Centers for Medicare & Medicaid Services
COVID-19 Office Hours
June 30, 2020
5:00 p.m. ET

Alina Czekai: Good afternoon. Thank you for joining our June 30th 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 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.

And we'd like to begin today's call with some updates on recent CMS publications and guidance. Last week, CMS published the Medicare COVID-19 data snapshot which summarizes the data on COVID-19 cases and hospitalizations for Medicare beneficiaries diagnosed with COVID-19. A factsheet and details on the methodologies can be found on our current emergencies page under the section for All Healthcare Providers.

Additionally, on June 26th, we revised our MLN Matters article to add the section Skilled Nursing Facility Benefit Period Waiver Provider Information and related billing instructions. This new section addresses several questions asked regarding how SNF should bill for renewed SNF coverage without first having to start a new benefit period for certain beneficiaries who recently exhausted their SNF benefits.

Additionally, as healthcare organizations enter phase two and gradually reopen, CMS published guidelines for phase two visitation for patients who are COVID-19 negative as well as FAQs on nursing home visitations. These documents contain principles and suggested guidance for safely reopening some facilities to visitors as well as responses to several FAQs. Those sets of guidance can be found on our current emergencies page under the section for Healthcare Facilities.

Additionally, CMS has published several important updates regarding the changes to staffing information and quality measures posted on the Nursing Home Compare website and 5-Star Quality Rating System due to the COVID-19 public health emergency. And this memo can be found on our current emergencies page under the section for Healthcare Facilities.

Finally, there have been several questions from the past few office hours that we were able to take back to our CMS colleagues for follow-up and we'd like to share the answers to those questions on today's call.

Our first question is regarding telephone code 99441 through 99443 for a hospital-based clinic. If it's a provider-based clinic that split bills, would it also be applicable to bill the Q3014 or does the additional reimbursement for these codes already encompass everything in the actual visit? And the response to that question is, the Telehealth originating site fee Q3014 can be reported with any professional service on the Telehealth list including telephone evaluation and management services, CPT codes 99441 through 99443.

Our next question regarding alternative sites reporting under quality reporting requirements, can we assume that these care centers are not subject to the reporting requirements? Can you confirm?

And the response to that question is, participation in CMS' hospital inpatient quality reporting and value-based payment program is expected by alternative care sites. Hospitals participating in these programs that are billing for care delivered at the ACS under the hospital's acute CMS certification number will report to CMS under that CCN on behalf of the ACS. In ACS independent of

a hospital participating in CMS programs that has an applicable CCN would need to register as its own hospital.

And operator with that, we will open up for questions from the line. We do ask that everyone keep their questions to one question or one question and a follow-up. Thank you.

Operator: Ladies and gentlemen if you would like to ask a question at this time, please press the "star" then the number "1" key on your touch tone telephone. Again, that is "star" then "1" if you'd like to ask a question.

Our first question comes from the line of (Ronald Hirsh). Your line is now open.

(Ronald Hirsh): Hello there. I have two questions, of course. First is, can you confirm that the SNF 3-day waiver applies to every SNF and swing bed in the U.S. still and the doctors do not need to document the hospital's being affected by COVID in order to use that waiver? We're getting a lot of push back from nursing homes in areas where the case rate has dropped, that now the waiver doesn't apply or they need some kind of documentation?

(Jason): And you're referring to the 3-day waiver not the swing bed provision for hospitals?

(Ronald Hirsh): Yes. Correct.

(Jason): So, this is a blanket waiver that is available nationwide and that is an option for facilities to utilize as with all waivers that are available it is at the discretion of the provider, the facility to utilize those and they may or may not choose to utilize them depending on the circumstances the community finds it, so.

(Ronald Hirsh): So, if they use it and they put the DR condition code, it's not going to be audited and ask for proof that there was cases in the community or anything?

(Jason): Well, I can't speak to all circumstances in which they – there may be some review and the review could differ any number of particular circumstances but

what they would need to do is note that they're excising that waiver and that it's related to the COVID emergency.

(Ronald Hirsh): OK. Thank you. Now, my other question for Ryan, and there's still lot of confusion over G0463, the facility fee and I'm wondering if you could give us one concrete example where that code can be use when as a patient in their home or it's designated as a provider-based clinic, what kind of service that would be – that would warrant facility fee billing?

