Centers for Medicare & Medicaid Services
COVID-19 Office Hours
Moderator: Alina Czekai
May 26, 2020
5:00 p.m. ET

Operator: This is Conference #8977438

Alina Czekai: Good afternoon. Thank you for joining our May 26th 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' temporary actions that empower local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote telehealth and Medicare.

And while members of the press are always welcome to attend these calls, we ask that they please refrain from asking questions. All press and media questions can be submitted using our online media inquiries form which can be found at cms.gov/newsroom. Any non-media COVID-19 related questions for CMS can be directed to our e-mail box, which is COVID-19@cms.hhs.gov.

Operator, let's please open up the lines to take our first question.

Operator: Hi, participants. If you would like to ask a question, please press star one on your telephone keypad. Again, that’s is star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of Angela Simmons at Vanderbilt. Your line is now open.

Angela Simmons: Yes, thank you for taking my call. A quick question about psych admission. If you have a patient who's in a distinct part excluded psych unit and is then determined to have COVID, and you need to move them and isolate them so that – for infection control purposes, you want to move them back out of the psych unit. You would continue to bill that as one case.

I just want to confirm that it's not two separate admissions, a discharge from psych and a readmit. The patient, in theory doesn't need to be admitted for COVID. They're not that ill but they do need to remain because of their psychiatric issues.

Male: Yes, under the existing waivers, you could relocate that patient if necessary.

Angela Simmons: And it's one admission that way - not two? Hello?

Male: Yes, yes, you could continue to have that as one admission under the psychiatric in-patient.

Angela Simmons: Thank you.

Male: Sure.

Operator: Your next question comes from the line of Brad Philbanks of the University of Texas. Your line is now open.

Brad Philbanks: Great. Thanks for taking the call. I've got an easy one for you today, I think, but I still think there's some confusion around it. So, if an asymptomatic Medicare patient self-refers for the COVID test or the antigen test, does it have an order if self-refers? Will Medicare pay for that? Could you hear me?

Male: Yes. So, the Medicare requirement for a physician's order has been eliminated in the IFC second interim final rule that we issued. And obviously there may be – but we do note that that speaks only to the Medicare rules. The FDA, EUA has some discussion about the role of a health professional.

And obviously state law also may have requirements or limitations there as well. So, for the Medicare payment part of the picture, we don't have a

requirement for a physician order during a PHE for the specified test in the interim final, but there may be other bodies of law that require something.

Brad Philbanks: OK. So, I read that part of the rule and it's still said, a written order is not required, but you had to have an order so, and it could be from another – a different provider, not just a physician.

So, I was under the assumption that they're still requiring some sort of order from a provider, but you're telling me that that patient can self-refer and we wouldn't have an order and we can get reimbursed for that.

Male: The issue really is that the, I mean, try to be a little bit more direct in terms of your question. The issue is that the FDA hasn't actually paid now – since we've issued the interim final rule they may have, I think they've approved at least one soft order test. But in general, the FDA has a number of limitations on the circumstances under which a test can be used and, they generally speak in terms of a professional of some kind being involved.

And so, I don't want to speak for the FDA, but you would really want to make sure that you – my suggestion would be for purposes of the FDA or state law that you go to each of those to make sure you've got what you need there, the FDA, the approvals.

The manufacturer probably can put you a sort of a decent place to figure out exactly what's in there if you don't want to meet - need to be able to figure it out on your own necessarily. And then – but for Medicare purposes, we don't have an ordering requirement.

Brad Philbanks: OK, thank you.

Operator: Your next question comes from the line of Tee Faircloth at Coordinated Care, Incorporated. Your line is now open.

Tee Faircloth: Hi, thank you very much. This question is on swing beds and it's great to see the CMS realize the importance of swing beds. But my question has to do with rural hospitals who depend on swing beds and have depended on swing beds since 1980 when this became a federal program.

And we're starting to see rural hospitals here are losing all their swing bed referrals from large hospitals. And that I don't think that was the intent of the program. It was not to benefit big hospitals, expensive rural hospitals.

