Centers for Medicare & Medicaid Services
COVID-19 Office Hours
July 7, 2020
5:00 p.m. ET

OPERATOR: This is Conference #: 3048844.

Alina Czekai: Good afternoon. Thank you for joining our July 7th CMS COVID-19 Office Hours. We hope everyone enjoyed the 4th of July weekend and 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 frontline to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and healthcare system 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 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 COVID mailbox which is covid-19@cms.hhs.gov.

As always, we appreciate your questions and are working to resolve and action them as soon as possible. Please do keep in mind that the questions discussed on this call are general representative questions and your specific circumstances may be different; therefore, the information provided may not always be applicable to your unique situation. And today, please do keep your questions to one question or one question and a follow-up.

Operator Ryan, please open up the line for questions. Thank you.

Operator: That is noted. And ladies and gentlemen we are about to start the question and answer session. To do that, please press “star,” “1” on your telephone keypad. Again, please press “star” then the number “1” on your telephone keypad.

We have a first question on queue. Please state your first and last name and your organization name. Your line is now open.

Female: Yes. I'm not sure if you can hear me.

Alina Czekai: Hi. Yes, we can hear you. Thank you.

Female: Yes. Thank you. I'm sorry. I wasn't sure who the operator was referring to. Thank you so much for taking this call. My question relates to the Skilled Nursing Facility waivers that have been put in place regarding patients and the 3-day qualifying stay.

The waiver states that for people who experienced dislocations or otherwise affected by COVID-19, the waiver is applicable to – and we have some Skilled Nursing Facilities in our area that are refusing to take patients based on this waiver if the patient does not have COVID-19 or they perceive that the hospital must be at surge capacity which would activate the waiver based on patients being displaced due to the pandemic.

So, if the hospital isn't full and patients aren't being displaced, they don't believe that the waiver applies and I'm just trying to get some clarification on the otherwise affected boarding and whether patients have to have COVID and whether the hospital has to be closed to accepting new admissions or at some point of surge capacity for this to be applicable.

Male: Yes. Thank you for you question. There are two parts to this waiver. As you were describing one aspect is the 3-day – the waiver of the 3-day inpatient requirement. That provision is waived and does not require 3-day inpatient stay. In fact, a hospital stay is not necessarily required. What's necessary is that the patient have skilled need for entry for SNF care at that time, whether it was under three days in the hospital or otherwise were community entry to

the facility. The patient does not need to have COVID. We have several FAQs available on our website that describe this in more detail.

The second provision that you referred to with regard to the dislocated or disrupted aspect is in reference to what would occur upon the exhaustion of their 100-day benefit and use in that, that's expected to be more than a more limited circumstance.

The one thing that we do say about all of our waivers is it is up to the provider, up to the facilities should they choose to exercise this waiver and not all facilities may choose to exercise any particular waiver based on their own choices or the circumstances with which they find their community. So, it is possible that some Skilled Nursing Facilities may be choosing not to exercise this waiver at this time.

Operator: Your next question. We have our next question on queue. Please state your first and last name. Your line is now open.

Dr. Torras: Is it me?

Alina Czekai: Hi. Yes, we can hear you. Thank you.

Dr. Torras: Oh, OK. So, it is me. So, Dr. Torras. I gave my name and everything at the beginning, but I don't know why it didn't saved but I sent a question on June 23rd at that last office hours about prolonged because of the new 2020 codes being able to use the time that was spent before and after the visit to be added to the overall amount and I never got a response back.

Ryan: I think that we're still taking a look at that and we'll have that either for the next office hours call or have it posted to the website.

Dr. Torras: OK.

Operator: We have our next question on queue. Please state your first and last name and your organization name. Your line is now open. And the last four digits of this phone number are 7660. Thank you.

Barbara Cobuzzi: Oh, hi. My name is Barbara Cobuzzi. I'm a consultant. I just want to clarify, if the hospital outpatient department is relocated to the patient's home and the patient can only connect with audio. They don't have the ability to collect – to connect with audio-video, so the visit is technology-based. It's not a telehealth visit because the patient's home is part of the outpatient facility. Are they allowed to bill with the 99441 through 443 even though it's not a telehealth visit? It's just a technology-based visit.

Ryan: So, you're suggesting that the professional would be billing the telephone evaluation management code?

Barbara Cobuzzi: Yes.

Ryan: So, the telephone evaluation management codes were added to the telehealth list. So, they would be billed by – like a telehealth service and similarly the – under the OPPS then the telehealth provision insight facility fee could be reported in case as well there's a professional telehealth service reported.

Barbara Cobuzzi: So, even though this is not considered telehealth, it's technology-based we still can use the 99441 to 443?

Ryan: Right. So, the telephone evaluation management codes are considered telehealth during the – under the context of the public health emergency.

