, which is not required. Form Locator 1 is. And so I'm having an issue with why we're having to report a department when the claim doesn't have a department.

Does that make sense? Like – and other thing that – you have our 835 file, right, that has all of our addresses in it. So here we are relocating our entire hospital, right, because of the pandemic. And so I don't understand why we need to give a list of departments. That's the first thing.

And then the second thing that I'm struggling with is what if the patient has multiple services on one date of service remotely. There is – then you're going to have multiple departments. So that's the second piece to it. And then the third and final piece is the P.O. boxes. Nowhere in any of the documentation that I can find – and if you point me in the right direction, it will be delightful – about we cannot submit P.O. boxes. That's what I was told by the regional office. And I inform them that there is nothing out there on the FAQs that says you cannot. What they do is basically they take it back to the hospital and say, "Provide us a physical location for that patient, a physical address."

Well, if it's a rural health area, they don't even necessarily have a street address. So I – those are the three things that I'm really struggling with. And I'm hoping that you can give me some help with the relocation and the thought process because you don't have the departments on that, the UB-04. I'm sorry. You just don't. So ...

CMS - Male: OK. So sure. Soyou might have to remind me of pieces because there are – there are few things in there.

(Brenda Sholky): I get it. I totally get it.

CMS - Male: The first one, you're asking about providing the address of the original either on campus provider-based department or accepted off campus provider-based department. And that is included in the FAQs on page 35 under the B, c. That that should be included in the information provided for the temporary emergency relocation request.

(Brenda Sholky): Is that in the address, sir? That's the address of the hospital. That's not a name of a department. That's what I'm saying, is we're providing an address to them and they're kicking it back because they don't have a department name. That's what CMS Regional Office in San Francisco is requiring us to provide to them.

CMS - Male: Again, I think it's the address of the department that is – that would be providing the service. So if it's a provider that would normally be at a particular location, this would be – that would be the information put on the form.

(Brenda Sholky): But that's not – but, sir, in all due respect, it's not the name – it's the hospital's name. So Harborview Medical Center for example would be the name of the department and I could get – or, excuse me, name of the hospital. And I would give you the Harborview Medical Center's address. They're telling me, which we had provided both of those items – they are telling me that that is not a department. They are stuck on the name and the word department. And that's where I'm like it doesn't say that you need to give a department.

I totally get it. If you are relocating the hospital to a patient's house, there, it's not – there's no department name on the claim. That's where I'm struggling with that one. I apologize I interrupted you.

CMS - Male: Right. So the – agree that the description here is the address of the accepted off campus provider based department. And the department would be located at an address. And that you're asking for that department to be temporarily relocated to the patient's address. So in that case, that the original location is where the department is located.

(Brenda Sholky): So we would – but that they're denying it because it's saying it's not a department. That's what they're denying. They're saying, "Yes, you're giving us Harborview Medical Center's information. And, yes, you're giving us the address. But you're not giving us the department." And I said the departments nowhere on the claim. If you look at the CMS 1450 completion of the UB, right, there is nothing that says department because you guys don't tell us what department where we can put people. Right. So that's what I'm struggling with, is that I get it.

But what I'm saying is if we have completely – if you are performing let's say radiology, right, or ultrasound – let's do ultrasound – if you're doing the ultrasound at Harborview Medical Center and I'm providing it in the emergency room or I'm providing it in – on that hospital based clinic, that it

could be – it could potentially be provided in multiple locations. That's what I'm struggling with.

And so if we tell you, OK, radiology, I mean it doesn't – it doesn't make any sense. Does that make – am I explaining it correct – understanding – I am having a hard time understanding.

CMS - Male: Yes. And understand that concern.

(Brenda Sholky): Because when you walk around with an ultrasound, right, you're going over to the ED to see if the person has a (DDT) or you're going to go up to general surgery because, oh my gosh, you think the person's having ED to check their (corotage) really quickly. You're going to go to the IV therapy room to actually try to place a Hickman or a – in a central line. Right.

So that that's three different departments. And that's all being performed at Harborview Medical Center. So that's where I'm – I'm using Harborview because it is a – it is the hospital that basically they kicked back to us and said we need to list the department. And I'm like you – but – and then I'll – I said, well, what if they have multiple services on a day. They could not answer because I'm like that's multiple departments.

So that's where I'm – it's not make sense. So I need some clarification because we're getting items kicked back that is frustrating, number one, but, number two, we also are providing P.O. boxes. That nowhere can I find that you can't put a P.O. box down for an address of a patient. If that's the address, what we have for the patient, that's the address we have for the patient. Right. We shouldn't have to go hunting down the person. That's there're several layers of confusion on my part. I apologize.

CMS - Male: Sure. So for that patient, the address that's provided should be the location that the patient is receiving the service. So that that's why a P.O. box wouldn't suffice this because that that patient would not be receiving the service at the P.O. box.