(Ryan): So, (Dave) I don't know if you're on the line and you want to take this.

(Dave): Yes. So, the sort of difference between this Telehealth billing which would be for where the hospital charges the originating site fee, if there's a true Telehealth service – service that would be provided through Telehealth regardless of the pandemic and it just so happens that because of these flexibilities the hospital is the originating site then you would bill with the originating site fee on the facility side.

If the service is not a true Telehealth service and is either being provided in person or is being provided using technology but is not a true Telehealth service, then you would bill for that service using the standard OPPS billing procedures and would either append the PO modifier if you (sought) a temporary extraordinary circumstances relocation request for the provider-based department or the PN modifier if you have not for that OPPS service provided in the patient's home.

(Ronald Hirsh): Do you either give us an example?

(Dave): For instances, drug administration was provided at the patient's home, that would be an example of code that could be billed using that – using that authority.

(Ronald Hirsh): OK. So, that's just circumstance for the – there's actually a nurse or somebody at the patient's home. That makes sense, but how about the kind of the remote service? Do you have an example of that?

(Dave): It would be anything that can be provided through the OPPS but it would not be it wouldn't going to be provided through standard Telehealth.

(Ronald Hirsh): OK. Thank you and can we get new music on hold prior to the conference we're kind of getting tired the same songs?

Alina Czekai: Yes. We will look into that. Thank you

(Ronald Hirsh): Thank you so much.

Operator: Our next question comes from Susan Lucas. Your line is now open.

(Susan Lucas): Thank you very much for taking my question. I was wondering if there's any update on the tentative termination date to the public health emergency that's currently scheduled for July 26th. Can you give us any information please?

Male: I don't have anything more to share. I know this has been the subject of some news reports and I know that you should – I just know that you should be probably be focused on the webpage where the PHE is currently posted this is the sort of the best place to get updates.

(Susan Lucas): OK. Thank you.

Operator: Our next question comes from Rico Linda. Your line is now open.

(Rico Linda): Thank you. Last week, you answered a question about Telehealth and does the practitioner have to be in the country. And the answer was, you have to have to be in the United States.

My question is, looking at Puerto Rico, Guam, and the Virgin Islands, since that falls under Medicare, if you had a practitioner license in the State of Florida and may now go to Puerto Rico for some reason which is the Medicare jurisdiction, would they be able to do a Telehealth visit with the Medicare patient in Florida since they're licensed in Florida? Put a little twist to that.

(Dave): Puerto Rico, the Virgin Islands, and what you noted are in the United States, and so then it just becomes an issue of the practice of medicine and skilled for

practice related to their state loss in terms of where they can practice in terms of a jurisdiction or which they're located at that time?

(Rico Linda): Correct. But CMS – what CMS would not prohibit it once the State of Florida was OK with it in that example.

(Dave): That is correct.

(Rico Linda): OK. Thank you very much.

Operator: Our next question comes from Christopher Shank. Your line is now open.

(Christopher Shank): Hi. Thanks for taking my call. We have a medical group down the Los Angeles County area and we are seeing a surge in COVID cases in that area. But we've had a question come up surrounding our annual wellness visits being done via Telehealth because that's we want to keep our Medicare age population safe at home during this pandemic.

We're finding that many patients don't have blood pressure machines or scales to take their weight and as the height, weight and blood pressure components that are needed for annual wellness visits, if we're unable to obtain those when the annual wellness visit is done via Telehealth and we document why we are unable to obtain it, can we still bill for the annual wellness visit due to the pandemic or are we not able to do it and we have to delay it until when the pandemic is over?

(Ryan): And I think we have frequently asked questions on this very topic. The requirements for what needs to be done as part of the annual wellness visit haven't changed relative to the Telehealth flexibilities during the public health emergency. And as it sounds like you know already the patient reported vitals, et cetera, (can suffice) but there hasn't been additional changes to those rules outside of that flexibility.

(Christopher Shank): OK. So, we can only accept the patient reported but if the patient can't report on them then we're unable to bill for the annual wellness visit?

(Ryan): Right.

(Christopher Shank): OK. Great. Thank you.

Operator: Our next question comes from Jamie Nakery. Your line is now open.

(Jamie Nakery): Hi. Can you hear me?