But is it – would it be possible under the best efforts to transfer a patient to a SNF to include the fact that they need to actually check with the rural hospital swing beds or give some sort of preference to rural hospitals swing beds?

Because as it stands right now, we've got hundreds of rural hospitals that could close due to lack of swing beds and the lack of that whole supply that they've depended on for 40 years suddenly cutting off, and it's pretty ugly in rural America on that.

And really my question is, can we get something in that order that says, under best efforts under SNF that also says they have to try to move a patient to a rural or make an attempt to move a patient to a rural hospital? Would that be possible?

Jason Bennett: Thank you for raising that concern. It's certainly an item note we can go back and talk about whether we would make an adjustment or a clarification to the waiver along the lines since you have suggested.

Tee Faircloth: Thank you so much. And who is this again? Sorry.

Jason Bennett: This is Jason Bennett.

Tee Faircloth: Thank you so much, Jason. I appreciate it. Have a great day.

Operator: Your next question comes from the line of (Stacey Hill) of Franciscan Medical. Your line is now open.

Stacey Hill: Hi, thank you for taking my phone call. We have questions surrounding the 99211 for the swab collection. We wanted to know - there is an assessment portion of that, and we're wondering if what would be considered an assessment. And I have a second part to that question as well.

Male: So, for the – in the second interim final rule, we've established the policy that the 99211 could be billed when just the specimen collection is provided. And so in terms of like a physician practice billing, for example, if the only service is specimen collection, then a 99211 could be reported regardless of what other services might be furnished as part of that.

And under ordinary circumstances, of course, the assessment that would need to be a part of that would be whatever would be medically reasonable. But for during the public health emergency, the 99211 can be reported just for the specimen collection itself.

Stacey Hill: That's great to hear. Also being that we can bill this for a new patient, what happens if that patient is new to us, billing just for the swab, can then later, are we able to build that patient as a new patient for that following visit?

Male: I certainly appreciate that question. We're still looking into that. It's a good question that we've received before, and we're working on developing the answer for that as well.

Stacey Hill: OK. Good, good. All right, that's all I have. Thank you for all you guys do.

Operator: Your next question comes from the line of In Israel from Nova Health System. Your line is now open.

In Israel: Hi, my question is related to our distinct hospital IRF unit and the 60% rule. Specifically, the DDS and DDS that is supposed to be added to the end of the unique patient identification number, does that apply only to freestanding IRFs or does it also apply to the distinct hospital unit?

Jason Bennett: The information that was related in the second interim final rule is specific to freestanding inpatient rehab facilities. The 60% rule is more generally applicable.

In Israel: OK, thank you. So, if it's only for the freestanding, how do we notify the MACs that certain patients didn't apply to that 60% rule? Is that notification necessary or do we just document it in the medical record?

Jason Bennett: Yes. For now, you would make documentation in the medical record and there is some additional guidance forthcoming on when certain modifiers should be used.

In Israel: OK. All right. Thank you very much.

Operator: Your next question comes from the line of Denise Webber from United Health Service. Your line is now open.

Denise Webber: Good evening. Thank you for taking my call. My question is going back to teaching physicians and the residency element where we are now allowing telephone calls under the primary care exception, yet everything I'm reading relating to the precepting of those cases is that the precepting must be done virtually face-to-face.

So, the example we're having is our resident is working from home as is the teaching physician. The resident is rendering all health services whether they be virtual or telephonically to the patient. In normal circumstances, that case would be precepted within the clinic with a face-to-face between the patient and or the – excuse me – the resident and the attending.

The attendings are questioning the validity of the necessity behind the face-to-face virtual precepting. And the second half of that question is because the telephone calls are time-based, if they truly do fall under the primary care exception for the point of clarification, are we stating that the resident's time is billable?

Male: So I'll start with the second question. The resident's time would be billable in this case or rather than the resident's time being billable, I would say that the code selection that would be reported, the appropriate code that would describe the service should be based on the time directly interacting with the patient.

And that could be the resident doing that portion of the service, though it would still be the supervising or teaching physician who would be reporting the service. So I hope that answers the second question.