(Brenda Sholky): So if that's all we have on the patient, that – so that you're requiring us to contact the patients with a P.O. box and get a physical street address even if possibly they don't have one because they're a rural patient.

I get – I understand what you're saying. I'm just saying for an institution that treats the homeless population, which we do, there is we treat people that are from the rural health parts of that state. If we only have a P.O. box, we only have a P.O. box. But it sounds like regardless, we're going to have to call the patients back or call the patients and say, "Can you please give us your street address so that we can enter it in to the spreadsheet?" And it wouldn't be on then the actual UB. So if you compared the UB to the spreadsheet, it ain't going to match. Does that make sense?

CMS - Female: CMS colleagues, I think – thank you. CMS colleagues, I think we might need to take this one back. (Brenda), we can provide an update on our next office hours call. I've also taken down ...

(Brenda Sholky): Awesome. OK. Great.

CMS - Female: ... your phone number. We could try to follow up with you that way as well.

(Brenda Sholky): That would be delightful. Thank you so very much. I apologize for taking so much time.

CMS - Female: No worries. We'll take our next call please.

Operator: Your next question comes from the line of (Ima Bender) with Mount Sinai Hospital. Your line is now open.

(Ima Bender): Yes. Could it – hi. Thanks for taking my call. I'm still trying to get some clarification from Medicare regarding antibody testing to identify patients with plasma – possible plasma donation. So I don't know if CMS had a chance to come out with a policy on that. The question comes out, can we bill for the service. We're not. There're some disagreements about what are – we should be billing the insurance of Medicare for the service or we should be providing that for free. But it's in conjunction with identifying patients who might be possibly good candidates for plasma collection.

Do you – do you need a little more clarification? We sometimes go on the community where we had high COVID rates, where patients have COVID. So they are good candidates to identify patients who may have high count of antibody and ask them to donate the blood for plasma collection. That is used to develop products to help take care of COVID.

CMS - (Joanna): Hi. This is (Joanna). And so I'm not sure that we were able to come up with an FAQ published specifically for this. I'll work with my colleagues and see if we can perhaps come up with one. So generally, for the Medicare program, Medicare would not cover the cost of determining whether or not a patient is a qualified donor.

(Ima Bender): OK. Some of this work is done sometimes under research umbrella. But the research that came from the government does not have any budget to cover the actual COVID testing. They may cover the actual blood product that may be administered to the patient while they're hospitalized. There is no precision in some of these kind of research umbrella contracts with the government that have any coverage for COVID testing itself. And as you know, COVID testing itself is not cheap to actually to perform the test. And the test ...

CMS - (Joanna): Well ...

(Ima Bender): You know my facility has a unique code actually where it actually does the testing and it will to titer, which determines the count of your antibody in your blood. So I think it would be helpful to come out with some kind of policy or a few clarification.

CMS - (Joanna): Sure. So it – so there is – there is kind of two different issues at play here. That although I completely understand how they are integrally related. They – so Medicare does cover antibody testing.

(Ima Bender): Right.

CMS - (Joanna): So we do cover that for the – for the treatment for that individual patient that is being tested. So you could – that patient could have an antibody test. Those

results would go back to the patient. They could discuss that with their practitioner and what not.

But testing in particular where – when a patient is tested and antibody testing results never go back to that patient and it is not discussed with their practitioner and things like that. Medicare is not able to pay for that solely for the purposes of determining whether or not that patient is a donor.

There – in order to cover the antibody testing, there needs to be a reason why that test is reasonable and necessary for the patient that is being tested. And I – you understand that I have heard the concern – I have heard the concern about the budgets for testing from other institutions as well. I have not heard how other ones if they have managed to come up with other ways join in for funding and what not.

But for the Medicare program to be able to pay for antibody testing, that it is – it – the test determines necessary for that individual patient being tested. So the whole circle of testing would need to come back to them. The results would need to be discussed with them. It would mean – be needed to be determined that they need the test, that is medically necessary for them and not solely for the purposes of determining whether or not patient is a qualified donor.

(Ima Bender): I think it would – just helpful if you probably publish this frequently asked question for the (thing) you raise on the kind of one of the (criterias) that the test has to be discussed with the patient and they have to provide an ...

CMS - (Joanna): Yes.

(Ima Bender): ... information for the primary for some treatment or another. I think that might be helpful to clarify for providers. And then I guess providers will have to look for alternate sources of funding maybe through FEMA because it's all related to COVID treatment or developing the area's COVID treatment options. So you have to kind of tell these patients to find the patients who can provide you the material that can be used to develop these treatments. So I think it would be helpful to come out with some kind of a policy guideline or for alternate sources of funding for providers.

CMS - (Joanna): OK. Well, thank you for the question. And thank you for that feedback.

(Ima Bender): Thank you.

Operator: Your next question comes from the line of (Christa Barnes) with University of Texas. Your line is now open.

