# Centers for Medicare and Medicaid Services
# Questions and Answers
# Physicians, Nurses and Allied Health Professionals Open Door Forum
# Wednesday, March 1, 2023

1. Question: A question on the IDR process. One, do you have a sense of the timing on when you'll announce the rules related to the dates of service after October 25th, 2022? That's the first question. And is the agency also thinking of issuing any guidance with respect to the decisions that were made during the period of time between October 25th, 2022, and February 6th, 2023, which was the date of the vacation of that order of that final rule. So, you have a cohort of claims that were adjudicated to a now vacated standard. And do you expect guidance to be issued with respect to decisions that were made to a now vacated standard?
    a. Answer: We are working to get that updated guidance out as soon as possible and resume those determinations on disputes for items and services furnished on or after October 25th, 2022. We hope to get that out soon, but I can't provide any concrete updates on timeline. We are just working as fast as we can. And we will plan to clarify questions around disputes that were processed before the issuance of the ruling as well.
2. Question: I have two very specific questions. It's with regard to the Medicare physician fee schedule outlining that PTs, OTs, SLPs, and audiologists, can continue to see patients at least through the end of 2023. And this is understood to be in a private practice. Now, with Hospitals Without Walls season for a facility-based PT, OT, SLP, audiology practice, I'd like to confirm that we can no longer bill those services from a facility-based outpatient permit. And the second question is going to be with regard to payment parity through the end of 2023 for a facility-based outpatient department, hospital outpatient department, whether or not we can continue billing the facility component of an E&M visit, which is G0463 through the end of 2023.
    a. Answer: With regard to billing HCPCS codes G0463 and Q3014—both of these services will only be billable if the beneficiary is physically in the hospital post-PHE. If both the practitioner and the beneficiary are located in the hospital (and all applicable billing rules have been met) the hospital would bill for G0463. If there is a professional service being provided by a distant site practitioner via Medicare telehealth, and the beneficiary is in the hospital, the hospital would bill G3014. (FAQ pending) Through 2024, any originating site may bill the originating site facility fee provided that the patient is

physically at the site, however if the beneficiary is at home, there is no originating site facility fee.

3. Question: I have spoken to a lot of providers and also DME suppliers who are very anxious about the patients who benefited from the Medicaid expansion that was part of the public health emergency, concerned that these patients may lose coverage and not be aware of it for a period of time, depending on how efficient the States are at informing them, and that there may be a period of time during which they receive services or receive DME or other things, which later turn out not to have been eligible for Medicaid coverage, and therefore there may be recoupments, not to mention the impact on the beneficiaries, most importantly. So, I was wondering if CMS has any expectation of a solution to that. For instance, informing providers and DME suppliers and others who might be impacted, and informing patients as well, of an impending loss of Medicaid coverage.
    a. Answer: So, take a look at our Medicaid unwinding pages. The CMCS folks have a Medicaid unwinding machine going where lots of materials are out there. We're making sure patients are looking for those items. I hear a little bit of a policy question in there about what is CMS doing, if anything, about the possibility that some people could get - a practice could do an eligibility check that comes up with an affirmative answer, but it turns out not to have been correct. Encourage folks to stay tuned - to tune in to those Medicaid unwinding - there are a lot of those unwinding calls as you point out, it varies quite a bit from State to State, how that's going and there are resources. Thank you in this audience for bringing forward the kinds of things that we all should be thinking about. The Medicaid eligibility is really important, because as many of you know, the States have been able to receive the federal matching payment in spite of not - in fact, because of not dropping people from the rolls for eligibility. They're keeping people on. And some people will lose their coverage. So, that's really important.
4. Question: I had questions about Hospital at Home and Hospitals Without Walls, but I am sending an email to Partnership right now. My second question is around virtual supervision. And thank you so much for addressing it in the new document. My question is, does it cover all types of virtual supervision, including the primary care exception? If you look at the Medicare Telehealth Frequently Asked Questions FAQs from 3/17/20, it actually lists out in two or three separate sections all different types of virtual supervision. So, it talks about virtual supervision for education purposes under primary care, for diagnostic purposes, the shifting from direct to general. in this new document that just came out, virtual supervision, and it gave like two examples,

but it didn't cover all of them. Can we assume that all types of virtual supervision is extended until December 31st, 2023?

   a. Answer: Thank you for your question, please refer to the factsheets and FAQs documents, starting with https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf, the Current Emergencies Page, as well as the various provider specific pages that these sites link to, and please keep monitoring these pages. We are continually working to update these pages to help you understand the effects of ending the PHE. Your Medicare Administrative Contractor is likely your best source of information if you're trying to apply your individual circumstances to doing business with Medicare. We're of course happy to answer policy questions that remain.