For Medicare payment – in terms of the Medicare payment rules themselves, in the situation of an audio only telephone evaluation and management service, if that is indeed personally provided by the resident, then the Medicare teaching physician rules would require that the supervising or billing practitioner be available via audio and video in order to meet the supervision rules that are in effect during public health emergency.

That's not to say that any other, I think that's sort of the extent that we could talk about that in terms of the precepting rules that govern the sort of any other applicable rules for the teaching physician relationship, I think we wouldn't be able to weigh in on. But for the Medicare payment rules themselves, the audio/video availability would meet the supervision requirements for that kind of service.

Denise Webber: OK, I'm just going to restate what I heard you say to make sure I'm clear.

Male: Sure.

Denise Webber: They have to be available by audio and video.

Male: Correct.

Denise Webber: They don't have to precept that way, but they have to be available to the resident.

Male: Correct. They have to be available to meet the direct supervision aspect of this for billing that particular service.

(Denise Webber): OK. And then just again to recap the other half of that question, when it is a telephone call rendered by a resident, because those are time-based calls, we can use the resident's service time in that encounter.

Male: Right.

Denise Webber: Beautiful. Thank you very much.

Male: Sure.

Operator: Your next question comes from the line of Cathy Paul from St. Luke's Health System. Your line is now open.

Cathy Paul: Thanks for taking my call today. And I had two questions, both of them dealing with the patient encounter in their home. The first is kind of just a little bit of insight. There was a little confusion last week on a MAC webinar that I was on, on how to enroll the patient homes and what it revolved around was, and I believe I got it from my – the way I interpret is that if we had several patient homes, that we could put the six interval pieces on a spreadsheet being HIPAA compliant and wouldn't have to submit every patient's home individually. Is that a correct interpretation?

Male: So, if you're planning to bill for these services under the OPPS either on campus department or accepted off campus department that is relocating as a result of the public health emergency to the patient's home, you would need to submit an extraordinary circumstances temporary relocation request that includes the location at which the services would be furnished.

Now, if you have a department that is planning to relocate to a number of patients' homes, you could submit one request that includes all the standard information that you mentioned, and then also the list of the number of patient homes on one request. But it's not – but you do have to include in the temporary relocation request all the addresses that which a service will be rendered.

Cathy Paul: Great. Perfect. I was referring to the outpatient department and the OPPS. Thank you. The second part of the question dealing with the patient's home, then I would presume, since it is the outpatient department of the hospital and the patient's home, is my presumption correct that we could provide therapy services there? PT, OT, SLP?

Male: You can provide therapy services. You can provide therapy services and they'll be paid as normal regardless of the – as long as you have an extraordinary circumstance of relocation requests, then you would append the P.O. modifier. If you're not, then you would append the P.N. modifier, but it would be paid the same way either way.

Cathy Paul: Yes. Despite the P.O. and P.N. right now with the PHEO would be paid the same. Thank you. Hey, you answered both my questions. Thanks.

Operator: Your next question comes from the line of Inice Rowe from Inova Health System. Your line is now open.

Inice Rowe: Hi, thank you. Yes, my question kind of follows along the previous caller's question related to the P.O. and P.N. modifier. We are struggling on how to apply this for the hospital outpatient departments. So, as I understand it, the P.O. modifier is required along with the extraordinary circumstance notice if we want to be paid under the OPPS. And if it's a MPFS service, Physician Fee Schedule based service like therapy, we would report the P.N. modifier.

Now, as far as patient's addresses or location addresses for the L2310 service facility location address, when is that reported? For instance, services that are performed with a provider that is on campus at the main hospital providing services for the patient at home within L2310, address be required on this patient?

Male: So, just to step back to the first part, for the therapy services provided in the home, you would append the P.N. modifier if you did not seek an extraordinary circumstances relocation request. If you did, you could append the P.O. modifier, but because it's a PFS service, it would have the same payment either way. But it would generally bill with whether or not the department had filed that request or not.

And on the second part, I was having a little trouble getting that. You're asking if it's an on-campus department that is relocated to the patient's home, what address should be on the claim. Is that the question?

Inice Rowe: Correct. Yes, what service address would be on the claim?

Male: It would be the main provider address, the on-campus address.