Alina Czekai: Hi. Yes, we can.

(Jamie Nakery): Hi. So, on – in an earlier FAQ on May 27th, CMS answered questions about situations where the video is disconnected during an audio-visual Medicare Telehealth visit due to technological issues, and CMS said that practitioners should report the code that best describes the service in that situation.

My question is whether CMS will be providing guidance to physicians on how to document their compliance with this instruction given that there are some leeway or sort of confusion in terms of what happened to the call has disconnected and right now that judgment seems to be up to the individual physician?

(Ryan): Thank you for your question again. So, I think that's right at the moment that would be up to the individual physician for their particular concerns I would recommend contacting your Medicare Administrative Contractor in lieu of a specific documentation rules or coding rules that are national related to those circumstances. I think as we previously said we'll take a look at that.

I think we want to be sure not to construct rules that will allow for all of the complexities that happen relative to when certain portions of the service are provided and then interrupted that could really be all wide range of circumstances and so as we contemplate how to be as clear as possible with that we want to do so without being prescriptive recognizing that each individuals (expense) is going to be a little bit different. And so, while we continue to contemplate that I would recommend reaching out to your MAC.

(Jamie Nakery): Great. Thank you for that answer. Just a quick follow-up and you might not be able to answer this. But in the event that there's any sort of like subsequent auditing process that happens to look at how physician's billed in specific

cases, in the absence of instruction, does that mean that sort of good phase of the physician will be sufficient?

(Ryan): So, I don't think we can proactively answer that particular question. I think as we previously said the intention in not answering it isn't to create a circumstance where a good phase efforts are not recognized but I – again ...

(Jamie Nakery): Yes.

(Ryan): I think that's where the MACs would be a good resource to talk with about how those particular views might be – might be looked at in terms of what's being documented.

(Jamie Nakery): Great. Thank you very much for that answer. That's very helpful.

Operator: Our next question comes from Aaron Loud. Your line is now open.

(Aaron Loud): Good afternoon. I have a question regarding COVID-19 pre-procedure testing. I was wondering if Medicare had established national policy to pay for COVID-19 testing administered prior to and in association with the procedure performed that in ambulatory surgical center?

Male: We don't have a published national policy about that situation. We do have obviously the long-standing guidance and application of reasonable necessary and the standards in that regard and that MAC obviously administer in accordance with those long-standing policy. So, if there are particular questions about the application of the RFN standard within the context of pre-procedure, we would point you to the MACs for that as well.

(Aaron Loud): OK. Thank you very much.

Operator: Our next question comes from Sandy Sage. Your line is now open.

(Sandy Sage): Hi. So, there's been a lot of discussion about the hospitals without walls and the OPPS services being provided as a hospital outpatient department. Does that also apply to critical access hospitals or only PPS hospitals?

Tiffany Swygert: Hi. So, for critical access hospitals and hospitals without walls in general, it's a matter of the provider-based rules under in 1135 waiver during the public health emergency. So, to the extent that the provider-based rules apply to critical access hospital that waiver would extend to critical access hospitals as well.

(Sandy Sage): OK. Thank you very much. I appreciate it and the hold music is fine. I do have a comment though, we're really disappointed that the price transparency rules are not going to be postponed, if you guys could just pass that on it's been a really difficult time with dealing with the COVID and the PHE and to have to have that effect through January 1st, it's going to be very difficult for small hospitals. So, we just want to throw that out there. But thank you very much.

Male: Thank you.

Operator: Our next question comes from Ken Hoke. Your line is now open.

(Ken Hoke): Hi again. Thank you for taking my call. So, I just wanted to clarify on the actual 99441 through the 443 for an outpatient hospital clinic lingering the telephone services but then this is now afford of the Telehealth code from Medicare for the extension.

I know that earlier on the call for the traditional practice you guys confirmed on the Q-code. But for the extension of the hospitals both outside for an outpatient clinic under the hospital structure, would we be applicable to bill the G0463 with the 99441 and 443 under the extension program?

(Ryan): So, I want to make sure I understand the question. So, in general the – when a professional Telehealth service is furnished including the telephone evaluation and management services which around the Telehealth with then the code that we must (probably) to the hospital to bill would be the Telehealth originating site facility fee.