5. Question: I just wanted to confirm on the extended telehealth for Medicare and telehealth. That's still going to be coverage through like home hospice outside of other than rural areas, correct?
   a. Answer: Referring to circumstances when providing services via a telecommunications system while a patient is receiving routine home care under the Medicare hospice benefit. That flexibility will expire with the end of the PHE on May 12, 2023. If they are referring to conducting the face-to-face encounter via a telecommunications system, that will continue until December 31, 2024.
6. Question: Currently, the telehealth waivers allow physicians and advanced practice practitioners to see new patients via telehealth. I am curious as to whether that flexibility will be extended or if it will end with the PHE.
   a. Answer: Thank you for your question, please refer to the factsheets and FAQs documents, starting with https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf, the Current Emergencies Page, as well as the various provider specific pages that these sites link to, and please keep monitoring these pages. We are continually working to update these pages to help you understand the effects of ending the PHE. Your Medicare Administrative Contractor is likely your best source of information if you're trying to apply your individual circumstances to doing business with Medicare. We're of course happy to answer policy questions that remain.
7. Question: My question has to do with mental health documentation requirements in a non-facility setting such as a physician office. So, I have found in the benefit manual, and also in the mental health booklet that CMS has put out, that an individual treatment plan is required in settings such as outpatient hospitals, inpatient psych

facilities, but there's nothing specific to what - if an ITP is required when the patient is seen in a physician office. Can anybody help clarify documentation requirements?

   a. Answer: Thank you for your question, please refer to the factsheets and FAQs documents, starting with https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf, the Current Emergencies Page, as well as the various provider specific pages that these sites link to, and please keep monitoring these pages. We are continually working to update these pages to help you understand the effects of ending the PHE. Your Medicare Administrative Contractor is likely your best source of information if you're trying to apply your individual circumstances to doing business with Medicare. We're of course happy to answer policy questions that remain.

8. Question: Looking for some clarification as far as remote reading for pathology. During the public health emergency, we had lots of pathologists being able to read different tests. If we had a pathologist that was sitting, for example, in New York, he was able to log in and read remotely any tests that were coming through in North Carolina or California. Does that fall under the same virtual supervision that is going to expire on December 31st, 2023? And do we see a way forward with the new technology that's been, I guess, started during the pandemic to where these pathologists can continue to read remotely to be able to get these patients their pathologists and tests read with more of a quicker turnaround, because we do have other pathologists sitting throughout the country rather than just sitting at one primary lab within a local area.

   a. Answer: Thank you for your question, please refer to the factsheets and FAQs documents, starting with https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf, the Current Emergencies Page, as well as the various provider specific pages that these sites link to, and please keep monitoring these pages. We are continually working to update these pages to help you understand the effects of ending the PHE. Your Medicare Administrative Contractor is likely your best source of information if you're trying to apply your individual circumstances to doing business with Medicare. We're of course happy to answer policy questions that remain.

9. Question: The tri-departments - this is related to the IDR process, and the NSA again. The tri-departments issued an initial report on December 23rd, and they noted of the over 90,000 IDRs that were filed, 69% were ineligible for various reasons. My question is, for some time through the community, we've been advocating for the mandatory use by the health plans of the RARC code. These are Remittance Advice

Remark Codes. The most commonly used RARC code is N830. The problem with that code is, it is literally, by definition, "federal/State." You noted in your report back in December that Texas is one of the principal states where IDRs are originated from. Well, Texas also has a State IDR process. So, if one gets the N830 code for a Texas clinician, there's not any way necessarily without other information, to know, should I file that in Texas, or should I file that in the NSA process? Can you comment about your current thoughts around mandating the use of the RARC codes? There are two codes specifically, N877, federal NSA, and N871. These are established American National Standards Institute codes. These were created for the NSA and adopted by ANSI back in March of last year. my question is, what's your current thinking about mandating the use of those codes? Because if we all agree we need to bring down the number, the percentage of ineligible claims, one of the best ways to do it is to mandate the use of the most appropriate RARC code, right? So, the default isn't just using that N830, which again, could refer to federal or State, but to use, like we say in CPT, CPT's principle is, use the most appropriate code to describe the service. In this case, use the most appropriate RARC code to describe the service and help us make sure that those State claims stay in the State process and don't go to the federal.

   a. Answer: Thank you for your thoughtful suggestion on improving the Federal IDR process by requiring payers to use appropriate NSA-related RARCs when issuing payments on claims subject to balance billing protections. We appreciate this suggestion and have directed it to the IDR policy team for further consideration. CMS continues to investigate and implement ways to improve the efficiency of the IDR process, including through operational changes, guidance, and rulemaking.

