Centers for Medicare & Medicaid Services
Physicians, Nurses and Allied Health Professionals Open Door Forum
Moderator: Jill Darling
January 27, 2021
2:00 pm ET

Coordinator: Welcome and thank you for standing by. Today's call is being recorded. If you have any objections you may disconnect at this time. All participants are in listen-only mode until the question-and-answer session of today's conference. At that time you may press star 1 to ask a question. I would now like to turn the conference over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, (Kelly). Good morning and good afternoon everyone and Happy New Year. This is our first Physicians, Nurses and Allied Health Professionals Open Door Forum. Welcome. We appreciate your patience. We had a couple of speakers who were coming from another meeting, and I wanted to wait to get them on. So we, again, thank you.

I'm Jill Darling in the CMS Office of Communications. And before we get to today's agenda I have one brief announcement. This open door forum is open to everyone, but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact CMS at Press@CMS.HHS.gov. And I will hand the call off to our co-chair, Dr. Gene Freund.

Dr. Gene Freund: Thank you. Thank you, Jill and welcome everybody to a new year of open door forums. I just wanted to say hello and welcome you and also suggest that if you have topics you want on the forum, if you have questions, that you can use the Partnership@CMS.HHS.gov for non-press inquiries, and we look forward to hearing those. And I'm going to turn it over now to my Chair, Mr. Gift Tee, of our Center for Medicare.

Gift Tee: Thanks, Gene. And good afternoon and good morning, everyone and happy New Year. I'll echo Jill's thoughts. I just wanted to give you a brief update on a couple of items this afternoon. And I think we'll start with updates to the 2021 PFS. Due to the enactment of the Consolidated Appropriations Act - as all of you remember, the rule went out a little bit late last year, December 2, and got published later in December.

But there was also legislation that went into effect at the end of December, that we implemented in a number of ways. So I'll let Morgan Kitzmiller walk you through some of the details on that.

Morgan Kitzmiller: Hi everyone. So following the release of the 2021 PFS Final Rule, the Consolidated Appropriations Act 2021 was enacted on December 27 of last year, and it included a few provisions that impacted the PFS, like Gift mentioned. So I'm just going to go through those things.

First, it provided a 3.75% increase in the PFS payments for calendar year 2021. It continued the 2% (unintelligible) (extension) through March 31 of this year. It reinstated the 1.04 on the (unintelligible) through calendar year 2023. And lastly, if you need implementation of the (unintelligible) code G2211 for (E&M) services until calendar year 2024.

So overall, these changes will result in increases to the PFS payment effective beginning on January 1. So CMS (recalculated) PFS payment rates and the conversion (unintelligible) to reflect these changes. The revised conversion (factor) for calendar year 2021 is 34.8931 and that applies to (more) services under the PFS.

You can find all this information under the (download) section in the calendar year 2021 PFS Final Rule that you can find on CMS.gov and then you search CMS-1734-F. I think that's everything. So I can hand it back to Jill.

Jill Darling: Great. Thank you, Gift and thank you, Morgan. Our next topic is from Desiree Haskins on documentation requirements reminder for physicians ordering repetitive scheduled non-emergent ambulance services. Desiree?

Desiree Haskins: Yes. Hello everyone and welcome. My name is Desiree Haskins with the Center for Program Integrity. This is a reminder about documentation requirement for physicians ordering repetitive scheduled non-emergent ambulance services for Medicare fee for service beneficiaries.

Medicare covers repetitive scheduling non-emergent ambulance services if the services are medically necessary to establish when the beneficiary's condition is such that use of any other methods of transportation is contraindicated and the ambulance supplier before furnishing the service to the beneficiary obtains a written order from the beneficiary attending physician certifying that the medically requirements are met.

The physician's written order, a physician's certifying statement dated no earlier than 60 days before the date of service is furnished. The ordering physician is required to provide the ambulance supplier with the physician's order and documentation from the beneficiary's medical records to support medical necessity. A signed physician order does not, by itself, demonstrate that the transports are medically necessary.

Relevant documentation - relevant documentation should provide a clear description of the beneficiary's current condition requiring ambulance

transport. That documentation should report the beneficiary's condition at the time of the transport and dated prior to the requested start date of transport.

Medical documentation - medical documentation should provide sufficient information to support the physician's certifying statement. Documentation can include but is not limited to, doctor progress notes, nursing notes, history and physical exam, physical or occupational therapy notes, home healthcare notes, and end stage renal disease monthly capitation payment provider notes.

Documentation must be from a clinician who provided services to the beneficiary, not the ambulance supplier.