(Ken Hoke): So, it would be the actual Q3014 and not the G-code, correct?

(Ryan): Right.

(Ken Hoke): OK. Thank you.

(Ryan): Sure.

Operator: Our next question comes from Valerie Heidi. Your line is now open.

(Valerie Heidi): Thank you for taking my call. So, I want to follow-up on the question that just was presented and also this was post on June 23rd, Office Hours call. I'm hoping that we can have more clarification on addressing the COVID screening for patients presenting without symptoms or (fear) of exposure specifically as I already presented the preoperative COVID screening as recommended by the CDC because we have finding that the advised diagnosis for the revised ICD-10 coding guidelines of Z11.59 is resulting in denials. Do you have any additional information on that?

Male: So, what's the – just the billing context with it, what side of care and what kind of bill and for what service?

(Valerie Heidi): So, this is for the preoperative screening where the patients had come into the drive-thru screening for the COVID test. And there aren't orders associated because we're not necessarily having the orders needing to be necessitated for the screening so they're coming for these screenings preoperatively and they're not symptomatic.

Male: And the context is that the patient is being referred to preoperative screening by practitioner or ...

(Valerie Heidi): By a surgeon, correct.

Male: Are they coming – are they coming in from the community from the surgery?

(Valerie Heidi): Yes.

Male: And then you're submitting it in OPPS as or some other ...

(Valerie Heidi): The Z11.59.

Male: I think that falls within the parameters of earlier question as sort of more specific example. So, I don't have more for you than our suggestion to talk to the MAC. The MAC obviously have – they manage the application of the (reasonable) necessary standard and they may be – they might have may be gave with you and some (question) on that if there's – if you're having a challenge getting an answer there then we can obviously help but I think – I wouldn't want to send you out other the – to any other place in MAC first since they would be managing the administration of the program and payment of claims on these circumstances as a first sign.

(Valerie Heidi): Yes. I hear you and I do believe that that has already been attempted but having very little guidance in regards to our MAC feedback. And I know that last week when this was presented, Diane Kovach had mentioned that it would be looked at further and then just wondering if there was anything else perhaps that she's been able to discover in that regard.

(Mike): And this is Mike.

Male: Go ahead, (Mike.

(Mike): (Inaudible) work with(Diane) and we're looking into this issue.

(Valerie Heidi): All right. I really appreciate that. And secondly, on that question we touched on it briefly but when the patient catches when that there isn't an order that's necessary and they come to be tested for COVID without symptoms on their own accord for the screening, what are your recommendations on that? Does that would also fall more in the Z11.59 but there isn't in order because the patient just coming at their own freewill for the test?

Male: So, this order requirement was a condition of payment and we don't have that order requirement anymore after (IFC-2). The question of reasonable and necessary is one that still applies and separately from the question of an order or otherwise. And so, the MACs are working through those circumstances and I think it's kind of (parcel) along with the question that we – we're just discussing.

(Valerie Heidi): All right. Well, thank you. I appreciate your work and efforts.

(Jason): Thank you.

Operator: Our next question comes from Denise Wibber. Your line is now open.

(Denise Wibber): Hi. Good evening. Thank you for taking my call but you have already answered my question. You can go on to the next.

Operator: Our next question comes from Christina Margiano. Your line is now open.

(Christina Margiano): Hi. Good afternoon. And thanks for taking the time for having these calls. So, my question revolves around previous guidance that was discussed on the calls in regards to providing individual and group therapy. The conversation late May, early June was that in order to provide the individual group therapy, you have to be a partial hospitalization certified facility.

So, I wanted to clarify. There's been any additional relaxed rules for that. We have several facilities that are only IOP certified in their state so there is a lower level of care then of your traditional and partial hospitalization.

So, with that I'm willing to understand if there was any additional relaxed rules that would open that up so that we could better serve our population by providing individual and group therapy through Telehealth.

(Dave): So, just to clarify, you're talking about circumstances that are not when the patient is in a PHP or partial hospitalization circumstance, is that correct?

(Christina Margiano): Correct. It would be like if they were providing IOP, like a group – individual group therapy – excuse me, the 90832 in an outpatient setting. So, that on a prior call, the discussion was that the Telehealth portion or the group therapy and individual therapy is only available – or billable if you were a partial hospitalization program.