Inice Rowe: OK. So the on-campus address whether it's a P.O. or P.N. type service – oh, no, no, I'm sorry. OK, I get what you're saying. And if the provider was an off-campus provider, so like one of our off-campus sites that normally reports

that P.O. modifier and we performed like the Q3014, the originating site, we build that originating site service, would we then use that off-campus address on the claim like we would normally do with the P.O. or P.N. provided service?

Male: So, I believe it would be the address would maintain the same sort of the same address as would have been used prior to the relocation for what's on the claim.

Inice Rowe: OK. I think that's what I was asking. Thank you so much.

Operator: Your next question comes from the line of Barbara Goodman from LHC Group. Your line is now open.

Barbara Goodman: Thank you so much. I just have one question about the E&M guidance. So for the following set of codes like the 99341-350, 99324-99328, 99347 through 99350, it's the home and the assisted living codes, and these are the ones that we have physician services out and about in the community.

We bill off of those codes and we currently have been doing exam, history and medical decision making to render our E&M level of service. So my question is, when you look at the interim final rule, the guidance that you guys have put out, it talks about office and clinic type codes being based off of medical decision making and time or time.

And so, I'm wondering if they're done on telehealth. So, if we do telehealth for these patients that live in those assisted livings or in their home, would we choose our level of service based off of medical decision making or time or would it have to be off of the exam, history and medical decision making?

Male: Sure. So, we definitely appreciate the question. So, in terms of the policy that's in that second interim final rule that allows for the flexibility for time and medical decision making for selecting the level of code, that only applies to the office and outpatient E&M and in great part because those codes will reflect that policy even outside of the PHE beginning January 1st.

For the other evaluation and management codes, for some of them, those flexibilities aren't available. However, I would point out that what we have said and what we reiterated in that same interim final rule was that the appropriate code to report and evaluation management service particularly in this scenario may not be completely aligned with the location of the patient from an admission status, for example.

And so, it could be that the service that is really being furnished is better described by an office or outpatient evaluation and management visit rather than say an inpatient visit or a home visit. So, we would expect in other words that even in many cases when the patient is at home, they may be receiving from a professional service perspective.

That visit might be coded or reported as an office outpatient visit, even if the patient is located at home, in which case, then the flexibility in terms of the level selection will continue to apply even in cases where the patient is at home.

And if the level of service is best described or the kind of service that the professional is providing is best described by an evaluation and management code of a different setting, then the current policies or the permanent policies that apply to level selection for those services continue to apply regardless of whether or not it's being furnished via telehealth.

Barbara Goodwin: OK, so, we had understood that what we're making our home visits like we always have that we would continue to use the same E&M service codes but just use a modifier, so, but you're answering my question. So we should – because there's consultants out there telling us that it should be based off of medical decision making alone.

And so, as we're looking at our compliance, we're trying to figure out - should we do it off of the history, exam and medical decision making or the other, and I think you've answered my question. I really appreciate it.

Male: Sure.

Operator: Your next question comes from the line of Christina Merjanu from Alta Hospitals. Your line is now open.

Christina Merjanu: Hi, thank you for taking my call today. And just a quick note, we really appreciate you having these calls. It offers a lot of clarity and helps us be more compliant. So my question revolves around the expansion of services for physical therapies, for the therapies and the HOPD expansion.

So my first part of my question is, does the relocation request only apply to facility billing, because we have an employee position model in some of our hospitals, and so I would like to delineate is the relocation request specific to facility billing only? And then the second part of the question is, is there a delineation between the expansion of services, the relocation requests and home health?

Male: So the answer to the first question is that – I'm sorry, could you repeat the first question? I was thinking about your second question and I lost the first one.

Christina Merjanu: Of course, no problem. So, on the relocation request, does that apply only to facility billing, or whether they apply to physician's telehealth as well?

Male: Yes, it's only for the facilities bill it applies.

Christina Merjanu: OK, perfect.

Male: So, just to add to that, the professional billing associated with that wouldn't require that, but it could be billed via the telehealth.

Christina Merjanu: OK, and then the modifier 95 would apply to the professional portion and then modifier 95 would only be used on professional claims. Is that my correct – am I understanding correct?