In addition to the reminder document requirements, we wanted you to know that Medicare has the prior authorization model for repetitive scheduled non-emergent ambulance.
Prior authorization - prior authorization establishes a process for ambulance suppliers to request an approval from Medicare, prior to rendering transport, using the medical documentation and an order from the beneficiary's attending physician.

The prior authorization model is currently operating in the states of New Jersey, Pennsylvania, Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, and South Carolina. Although we have been approved for nationwide expansion, at this time we do not have a timetable for expanding in remaining states states and US territories. We will give notice prior to expanding.

Additional information about Medicare requirements can be found in Title 42 of Code of Federal Regulations 410.40(e) and 410.41. Information can also be found in the Medicare Benefits Policy Manual, **chapter 10**. Additional

information about the model can be found at http://go.cms.gov/PAAmbulance . And I'll repeat that again, HTTP://go.cms.CMS.gov/PAAmbulance.

Thank you for joining the conference. I will hand the call back to you, Jill.

Jill Darling: Great. Thanks, Desiree. I'll hand it back to Gift in regards to our third bullet.

Gift Tee: Thanks, Jill. So I just wanted to inform folks and I'm sure all of you are aware of a lot of information that CMS has put out in the past months on COVID and CMS's efforts in that regard. There's a ton of information out that I suspect will answer a lot of questions that you all my have out there, on our Web site at www.CMS.gov/COVIDVAX and that's C-O-V-I-D-V-A-X. There's also a toolkit located at www.CMS.gov/Medicare/COVID-19/CodingCOVID19-Vaccine-Shots.

And there's a ton of billing, enrollment information, links to the (Max) hotlines for enrollment. So I encourage folks to certainly go there. We've taken a lot of time to put a lot of crucial information that I suspect you'll find very helpful, at those locations. And back to you, Jill.

Jill Darling: Thank you, Gift. That is today's agenda. And now (Kelly), can you please open the line for Q&A?

Coordinator: Thank you. Sorry about that. We will now begin the Q&A portion. If you would like to ask a question please press star 1, unmute your phone and record your name clearly. Your name is required to introduce your question. If you want to withdraw your question you may press star 2. Again, to ask a question press star 1. It'll take a moment for the calls to come through. Our first question comes from (Shay Vaughn). (Shay), your line is open.

(Shay Vaughn): Hi. Thank you for taking my questions. I wanted to find out - we're new to anesthesia billing and I did review the anesthesia manual out online, but it didn't contain any information regarding any limitations for billing on the same claim. I wanted to find out if claims are - if a claim say a single claim is required to be billed for anesthesia and CRNA services, whether the CRNA is under medical direction or not, is there a requirement for such a thing?

Louisa Sabatino: Hi (Shay). This is Louisa Sabatino. We are still actually looking at those questions that you sent in about that. In general, we would say that to the extent that services are provided for the same patient, for the same procedure and the same date of service by providers who are going to be billing through the same entity, those should generally be billed on the same claim. However, we are looking into the specifics of the questions that you sent in.

(Shay Vaughn): Wonderful. Thank you so much, Ms. Sabatino.

Coordinator: Our next question comes from (Stephen Sweetkirk). (Stephen), your line is open.

(Stephen Sweetkirk): Hello. Thanks for your introduction and thank you for being there. My question is I heard about the ambulance service. So you're saying that if we do summons an ambulance in emergent care that it probably will be rejected and we have to fill out paperwork to get it covered. Is that right? Thank you. Hello?

Angela Gaston: Hi. This is Angela Gaston. We may have lost Desiree. Her announcement was only for non-emergent ambulance that's scheduled in advance. Not emergent.

(Stephen Sweetkirk): Okay. Thank you.

Angela Gaston: Yes.

Coordinator: The next question comes from (Carrie Stevens). (Carrie), your line is open.

(Carrie Stevens): Hello. I live in - or our organization is in North Dakota and we had a prior requirement of submitting post-op CPT code 99024 on our claims for the past several years and we did search the CMS Web site for 2021 and are not seeing - it's actually not quite clear if we still need to submit post-op (sort of) visits on our claims going forward, in 2021. Does anybody know if that's still a requirement for North Dakota?

Gift Tee: Hi there North Dakota. Absolutely. This is definitely a topic that CMS is very interested in. This is a global services policy issue. So please continue to submit the 99024 because that information is crucial to how we think about the policy going forward.

(Carrie Stevens): Okay. Is it - will there be a time where that's no longer needed?

Gift Tee: I suspect that when that time comes we'll be telling the world about it. So I would…

(Carrie Stevens): Okay.

Gift Tee: …stay tuned. But for right now the information is crucial so please and thank you.

(Carrie Stevens): All right. Thank you very much.