And we've been researching this internally and I haven't done clarification and if we can bill that and we do have a very high volume of behavioral health patients that were – we would like to be able to extend our services to.

(Ryan): So, in terms of the outpatient services for behavioral health, are you – you're referring – I think the code you're referring to is 90832 but that's an individual psychotherapy code. Are you talking about the group therapy or ...

(Christina Margiano): Yes. Both actually. Both.

(Ryan): So, in terms of the individual psychotherapy, that service can be paid in the hospital outpatient setting as well as in the physician office setting and those codes are in the Telehealth list.

(Christina Margiano): OK.

(Ryan): So, both for group psychotherapy and for the individual psychotherapy.

(Christina Margiano): OK. Are there any license – because my concern was the license to requirement. So, we could do those as a license to IOP in the state and we wouldn't have to be partial hospitalization certified, is that – am I understanding that correctly?

And the reason I asked is or even ask for the clarification is in one of the last FAQs that came out, the rules kept circulating around the partial hospitalization program. So, that – our interpretation of that was that you had to have that PHP certification. So, we just want clarity to make sure that we are billing compliantly.

(Ryan): So, I think – I think one of the things that sort of shipped me out to take – to be sure I got the right answer is to make sure that you're – so, for Medicare purposes, those services would require certain levels of certain standards but also the states cope would come in the play.

And so, again, I would recommend reaching out to your local Medicare Administrative Contractor in case with, it sounds like the services from my – otherwise be part of partial hospitalization but under the circumstances might be – might fall under another Medicare benefit but given that particularity of the question. So, I recommend reaching out to your MAC.

(Christina Margiano): OK. And I have and gave me a 45-day – 45-day turnaround timeline which is just totally unacceptable and the MAC is already in.

(Ryan): Sure. If you can submit what you submitted to them in writing to ask to the mailbox and we can – we can take a look at it.

(Christina Margiano): I already have. I submitted this morning.

(Ryan): OK. Well, we will – we will do so.

(Christina Margiano): OK. Perfect. Thank you so much.

(Ryan): Thank you.

Operator: Our next question comes from Marie Berlinar. Your line is now open.

(Marie Berlinar): Yes. Hi. I have two questions related to the temporary emergency circumstances relocation of a provider-based department to a patient's home. First, is I know that hospitals can begin furnishing services to patients in their homes and then submit the official request to have the homes designated as provider-based department within 120 days at the start of services.

My question relates to claim submission for the services and specifically, does the hospital have to have submitted the relocation request with that patient – with that particular patient's address on it before it can submit a claim for services furnished at that location? And I guess, if not, how does the claim submission work?

And my second question related to the same – the same situation is, when a patient is receiving home health agency services concurrently with hospital outpatient services and the patient's home can not according to the (rags) be both an outpatient department and a home at the same time, how do the time periods get defined for both providers to be able to furnish services at the same time?

Can the location be at home on Monday, Wednesday and Friday for a home health services and then an outpatient – the provider-based department on

Tuesday, Thursday, Saturday for outpatient hospital services or how does that work?

(Dave): So, to answer your first question, there is no requirement to hold claims or for either sending or receiving anything back on the relocation – the temporary relocation request. You don't have to sort of hold your claims to until that's submitted. So, that's not a requirement before the claim is submitted.

(Marie Berlinar): OK. So, they submit the claim then with the patient address and if somebody knows eventually that the patient's address has been a temporary extension relocation or ...

(Dave): Right.

(Marie Berlinar): And get married at some point? OK.

(Dave): Yes. That can be provided later.

(Marie Berlinar): OK. Great. Perfect. And sorry, I interrupted you.

(Dave): No. That was my answer for the first question and I'll defer to others on the second question.

(Marie Berlinar): OK.

Female: So, for your question – oh, go ahead Jason.

(Jason): Yes. I was just going to ask with regard to your second question, can you clarify the services that would be performed by the hospital and in the home as an extension of hospitals without walls. And I asked because the home health benefit is inclusive of therapy and services. So, there are some circumstances where being on the home health benefit would then exclude other types of services that ...

(Marie Berlinar): Yes.

(Jason): That is applicable if they are not part of the same bundle.