Male: That is generally correct, yes. So, it wouldn't for – right.

Christina Merjanu: OK.

Operator: Your next question …

Christina Merjanu: OK. The rest of …

Male: You had a second question, so I'll …

Christian Merjanu: Yes, the delineation between – we'd have some consultants expand on the breakdown, the expansion of services, the relocation requests and home health. So, I'd like to get some guidance from CMS on how each of those would apply.

Ing-Jye Cheng: So this is Ing-Jye. I guess I'll start by walking through kind of what we try to finalize or we did finalize in rulemaking recently in our second interim rule, which when we permitted the facility billing for therapy done at temporary expansion locations, including the home, one of the things that we talked about in that rule was that the patient needed to be a registered hospital outpatient.

And so when the patient is receiving services as a registered hospital outpatient, the home would essentially serve as the hospital for those services, which is how the services could be billed to Medicare and in that instance, then home health, the home would really in effect not see the patient's home for the purposes of home health.

Home health services could not be provided kind of at the same time. I don't know if that answers your question. I'm not really sure. You're asking us to expand on kind of each of three different items, but what I tried to focus on was how they intersect.

Christina Merjanu: That's helpful. My follow up question would be, so with the second round of expansions that would not include home health then for the expansion of services and strictly for outpatient hospital departments. And then with that, will there be an expansion or do you expect the expansion of home health services as well?

Ing-Jye Cheng: So I don't know that I could speak to the future, but certainly with respect to the therapy being provided in the home and what was described in the interim final rule recently that focuses on services that would otherwise have been provided by the hospital outpatient department.

Christian Merjanu: OK. Thank you. Very much appreciate it.

Operator: Thank you. And your next question comes from the line of Kris Siefring from Mercer Health. Your line is now open.

Kris Siefring: Yes. My question has to do with the P.N./P.O. modifier when we're billing things as off campus locations for the hospital in which we would enroll the patient's home address at the location under the waivers. I guess I understand that P.O. means exempt that'd be prior to like the hospital it has, I guess, what do they call it, they always had that location as the hospital base.

And the P.N. is one that is not paid on OPPS that has not been grandfathered, I guess. And my question is, if we have some services, like for example, the Q3014, in which we may be doing like being the originating site of a telehealth visit. If we can bill a P.N. for those services as those would not be paid in OPPS anyway, but be billed under – they get paid under a flat fee.

So then we have other services and what the dietitian may do an MNT visit with a patient, we may want to build a CPT code for that and MNT services, and that we would want to build a P.N. modifier because that would pander OPPS.

I just did the same location at the department. I guess they keep calling it the department. The department is the patient's home. So as long as it's not the same day and it's different the patient homes, can we build some with the P.N. and some of the P.O. depending on the service? And always we would do this is to eliminate the burden of collecting all these addresses, with personally no payment differential.

Male: Yes. So, when we say it depends on the location of the department, the department before the relocation that's providing a service. So if you have a department that was on campus that is now providing a service in home and billing under the OPPS, you would submit that temporary relocation request for that address.

If you also have an additional department that a separate department billing for services that aren't paid under the OPPS, you wouldn't need to submit a relocation request for that department. You could just bill under the P.N. modifier. So, or for the service that isn't currently paid on OPPS, you wouldn't – then you would have a PFS payment for it.

So you could have multiple services. You could have services some paid under the P.N. and some paid with a – billed with a P.N. and some of the P.O. cause they're coming from different departments, and one department has gotten that relocation request and the other has not.

Kris Siefring: So, if it's the same department, you can't just pick and choose whether it is the P.O. or P.N.? And so we have a grandfathered location, so we we're always meant to establish a P.O. but this grandfathered location provides some services that have a payment differential under OPPS and provides some service that do.

So it just doesn't save the administrative burden of requesting all these addresses. We were just wondering about some of the services with a P.N. and some services of P.O. but it sounds like you're saying no, it's by that department has to be all P.O. and import every address, even if it isn't going to be a payment differential.