Coordinator: Our next question comes from (Robin Shipping). (Robin), your line is open.

(Robin Shipping): Hi. Thank you for taking my call. My question is related to the COVID vaccine and particularly, you all have noted in the Interim 4th Final Rule that you expected the COVID-19 vaccine to be placed categorically, in the same place as the flu and pneumonia. And since this interim final rule, the Federal Register that addresses this section, Section 410.57, has been updated to include this.

If we go to the Medicare Benefit Policy Manual Chapter 15 and 16, each of these discuss that flu and pneumonia are not - do not require an order nor do they follow the Incident 2 requirements. And my question is whether or not we can make that same assumption for the COVID-19 vaccine considering it's in the same category.

And the manuals have not been updated and many of our institutions across the states, as you know, are trying to do large vaccination centers and we really need to understand and have documentation from CMS related to orders and supervision for these services.

Gift Tee: Hi there, and others will probably weigh in as well too, but I think that's right. You can assume the same rules apply in the sense that there is no order that's required and the incident too as well too, is similar to how we would be treating the flu vaccine. So…

(Robin Shipping): Okay.

Gift Tee: …there should be some information coming out or at least answers to questions that will be put out maybe through FAQs or other media. But that is a way to think about it.

(Robin Shipping): Okay. Thank you so much. And again, thank you for holding these calls. They're really helpful.

Coordinator: As a reminder, press star 1 to ask a question. And our next question comes from (Ramp One). (Ramp), your line is open.

(Ramp One): Hi. Thanks for taking my question. This is actually regarding the 2021 E&M guidelines adopting by both CPT and CMS. The CPT editorial panel has stated that a provider who orders a diagnostic test of any kind may not receive medical decision-making credit for that order if they are also separately reporting a code for that test.

This logic represents a significant departure from the past 25 years in terms of how diagnostic data credit is allocated for the medical decision-making component of E&M services. So I'd like to know if A, CMS shares CPT's understanding of this guideline. And B, if CMS does share it, what about situations where another provider under the same Tax ID reports the test?

For example, a lab in a hospital system that employs the ordering physician separately, reports the test. In such scenarios, would the ordering provider then be able to get medical decision-making credit for their E&M service? Thank you.

Gift Tee: Thank you for that very detailed question, which I think requires a detailed answer. So if you wouldn't mind submitting your question to the mailbox - Jill, it escapes me at the moment. But we'll get it and we'll respond to you.

Jill Darling: Sure. It's Partnership@CMS.HHS.gov.

(Ramp One): Okay. So I will email that to the - to that email address. Thank you.

Jill Darling: You're welcome.

Coordinator: Our next question comes from (Janine Engel). (Janine)?

(Janine Engel): Hi, thank you. Yes. I have two questions I hope you'll allow me to ask, both related to time based billing. So the first is related to CPT codes 99358 and 59, the prolonged non-face to face service codes. So I understand and it makes sense that we can no longer bill those on the same date of service as the outpatient E&M codes, 99202 through 99215 as we can now include non-face to face time on the same date of service.

But in the final rule it was very unclear - it wasn't clearly stated whether we can still bill the 99358 and 59 on the date of service other than an outpatient E&M if we provide a prolonged non-face to face service on those days.

Gift Tee: Hi there. I think we'll take this one as well too. So if you wouldn't mind submitting to the mailbox and we'll get you an answer.

(Janine Engel): Okay. And then if I can quickly, hopefully, ask a second question that's also time related, and this has to do with resident time. So when billing on the outpatient side now, with the new outpatient E&M guidelines, in a GC or a GE clinic, can the resident's time be counted?

Gift Tee: Two for one. So I would include that question in your email to us and we'll get the right folks to answer it.

(Janine Engel): Okay. Should I write those as two separate emails to you guys or can I put it all in one?

Gift Tee: One email with two separate questions should be fine.

(Janine Engel): Okay. I appreciate it. Thank you.

Coordinator: Our next question comes from (Stacy Cohen). (Stacy), your line is open.

(Stacy Cohen): Hi. It's (Stacy Cohen) from Louisville, Kentucky. Thank you so much for taking my question. I'm new to this particular book of business. So I'm just now learning about all of the Medicare benefits and rules. And so with that being said, I read an article that showed a system's success with the RN, traditional registered nurse leading the AWVs, the annual wellness visits.

So I'm wondering is there a conference call or recording that I can listen to get more information about that, like how to bill, if the RN does it versus a traditional provider or APRN?

Gift Tee: That's a good question. I will tackle some of it but I think that we may need to get some more information from you via email.

(Stacy Cohen): Okay.

Gift Tee: I think you're aware that registered nurses can't bill directly versus maybe furnishing the service and having the supervising practitioner, the APRN bill for that service.