Barbara Cobuzzi: Right. When the patient's home has been relocated that's not considered a telehealth service? Correct? Because now the patient is registered as an outpatient.

Ryan: Right. And so – got it. So, I think you're suggesting and I'll ask Dave or Tifanny to confirm this. But in cases where there is a professional service being furnished but both are in the – both professional and the patient are in the hospital setting …

Barbara Cobuzzi: Right. Temporary location …

Ryan: … by virtue of the patient's home being made part of the hospital, then the originating site facility fee could still be reported and I think that's correct. I'll let others confirm that though.

Female: That's correct. Thank you.

Barbara Cobuzzi: OK. Thank you. I just want to make sure.

Operator: Your next question comes from the line of Diana Godfrey from AdventHealth. Your line is now open.

Diana Godfrey: Hi. Can you tell me if the – if there's a waiver and existence that allows a hospital-based skilled nursing unit to admit a queue care patient? We've seen the waivers for the rehab units and the psych units, but we have hospital-based skilled nursing unit that we would like to be able to use for surge capacity due to COVID and we have not seen something specific to a hospital-based skilled nursing unit.

Male: I do not believe there is necessarily that type of waiver that has been put in place in by the – in particular by the teams that are looking at the types of flexibilities can be available but would note that there is some broader flexibility in hospitals without walls that hospitals may want to consider as they do additional planning for surge capacity.

Diana Godfrey: OK. So, there is no waiver that allows for that. All right. Thank you.

Operator: Your next question comes from the line of participant with the last four digits of phone number 7117. Your line is now open.

Colleen: Hi. Good afternoon or good evening. My name is Colleen. I just have a quick question. I'm hoping you can answer. First, I would just like to thank you. You guys have been invaluable with these phone calls and I hope you know that and how much we all appreciate it. My question is, the 20 percent add-on, I know it was – it's an add-on to the IPPS but we received a couple of questions whether or not that applies to All Tax Services. Can you tell me, does the 20 percent add-on apply for services provided in an All Tax?

Ing Jye Cheng: Hi. This is Ing Jye Cheng. The 20 percent add-on apply to services provided to hospitals who are being paid under the inpatient patients – Inpatient Prospective Payment System, the IPPS. So, All Tax cases would be paid under the All Tax PPS and they're paid at the higher rate for admissions after I believe it was sometime in mid-January, I don't have the date right in front of me.

Colleen: OK. Now, thank you very much. I thought that was the answer I just wanted to confirm that my understanding was right so that I didn't give out misinformation. So, I appreciate that very much and I hope you all stay well and thanks quite frankly. Thank you.

Ing Jye Cheng: Sure.

Operator: Your next question comes from the line of Jeanelle Folbrecht from City Hope National. Your line is now open.

Jeanelle Folbrecht: Thank you very much. I have a question to confirm some billing codes for psychologist that are providing services particularly in April when we were transitioning from telephone to televideo. And I understand televideo, we are able to bill as if it were face to face and I wanted to confirm that but telephone there is some confusion at our institution in how to bill telephone services.

We've been billing them under psychology telephone codes which are 98966 through 68, and then when we see somebody for an hour or we listen to them for an hour over the phone, we bill two units of 98968. And I want to confirm if that's correct or ask if there's a better way to bill for services that are still provided by telephone.

Ryan: So, in the – for many behavioral health services that are on the telehealth list, they are available for use for audio-only or for telephone interactions. So, I think it would – it would certainly depend on which code best describes the service but in the case where there was a counseling for example where if that service were furnished in person, just as an example, if we're going to bill the psychotherapy code, most of the psychotherapy code is on the telehealth list and it's on the telehealth list now to be allow for audio-only. So, if that's the

code that were being reported for an inpatient service it could now be reported for a telephone service as well.

Jeanelle Folbrecht: And how far back is that retroactive? Can we know all the way back to mid-March on that? Or did it start at certain date?

Ryan: No. That is retroactive. I don't have the exact date in front of me but it is – but it is retroactive.

Jeanelle Folbrecht: OK. So, for services provided by phone, we can bill the face-to-face code?

Ryan: Right. As long as they're on the telehealth list and they're – and they're denoted as audio-only available and that is available on the CMS telehealth website.

Jeanelle Folbrecht: The patient had said that audio-only is available. OK. Thank you. That was very helpful.

Operator: Your next question comes from the line of Amy Shuts from Jupiter Medical Center. Your line is now open.

Amy Shuts: Oh, hi. I just had a question about telehealth for diabetes education. We saw that the list of possible providers is a registered dietician. I was wondering they were asking about an RN in the department if they could also do it and I see some other sites not CMS saying that dieticians are approved but nurses aren't or they are. So, I'm not really sure.