Male: Yes. So, if the address have sought a temporary relocation request for that address, then it would be appropriate to build a P.O. If that address has not had – you have not sought a temporary relocation request, then you would bill the P.N. So, if it's the same patients that you've gone through multiple times, you only have to have the one request for the department and you would just continue to bill P.O. for that address.

If it's a new patient that you're only billing services that you're not going to be paid under the P.N. for - under the OPPS for, then you could just build the P.N. and not have to submit a relocation request for that address.

Kris Siefring: OK.

Male: Does that make sense?

Kris Siefring: I think so. So you're saying the department is actually the new location like the patient's home. So it'd be the patient who's doing services at home that you want to be paid under OPPS you bill the P.N. and the report at once. You can always use the P.O., but the patient's home, you're only providing services that you don't – aren't going to get paid under OPPS, even like the Q, the originating site, there's always one of the doctors providing the service you're billing the originating site and if you want to bill the P.N. for those services you can, both of those sources are happening out of a department that at one time originally was a P.O. department before we relocated it? Does that make sense?

Male: Right, right, because the patient's home where you have submitted a request for is now the relocated department, whereas the ones who have not is not. For the first, you bill the P.O., for the second, you bill the P.N.

Kris Siefring: OK. I assume that's the originating department even though it was a P.O. like the one department has always been a P.O., we had to bill everything with the P.O., but doesn't sound like they want you to relocate unless you report it. You don't have to bill it. You can just use the P.N. if you don't or if you don't report the new address change and then once you do report you can use the P.O. OK. Thank you very much then.

Male: Correct. Sure.

Operator: Your next question comes from the line of (Cheryl Struck) from Jefferson Health. Your line is now open.

Cheryl Struck: Yes. Hi. Thank you so much for these calls and for taking my call. We've been looking forward to ask you some questions and have utilized your e-mail address, and so just wanted to get some clarifying responses. When it comes to telephone services, we appreciate that you have allowed for a parity from 99212, 99213, 99214 to the telephone only codes of 44123.

We wanted to get some clarification, because we acknowledged that with the 2021 rules, it is allowed for the outpatient office visits to be level based off of time and or MDM. So, one of our questions has to do with, can that parity

also apply as far as the decision making around the leveling of the telephone only codes?

So for instance, in circumstances where the minutes were not documented, if MDM supports the parity level of outpatient office visit, is that adequate to supply that code level? That's my first question.

Male: Thanks. Thank you for the question. So, the short answer is no. The use of - the flexibility for level selection for time and medical decision making only applies to the 99201 through 99215. The telephone E&M codes, while we did price them to the analogous established patient office visit levels, the coding rules for those telephone E&M codes remain the same.

And so, they are – I think they are reported based on time alone. And so, you would follow the guidance related to those specific codes.

Cheryl Struck: OK, thank you for that clarity. And I would just ask if there is any plans to reconsider that moving forward just for retrospective applications to some of these rules because obviously it is a service that is provided and needed so, just putting that request forward.

My second question, though, has to do with also telephone audio only. We recognize the additional provisions around the consent that you required and that it could be received from ancillary staff or on an annual basis.

The question is, is that if there is any allowance for based on the documentation within the note that the service was medical discussions occur, would that satisfy in exemplifying the consent was received from the patient?

Male: So the consent applies to the virtual check-ins and other services like that. I don't think that consent applies to the telephone E&M codes proper, although I should verify that, but the consent rules that generally apply to the briefer virtual check-in services and that needs to be separately documented in the record not sort of implied, but rather explicitly documented although, as you know, it can be done sort of broadly as opposed to on a per service basis.

Cheryl Struck: OK. All right. Thank you for that as well. And then the last question actually that I have has to do with high throughput laboratory testing. So, obviously there's a list that have been provided regarding the high throughput lab technologies that was as a guiding point initially. I don't know if there are any plans to update that list of available systems for this and use.

So for instance, Hologic is listed as Hologic Panther. My understanding is that Hologic systems also without the Panther feature has the ability to still meet the high throughput definitions of the amount of labs that are conducted from a volume perspective, the time turn around, and also, of course, have an increased cost to them.

So the question is, for instance, a Hologic system without the Panther feature, would that apply or is it strictly to that list? And if so, is that this plan to be updated?