(Marie Berlinar): Right. And I apologize. I'm not sure if I can think of one of on the top of my head. I am aware because it's clear on the regulations that if a home health agency is able to provide the service, then it can not be provided by the hospital outpatient or as a hospital outpatient department service in the home location.

Even if the home has been relocated as a provider-based department or designated or relocated provider-based department but the regulation clearly contemplate that a patient could be reserving – or receiving home health agency services concurrently with some hospital outpatient services.

And it states that basically I can't do that at the same time because home health agency services have to be furnished in the patient's home and the hospital outpatient department services are not furnished in the patient's home, they're furnished in the same address and the same location that has been designated a relocated provider-based department of the hospital.

And while I don't have an example of the service – I'm sorry about that I didn't realized that it's going to be asked, really sort of more asking conceptually how with those time periods be defined so that the patient in theory could get both.

(Jason): So, I'll defer it to another colleague to add some additional context but the purpose of the narrative in the regulation was to describe that certain services from home health can not be supplanted or duplicated by the hospital or by the – by the facility, by the other provider type. So, particularly – this is particularly relevant around therapy services where ...

(Marie Berlinar): OK.

(Jason): ... there can be different sources in which the beneficiary may receive therapy services and so it was, conceptually it was designed more around making certain that there was a deliberate choice on behalf of the beneficiary and the provider as to what was in the patient's best interest for the delivery of that type of care.

(Marie Berlinar): OK. That makes sense.

Tiffany Swygert: And to answer your other question with Jason just said it as exactly right. So, if the patient is under a home health plan of care and the services being furnished or services that could be furnish by the home health agency, we would not expect the hospital to furnish those services to that patient.

But in terms of the home serving as a part of the hospital or as provider-based department that can be turned on and off as needed and so it's only for the provision of the hospital outpatient services when the patient is a registered outpatient of the hospital that the home location would be serving as a provider-based department to receive those hospital services.

So, if on Monday there's a home health visit or home health services being furnish but on Tuesday there's a need for a hospital outpatient service, then that's perfectly fine. Again, as long as the hospital services are not supplanting the home health services but when the hospital services are being furnish it's important to remember that the hospital must register the patient as a hospital outpatient for those services.

(Marie Berlinar): That is perfect. That's exactly what I was looking for. And so, do they register and re-register the patient over and over again? Say under the exact example you were just saying, do they register the patient (inaudible) as a hospital outpatient Tuesday and then register then again re-register them on Thursday?

Tiffany Swygert: Well, it's when – it's as needed so ...

(Marie Berlinar): OK.

Tiffany Swygert: ... as long as the patient is receiving a service just as you normally would if the patient were to present at the actual hospital, you will register them and then when the service was completed unregister or follow the hospital guidelines for making sure that the appropriate timeframes for the furnishing of the care was reflected in the claim. It would – it would be very lame for this.

(Marie Berlinar): Great. Great. Thank you so much. I really appreciate it.

Tiffany Swygert: Sure.

Operator: Our next question comes from Janet Asnaro. Your line is now open.

(Janet Asnaro): Hi. I'm curious as we don't know when the end of the PIT is going to be. If there is any planning for when flu season begin? And if flu testing will be allowed to be at the drive-thru testing sites along with COVID. So, like – say a patient comes in, they have flu-like symptoms, it's flu season so we will detect them for flu and then if it's negative for flu then test them for COVID.

(Jason): So, you're – is your question about the ordering rule and whether or not it can (come) with the seasonal flu?

(Janet Asnaro): Well, not so much about the ordering rule but if the flexibility or it could be done at the parking lot site versus at person have going to walk in to the clinic?

(Jason): I see, for OPPS that sort of without wall strategy? (Inaudible) ordering (inaudible?)

(Janet Asnaro): Yes. For like physicians, sir.

(Jason): I'm trying to sort of (x-ray) the question to find the regulatory issue inside of it. Is it the – is it the PFS billing of the level one E&M? Is it the hospital without walls?

(Janet Asnaro): No. The level one. Well, the level – the level one that actually billing for the CLIA-waived flu test in addition to the assessment handling for the COVID. So, the 211 – 211 and the flu test code the 87804, please.

(Jason): I see. So, maybe the question is, is 211 available for seasonal flu test is performed without pandemic and without COVID test?