(Stacy Cohen): Right. Okay.

Gift Tee: There is that to think about. But as far as other information that could help, generally I think it's best if you shoot us an email and we'll see if we can try to find resources that would be helpful.

(Stacy Cohen): Sounds good. Thank you.

Coordinator: Our next question comes from (Robin Shipping). (Robin), your line is open.

(Robin Shipping): Okay. Thank you. My question relates to the primary care exception rule (unintelligible) the public health emergency, as noted in the calendar year 2021 physician fee schedule updates. We're a little confused as to what code set will be applicable outside of the MSA. In particular, level four and five (UN) established patients, transitional care management. There's a few others.

And we can certainly submit this question through email as well, but does anyone on the call have guidance on what particular code sets (clarity) will be applicable to the primary care exception setting and the rural health areas outside of the public health emergency?

Gift Tee: Yes. No, definitely send that one to email. I don't have the list off the top of my head, so I don't want to lead you down the wrong path.

(Robin Shipping): Okay.

Gift Tee: But we will definitely look at the question and provide an answer.

(Robin Shipping): Okay. Thanks so much.

Gift Tee: I should clarify that though…

Coordinator: Oh, no.

Gift Tee: I'm sorry.

Coordinator: Go ahead, Gift. Go ahead.

Gift Tee: I'll just clarify that that list that I referenced is really just a list of primary care exceptions versus a list that suggests what would be furnished outside of an MSA as we discussed in the rule. But we'll definitely address your question.

Coordinator: The next question comes from the line of (Shay Vaughn). (Shay), your line is open.

(Shay Vaughn): Hi. Thank you. My question relates to the Most Favorite Nation Model. As I understand it, based on the - CMS's page on that, that this was supposed to become effective January 1st but there was a temporary restraining order which delayed it through January 20. But then there was also an interim comment period which was supposed to end yesterday, January 26.

I'm just not clear on what the current status is for this model and how, you know, when we should look forward to more information and if it'll be updated on this - the CMS page for the Most Favorite Nation Model or if there'll actually be like a change request sent out on it.

Gift Tee: I think we may have to take that one back. I don't know that we've got folks that can speak about the Most Favorite Nation on this call. So this is becoming my favorite line. Submit us an email and we'll try to route it to the right folks.

(Shay Vaughn): Okay. Thanks.

Coordinator: Our next question comes from (Marcia), no last name recorded. (Marcia), your line is open.

(Marcia): Thank you. Would you mind repeating the email address where we can send our questions to?

Jill Darling: Sure. It's Parntership@CMS.HHS.gov.

(Marcia): Thank you very much.

Jill Darling: You're welcome.

Coordinator: Our next question comes from (Stephanie Katz). (Stephanie), your line is open.

(Stephanie Katz): Hi all, and I was really just following up on one of the previous questions too, regarding the non-face to face. And it was really in regards to the email as well. So I will just send that email request out to you as well.

Coordinator: Our next question comes from (Joshua Hodges). (Joshua), your line is open.

(Joshua Hodges): Hi. Thanks for taking the question. Very briefly - we received a question about vaccine administration. We understand that the reimbursement rates are on the Web site. But is there any requirement if a provider says they'd rather skip the paperwork; there's no cost sharing for the patient of course; is the provider required to bill Medicare for vaccine administration, or could they just administer and not submit a claim at all? Thank you.

Gift Tee: Louisa, I'm hoping you're still on the line. I mean to the extent that Medicare is going to pay we would want to bill our claim, right?

Louisa Sabatino: Right. So hi, this is Louisa Sabatino. Gift is correct. To the extent that the provider wants to be paid then a claim does need to be submitted. However, if the provider does not for whatever reason, wish to submit a claim and wishes to administer the vaccine without charging the beneficiary and that's…

(Joshua Hodges): Right.

Louisa Sabatino: …an important thing to underline, right, without charging…

(Joshua Hodges): Right.

Louisa Sabatino: …the beneficiary then the provider is free to do so.

(Joshua Hodges): Okay, great. And yes, this would be for someone who didn't care about the reimbursement; just wanted to get it done as fast as possible. So I just wanted to verify that.

Coordinator: At this time, there are no more questions in the queue.

Jill Darling: All right. Well thanks everyone. I'll hand the call back to Gift.

Gift Tee: Thanks, Jill. And thank you, everyone. We hope the information that we provided was helpful. And thanks for your questions. We'll endeavor to try to get responses back to you as soon as possible.

Coordinator: That does conclude today's call. Thank you for participating. You may disconnect at this time. Speakers, please allow a moment of silence and standby for your post conference.

END