Ing-Jye Cheng: Hi, this is Ing-Jye Cheng. So there was a list included in that ruling document and the list was really meant to provide examples. I think there was a "such as" or maybe "for example", in front of the list of technologies. Preceding that, I think was a definition which talks about the number of tests per day and it's 200.

So I think we would be looking for labs and others who are using the platforms to assess that and maintain the appropriate documentation to show that in fact, the technology met that definition. At the time, I think your other question was whether there were plans to update the list.

At this time, I'm not aware of any plans to update the list. Again, the list was meant to be not an exhaustive list, rather, just an illustrative list of examples so people had a sense of the types of technologies that we referred to for the $100 payment.

Cheryl Stuck: OK, great. Thank you. And that is what we were planning as far as assessing based on what I do recall it does say such as, but we appreciate the answer and thank you for the clarification and your time.

Operator: Your next question comes from the line of (Dawn Ricks) from Norton Healthcare. Your line is now open.

Dawn Ricks: Hi. I have a question regarding hospital inpatient E&M reporting. If a provider is reviewing records and talking to clinicians, nursing staff, et cetera, but does not see the patient visually from whether that would be the door or something visually to see the patient or on the phone to call them, they're only reviewing records and talking to the nurses, et cetera, coordinating care, so to speak or finding out about the patient. Is there a billable service in that hospital inpatient setting for that type of what they're doing?

Male: So, I think we wouldn't want to give specific coding advice and it certainly could depend upon a variety of circumstances, but the way the evaluation and management codes generally describe interaction, direct interaction with the patient. And so I think I would – we would defer to the CPT coding guidance on that.

I would point out that there are codes for interprofessional consultations, as well as several care management codes that describe non face-to-face care for patients. And some of those could be applicable depending upon circumstance.

Dawn Ricks: OK, so that they wouldn't – it would be between a physician or a provider of some sort, billing provider, and a nurse or not necessarily another M.D. or billing provider, but strictly just the clinical staff and reviewing the records et cetera.

But in a hospital setting, not being able to use coordination of care decision making and or time by itself, like you might could in office. I didn't know if there was any guidance on that. We have checked with consultants and they weren't real sure how to handle that. So, I would check.

Male: OK, again, I appreciate it. I think why I don't know the specific circumstances. There are various care management codes that do describe non face-to-face care, and some of them could be applicable in an institutional or a facility setting. So, I'd recommend taking a look there to see if any of those codes are applicable.

Dawn Ricks: All right, thanks so much.

Male: Sure.

Operator: Your next question comes from the line of Pamela Sharkey from Valley Health System. Your line is now open. Pamela Sharkey, your line is now open.

Pamela Sharkey: Hi. Sorry, I was on mute. I just wanted to clarify whether a 99211 can be used on the same date of service as a regular E&M if both were done at the same time, so a swab and a visit.

Male: No. So in the second interim rule, the primary change was clarifying that the 99211 could be used for the services associated with the specimen collection for both new and established patients, but it didn't change any of the underlying coding rules. So in situations where more than one sort of evaluation and management service are furnished, they would kind of be rolled up into one service.

Pamela Sharkey: Thanks. That's what I thought. I just thought I misunderstood. Thank you.

Operator: Your next question comes from the line of Mushy Iwom from Premier. Your line is now open.

Mushy Iwom: Hi, thank you. So, I was wondering if CMS can issue clarification to the MACs about paying claims with the DR code for the 60-day waiver. We're having an issue here in California with the Meridian. They don't seem to understand how the waivers work, and they keep telling us they're turning to CMS for clarification.

They've been telling us that for over a month now, and we have a lot of claims that are being rejected as they're stating the residents don't have any benefits. So, I mean, I e-mailed this in the past. I'm just wondering if some concrete steps can really be taken to ensure that providers don't have money held up.

Diane Kovach: This is Diane Kovach. I just want to make sure I understand your question. Is this related to the SNF length of stay being able to restart the 100 days or is this related to another issue?

Mushy Iwom: Yes. So this is a 60-day benefit waiver so to regenerate.