10. Question: My question is, I am working with an IDR entity on some disputes, and they came back maybe about a week and a half ago, two weeks ago, telling me that since my claims did not have a DRG on them, they were invalid claims, and they only gave me like 48 hours to submit claims with DRGs. And I called them and I corresponded with them through email telling them that these visits were all emergency room visits, and we normally don't bill DRGs on ER visits. They were adamant that that was wrong, that it is required even for ER visits, so they closed out my IDR reviews, and I've already paid money into that. I'm just trying to get clarification on that because I was on the website. I did mention using CPT, (unintelligible) print, and DRGs, but she said that the latest book is that the ruling or the guidelines do not state revenue codes, that I either need to bill with a DRG or - I did tell her there were corresponding CPT codes to the revenue codes on the bill. She said if we went with that method then each line item would be a separate dispute, which I found kind of ridiculous.

a. Answer: Please submit your complaint to the Federal IDR Mailbox at FederalIDRQuestions@cms.hhs.gov. Please include the dispute numbers for your three cases, the name of the certified IDR entity assigned to those cases, and contact information for yourself/ your organization. Once you submit your complaint to the mailbox, a Federal IDR team member will be in touch. In the meantime, please reference the batching and bundling guidance at: https://www.cms.gov/files/document/TA-certified-independent-dispute-resolution-entities-August-2022.pdf.

11. Question: I had a telehealth question as well in regards to PT, OT, and speech services. I know the Appropriations Act continued telehealth flexibilities for PT, OT, and speech through January 31st, 2024, but it looks like a lot of our Category 3 therapy codes are only covered through 2023. I wanted to see if you could share how CMS is looking at keeping all codes available, including those Category 3 codes through 2024 to make sure beneficiaries still have access to those services.
    a. Answer: It's something that we're actively chewing on, just given what the CAA asks us to consider. So, I would say, stay tuned.
12. Question: I am with the ESRD community, and we are still wearing masks, the staff and the patients. And I was wondering, will that end on May 11th or anytime soon after the pandemic has been lifted completely?
    a. Answer: This is something to talk about with your State or whoever does your surveying. Most of the CMS advice I've seen in the QSO memos, have made references to CDC guidelines. And my understanding is those guidelines aren't mandatory, or CDC in most places are calling them optional. However, healthcare facilities are also regulated by State and local authorities. So, the County I currently live in is requiring masks in all healthcare facilities still. And that's totally independent of the - anything federal about the public health emergency. So, it's much more a question for you to discuss locally. Obviously, in the ESRD environment - I don't have an answer for ESRD in particular. So, that's why I suggest you talk to whoever is doing the survey and certification work in - where you are. But the ESRD population, as we all know, is a population that needs extra protection against any kind of communicable disease, because they are pretty much by definition immunocompromised. So, that's it. But it will not - that decision is actually pretty much independent, if I'm not mistaken, of the actual ending of the public health emergency, because it has to do with circumstances on the ground. You don't need a tuberculosis public health emergency to institute and want to institute TB respiratory protection in that kind of a case, and this is no different.

13. Question: My question is regarding telehealth inpatient and ER consultation codes, GR425 and G0 through G0427, and then the follow-up codes, G0406 through G0408. We know that the traditional evaluation management coding changes that went into effect for hospital-based services this year, indicating that you've been code based on time and medical decision-making, but I've not seen any updates regarding these specific evaluation of management codes. And I was wondering if we're going to see any updates on these specific telehealth, ER, and inpatient consultation codes.
    a. Answer: Thank you for your question, please refer to the factsheets and FAQs documents, starting with https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf, the Current Emergencies Page, as well as the various provider specific pages that these sites link to, and please keep monitoring these pages. We are continually working to update these pages to help you understand the effects of ending the PHE. Your Medicare Administrative Contractor is likely your best source of information if you're trying to apply your individual circumstances to doing business with Medicare. We're of course happy to answer policy questions that remain.
14. Question: For the assessment and specimen collection for COVID testing, the professional billing has been using 99211, and CMS has been reimbursing that code. Do you know if that code will be continued after May 11th, and will CMS continue to reimburse?
    a. Answer: So, our policy was tied to the end of the PHE. And a lot of people that have asked questions on this call have hinted at the idea that CMS needs to consider on a broader perspective all the PHE flexibilities, and we're actively thinking, but for right now, our policy is set to expire at the end of the PHE for that code specifically, at least in that use case scenario.
15. Question: I have a general question regarding the change request and when there's something that is different from the final rule, specifically the prolonged services for the inpatient services, 99221, 223. When those changed this year, the final rule gave some description about how the time would be calculated for prolonged services, and there's a table in the final rule that says this is the threshold for those prolonged services. In the change request that just came out this week, those times are different. They are shortened by 15 minutes. And so, I guess my general question is, what takes precedence here, the final rule, the change request? Do we wait until it hits the actual manual? Where should we go because, you know, 15 minutes is significant with prolonged services.

a. Answer: We issued a correction notice (effective 3/15/2023) that's now available here: https://www.govinfo.gov/content/pkg/FR-2023-03-15/pdf/2023-04961.pdf