(Janet Asnaro): No. It's anticipation that we will probably still be under the pandemic when flu season begin. So, now we have a combination problem, could be the flu and or COVID. So, right now the goal was to keep patients that have

potential risks at COVID from being in the clinic, so we want them to go to the drive-thru clinic to be tested as to not expose other people.

So, in the same situation, if there – if there has symptoms but we want to rule out the flu as well as COVID determine which situation it is, could we test them and bill for the test the CLIA-waived test of the flu and then if the flu is negative go ahead and test them for COVID and then – and bill for the 211 for the COVID testing?

Male: And it was the fee schedule – go ahead Ryan.

(Ryan): Yes. I think under the current rules for the E&M code and you wouldn't bill to 99211 in the same day for the same patient.

(Janet Asnaro): Correct. It wouldn't be 211, it would be a 211 and the 87804.

(Ryan): Oh, I see you're asking about for the – for the other specimen collection code.

(Janet Asnaro): The CLIA-waived flu test. Yes.

(Ryan): So, the flu test itself. I see. OK. I think we have to get back with a definitive answer on that because I don't ...

(Janet Asnaro): OK.

(Ryan): In cases where two separate tests would be medically reasonable and necessary, I think that both tests could be paid as a general matter.

(Janet Asnaro): I do believe that they both could be paid, my question is can they both be performed in the temporary location of the parking lot?

(Ryan): Understood. Understood. We'll take a look at that.

(Janet Asnaro): OK. Thank you very much.

(Ryan): Thank you for your question.

Operator: Our next question comes from Jordan Johnson. Your line is now open.

(Jordan Johnson): Yes, ma'am. Can you all hear me?

Female: Hi. Yes, we can.

(Jordan Johnson): Excellent. Yes, just a quick question, how you related to the fact that HHS earlier kind of let the cat out of the bag yesterday that they would exercise the 90-day extension and you said the PHC website is the best place to look, so, I think you answered the question but can you all give many more insight or you all just going to hang it on for right now and just refer back to the PHC website?

(Dave): We're referring back to the PHC website.

(Jordan Johnson): Oh, I get man, I thought I'd save that. I like that. Thank you all so much.

Operator: Our next question comes from Arthice Campbell. Your line is now open.

(Arthice Campbell): Hi. Thank you for taking my call as many people have said. I have a question for you regarding a patient that was previously admitted for COVID-19 – excuse me, which was resolved and then 30-days have passed – excuse me it's not the roana I promise. Now, the patient is being seen for diarrhea and nausea and happens to have c-disk but they also retest for COVID and the patient is still positive, would the patient still receive the U07.1 COVID diagnosis for the case?

Male: What's the setting of care in the bill that which the diagnosis would be submitted?

(Arthice Campbell): OK. Thank you.

Male: No. It's to follow to your question is, which setting are we talking about. I'm trying to figure out where – how they diagnosed into the payment?

(Arthice Campbell): Yes. They are going to be admitted as an inpatient.

Male: OK. So, your question is whether or not you can code them with the diagnosis of having – with the – with the COVID diagnosis as an inpatient even though they previously been admitted with the same diagnosis?

(Arthice Campbell): Right.

Male: I don't – I can't think of a reason of why you weren't be able to. Is there something in particular getting at or worried about?

(Arthice Campbell): Well, someone asked me the question if there would be a diagnosis for someone that is a carrier of COVID.

Male: Oh, a separate diagnosis for being a carrier?

(Arthice Campbell): Right.

Male: I mean – I think from our – you'll have to sort of forgive my – we can talk to some of our clinicians here if it – if we need to but I think our understanding is that you – the one you have it or they don't.

(Arthice Campbell): OK.

Male: Are you certain that maybe the second test wasn't on anybody's test? And so, just a carrier and some other passion?

(Arthice Campbell): Yes. I'll go back to the person that asked me the question and confer with them but if they either have it or they don't and so ...

Male: I can tell you ...

(Arthice Campbell): Even if you're a carrier you have it.

Male: Well, yes. And I can tell you that the coding guidelines are very specific that they say that the diagnosis is not to be years. The ICD-10 diagnosis code for suspected cases. It's only for confirmed cases.

(Arthice Campbell): OK.

Male: And so, that might be helpful and that's on the CDC website where the ICD-10 codes have been updated.

(Arthice Campbell): OK. Thank you.