(Christa Barnes): Hey, it's – I'm back from earlier. I have another question. So I got back in line. And this is sort of elementary. But I wanted to verify some things. If a provider does the telehealth visits meaning like, say, the provider is on campus and the patient is, gosh, at a hotel while they do the visits. Can you bill an originating site fee regardless of where the patient is located as long as it's not "in the same location as the provider"? Or would the patient have to be in their home in a site that's been made temporary expansion site in order for the hospital to bill that originating site fee?

CMS - Male: So in order to bill the originating site facility fee, the – that the patient would need to be a registered outpatient.

(Christa Barnes): Right.

CMS - Male: And so ...

(Christa Barnes): What does that mean now?

CMS - Male: ... more that – (Dave), if you're still on, maybe you can help with this.

(Christa Barnes): Yes.

CMS - (Dave): Sure. See your question was whether someone would have to – would have to – whether a facility would have to make the patient's home a temporary expanded site in order to bill with the originating site fee. Was that your question?

(Christa Barnes): Yes. That's one way to look at it. Or another way is if a patient's sitting in a hotel or, gosh, anywhere like in a parking lot at Kroger and they do their telehealth visit on their phone, they are an – they are an – a registered

outpatient. And that we have scheduled them in our – in our – in (Epic). We have made contact, prepared the visit. That they're a registered outpatient for this visit.

And then they do it, the visit through the system. So could the patient be anywhere and we get to bill the originating site fee because we set up the visit or – because at the beginning, I thought it was only when the patient was in a location that had been made a temporary expansion site – I thought that that was what was making us be able to bill the originating site fee back in the early spring. But now, as the interpretation's s sort of more – it made me come back to this fundamental question of, wait, can we bill just an originating site fee no matter what all the time in conjunction with this professional telehealth visit regardless of whatever crazy place the patient might be sitting.

CMS - (Dave): So, first, it's going to depend on if there is a distant site practitioner on the other end of the service. So is the – is that practitioner at the hospital when they're conducting the visit or are they at home or somewhere else?

(Christa Barnes): Well, would it – would it matter if we're billing a telehealth visit? If the patient's not in a hospital location and the provider's not, you'd bill telehealth. And if the patient's not and the provider is, you would still bill telehealth, right, because either way, they're not in the same location.

CMS - (Dave): Yes.

(Christa Barnes): What – the scenario's a scenario where the patient's not in their home and they're not on our campus. Do you get to bill an originating site fee?

CMS - (Dave): So you would – if the practitioner is a distant site practitioner, then you would have the – you could bill the telehealth codes and receive the originating site fee assuming that it is hospital staff that's providing the telehealth service. It would do – in the situation you were mentioning before where the patient is at home and that home has received it, a temporary relocation request location, then if the practitioner is at the hospital, then you'd have the option that then you could bill the G0463 for a visit ...

(Christa Barnes): Right.

CMS - (Dave): ... on the outpatient side rather than the originating site fee. So ...

(Christa Barnes): And I'd – OK. I wonder if, well, I'm getting tripped up on here is when you say a distant site practitioner. I thought so the distant site practitioner is the doctor. You know in the old days, it's the doctor who's the expert who's being called to do a visit with the patient sitting out in a rural facility somewhere. Right. It – in this scenario, the distant site practitioner is the provider doing the professional telehealth visit. And in our scenario, we're a hospital, we're an academic medical center. We employ our physicians. But we also run a hospital. And we also run outpatient clinics. So this patient will have the – an appointment in one of our outpatient clinics with one of the doctors that we employ.

And say the doctor's at work but the patient's at a hotel somewhere and we want to do a professional telehealth visit. So we bill the professional telehealth code for the E&M visit, say. Do we – does the hospital outpatient department, which is also us, get to bill an originating site fee when the patient is in a hotel? Do you get to as a matter of course in conjunction with this professional telehealth visit? Do they already bill in there from (hand)?

CMS - (Dave): Sure. So again, I think if the location the patient is receiving the service at has been registered as a temporary relocation request site, and the practitioner is at the hospital, then you could bill it with a G0463 because it is as if the patient is receiving the service at the hospital because the practitioner is there as well.

(Christa Barnes): Right.

CMS - Male: If not, then it would be a – if the practitioner is not there, then it would be a telehealth service. And they could bill that, the originating site fee on the ...

(Christa Barnes): We too could. So ...

CMS - Male: ... on the – on (facility) claim.

(Christa Barnes): OK. So we get to bill that Q code even if a patient's in a hotel or in their car or whatever. It doesn't matter.

CMS - (Dave): Right.

(Christa Barnes): OK. Cool. All right. Thank you.

Operator: And this concludes ...

Female: Thank you ...

Operator: ... today's ...

Female: Thank you, (Charlie). And thanks, everyone, for joining our call today. Our next office hours will take place on November 17th at 5 pm Eastern. And in the meantime, you can continue to submit any questions to CMS at our COVID-19 mailbox. And again that email is covid-19@cms.hhs.gov. This concludes today's call. Have a good rest of your day.

End