Diane Kovach: OK. Got you. So yes, we are issuing additional guidance to the MACs on thatWe do know that there has been some confusion, so we're hoping to get that clarified rather quickly. Hopefully, you'll be able to see those claims processed shortly.

Mushy Iwom: Perfect. Do you know when that should be coming out?

Diane Kovach: I don't know the exact date, no. But I can tell you that we're actively working on it.

Mushy Iwom: OK, thank you. And then a quick secondary question is, with the CMS guide update the other day that stated that facilities should be trying to test all staff and residents weekly. Is there any talk about providing additional funding for that as it's extremely cost prohibitive on the providers and providers to be able to do that. Also crunch the numbers, and they were saying it would cost - if the numbers were aggregated nationally, it should cost about $440 million for providers to provide just one test to every staff member and resident nationwide.

Demetrios: So, this is Demetrios here. We have gotten some feedback in along the same lines and questions around how to pay for some of that, and we are looking and working with our partners across the government to consider that further. Obviously, where the test fits within a defined category for a payer of many sorts, then at least for the residents, there would be payment there.

But I think you're talking about new payment for circumstances where it wouldn't be covered or appropriate and rather than a testing, I mean, the staff testing in particular raises those questions. So, we recognize that those are challenges that providers are dealing with.

And obviously, there are a number of available sources already in terms of the Provider Relief Fund and some of the other things that Congress has made available, but definitely also thinking about what else we can do to be helpful in quite various facilities in the right direction as well.

Mushy Iwom: OK. And so can we expect any sort of update because I mean, as of right now, we're obviously trying to provide those, but especially like you mentioned on the staff – to provided at all staff is it's a lot of money.

Demetrios: Yes. I think part of this is that we are working to get out the recommendations and the thoughts about the best way to handle the pandemic in different facility contexts as soon as we can – as soon as we basically have that in mind as we work with our partners at CDC and elsewhere to get out the best public health information as soon as we can.

Sometimes that means that that information is out there before there's necessarily other kinds of options or information about payment and the like. I don't know that there's anything specific about – I don't believe that there will be anything specific with regards to staff testing soon, but there is the Provider Relief Fund if that helps and then we are actively exploring what other resources we can point people to in terms of work. We've just been funding sources.

Mushy Iwom: I mean, I think it would be a good idea to providers or perhaps able to bill Medicare for at least the uninsured funds for staff tests.

Demetrios: The uninsured fund is – the uninsured fund that’s run by HRSA and a couple of different funds out there. One is the Provider Relief Fund basically uncompensated costs, and then there's the uninsured fund, which is really directed at uninsured patients. I can imagine that both of those might be options for some of what you're getting at.

Mushy Iwom: OK. Well, I guess we'll just keep our eyes peeled for an update. Thank you.

Demetrios: Thank you.

Operator: Your next question comes from the line of Sheila Serabia. Your line is now open. Sheila Serabia, your line is now open. You may ask your questions.

Sheila Serabia: Thank you. Hi. Thanks for taking my call. Actually, I've heard this – my question answered a couple of times. I just didn't know how to get out of the queue.

Alina Czekai: Great, thank you. Operator, we'll take our final question please.

Operator: Your next question comes from the line of Tammy Frost. Your line is now open.

Tammy Frost: Thank you for taking my question. My question is related to hospice quality reporting. I'm aware we have an exemption for reporting at this time. But if we choose to submit our hospice item set and the hospice visits when death is imminent, can we include televisit in those visit measures or telehealth visits?

Male: I don't know if we have the right folks on the line to answer that one. I might have to take that one back. Do we any CCSQ team members who are in a position to answer that?

Alina Czekai: Tammy, we can take this question back and address it at the top of our next Office Hours if we don't have the right team member on right now.

Tammy Frost: OK, thank you.

Alina Czekai: Thank you. Thanks, everyone, for joining our Office Hours today. We hope these calls are helpful and we really appreciate all that you're doing as we address COVID-19 as a nation. Our next Office Hours will take place next Tuesday, June 2nd at 5:00 p.m. Eastern. And in the meantime, you can continue to submit your questions via e-mail at COVID-19@cms.hhs.gov. This concludes today's call. Have a great evening.

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