Male: You're welcome.

Operator: Our next question comes from Sue Rochelli. Your line is now open.

(Sue Rochelli): Great. Thank you so much. This is burning question so here we go. Regarding the phone call visit 99441 to 99443, the direction say should not be reported when originating from a related E&M service provided within the past seven days nor leading to an E&M service and then this is the question part, or procedure within the next 24 hours. So, define, or procedure.

Here is my clinical vignette. A glaucoma specialist in ophthalmology, has the patient come in and get their testing performed? Then the physician is going to review the chart note, look at the test, provide the information report and then have a phone call with the patient. Our concern is, will that phone if it's not a virtual exam face to face, be denied because that is with in that time period. Is it a procedure or are we talking surgery or what is procedure?

(Ryan): So, I think – I just want to make sure I understand your example. So, there's a preoperative – pre-procedure phone call alone or ...

(Sue Rochelli): No. The patient there's an order in the chart for treating glaucoma. The patient may be seen quarterly for a visual field or some other type of testing, so that was delayed during the original opening of the pandemic but now they're coming into the office.

All precautions are being done to do the test but the actual visit with the patient as it is a phone call not a virtual, is it going to be paid or will it be denied because it says phone calls within the past seven days are leading to or procedure. So, it's not two exams, it's a test and an exam but we don't know what the definition of procedure is. Is it a surgery? Or is it a test? Or what?

(Ryan): So, I think in general Medicare would defer to CPT roles surrounding that. That's something we can ...

(Sue Rochelli): Which would make it payable. All right. Which would make it payable. I'm – this is the number one question were being asked, so I wanted to be able to

provide an answer and it sounds like perhaps procedure isn't defined. We know that it's payable if it's a virtual exam but that language is there for phone calls.

(Ryan): So, I think for this particular codes because they have been made new repayable under Medicare for purposes of or for the duration of the public health emergency, I don't think this is a question that we have undertaken separate role making or guidance on and in those cases we would – we would generally conform with what the CPT and coding conventions were.

(Sue Rochelli): OK.

(Ryan): But we sincerely take that back to confirm that.

(Sue Rochelli): That would be fantastic. Then how will I know the outcome of that?

(Ryan): We can – we can there's a couple of different approaches. We could certainly consider adding it to frequently ask questions or if you want to send an e-mail to our e-mail resource box, we can get back to you directly.

(Sue Rochelli): OK. All right. You are all doing such a fantastic job. Where would we be without you? Thank you.

(Ryan): Thank you.

Alina Czekai: Thank you. And we'll take our final question please.

Operator: This question comes from the line of Renee Freesan. Your line is now open.

(Renee Freesan): Hello. Thank you so much for taking my call. Again, like have everybody stated I've been on all of these and I like the music too. I am – I'm hoping I'm not carrying this question but again it's on the G0463, the Q3014, Critical Access, RHC. I've been given some guidance and so I'm just trying to get the whole flow here.

So, the provider's home but registered as in hospital outpace – hospital outpatient – excuse me, can the originating site be utilized in, let's say the provider performs a visit by calling, telephone only, the patient at home, can

they bill Q3014? And the same would be what if it's audio-visual, can they bill Q3014? Critical Access Method II or RHC, FQHC? I was told that for the RHC that this would not – that this could not utilizes as they are not eligible for an originating site, as the home.

(Ryan): Right. So, for RHCs, they don't have the same flexibility in terms of the hospital without walls flexibilities. They can service Telehealth originating sites when the patient is located within the RHC but not when the patient is at home. Does that answer your question?

(Renee Freesan): All right. So, CAH with Method II would be the same then?

(Ryan): Under the CAH Method II, right.

(Renee Freesan): Yes. OK. That's what I thought to better – it's like people are getting a mixed up so I thought well maybe I just need to kind of get it off if they're the same so I just wanted to make sure, so. But I appreciate it and again thank you for everything.

(Ryan): Sure. Thank you.

Alina Czekai: Thank you. And thanks everyone for joining our Office Hours today. Our next Office Hours will take place next Tuesday at the same time, 5:00 p.m. Eastern and you can continue to submit questions to our COVID-19 mailbox. Again, that is covid-19@cms.hhs.gov. This concludes today's call. Have a great rest of your day.

End