Ryan: So, there are couple of different relevant policy here, I think. One is that, the individual professionals who would be able to bill Medicare directly and so there are – there are some registered dieticians who can bill Medicare directly and they could furnish those services and those services are on the telehealth list.

In cases – for those whose applicable credentials are registered nurses generally speaking they would not be able to bill Medicare directly for their professional services and so they would – well they may be able to be the

individual who's directly delivering the diabetes soft management training services in some cases but then they would then – those services will be reported by the relevant institutions like the hospital, in which case the telehealth rules wouldn't apply but the provision of remote services that the hospital might furnish would apply.

Amy Shuts: Well, thank you. So, this is the – yes sorry. So, this is a hospital department, so the nurses and dieticians work side by side so it could be either one at the department and then fill it on the facility bill?

Ryan: Right. So, that would – that would be like the other hospital services where the patient's home would might be a temporary expansion site, et cetera.

Andy Shuts: OK. Great. Thank you.

Operator: Your next question comes from the line of Maureen Davis from Northshore University. Your line is now open.

Maureen Davis: Hello. My question is regarding the CS modifier facility claims. This question was brought up few weeks ago in an earlier office call and I think you guys are going to take it back. I haven't heard or seen anything published or answered about it.

So, I understand the CS modifier goes on in E&M visit for which it results in the administering or the ordering of the COVID test, the actual administering of the COVID test and here is where the question comes in, the IFC said it's also related to items with services for the evaluation of the patient to determine the need for the COVID test.

And the question is – well, first of all, if you would give me an example of what would be considered an evaluation service? For example, we've been doing a lot of chest x-rays. So, what exactly aside from the E&M visit itself and the COVID test itself, what kinds of services could be considered waiving the cost sharing to add the CS modifier 2?

Ryan: So, in general the application of the CS modifier for those sorts of services would be for the evaluation management services and not for other services

that might be furnished if they're separately paid. And so, in the example that you mentioned when the – something like a chest x-ray would be separately paid as separately reported and separately paid that would not be reported with the CS modifier.

Maureen Davis: OK. And the follow-up, the – there was also a question of whether or not the test had to actually take place because if – let's say the patient was evaluated and the physician decided, no, we're not going to give you the test. Then, there would be no CS modifiers added to anything?

Because I guess I thought the intent was to not discourage patients from coming in if they have symptoms, they think they have COVID. They don't want to have to worry about having a deductible or a co-insurance. And so this would relieve them of that anxiety.

And so they come in and if it turns out that they don't have – that they don't get the test to begin with or that they have other services, they're going to end up with some co-insurance and deductible.

So I want to be clear because we've got so many different situations. I mean, we have hundreds of accounts that we're trying to evaluate on a daily basis to make sure, is this related? Can we add the CS modifier?

I guess I'm hearing from you to take a very narrow view and say that it's strictly the E&M visit for which you decided or to which the physician decided to give the test or to administer the test.

Ryan: Right. I think…

Maureen Davis: Are saying that there are no other services that would apply?

Ryan: It would be for the evaluation management visit only and I believe that the – well, I don't have the language in front of me. I believe that the provision in statute addresses that leads to an order or an administration of the testing so, that would be required for the modifier to be appropriately applied.

Maureen Davis: OK. So they must have had the test done, must have the COVID test for any CS whatsoever.

Ryan: I think it would, again, it would need to be an order or administration of the test.

Alina Czekai: Thanks Ryan.

Maureen Davis: OK. Thank you.

Demetrios Kouzoukas: And I'll just note that the – I think part of what we've been – they've been focused on in terms of applying this provision is the way that the statue is constructed and that there's only so much flexibility it gives us as well.

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

Sandy Sage: Thank you. First of all, the hold music is great. I just want to say that. Also the C 9803 for hospitals, does that HCSPCS code apply to state Medicaid as well? Should they be accepting that code for specimen collection for hospitals?

Ryan: So the state Medicaid programs, they make their own determinations based on how they've set up their program. There are some broad guidance around how Medicaid is treating testing that's directed at the states, but I think that would depend really on a particular Medicaid program and direct you to your state Medicaid program for that.

Sandy Sage: OK, thank you very much.

Operator: Your next question comes from the line of Dr. Tural from private practice. Your line is now open. Dr. Tural, your line is now open.

Dr. Tural: Oh, can you hear me now? Yes, can you hear me? OK. So, thank you so much for doing this. I was wondering for a visit, well, in our EMR, you can – they set up a video visit.

The patient can't get into the video visit and we have the staff call, tried to attempt that and then we did Doximity and we're able to get the video for like two seconds and then it crashed. And so then I just called them and spoke to them. Would that be billed as a 992H whatever number depending on how long it is or would that be billed as a virtual check-in?

Ryan: So, under the – during the public health emergency, there are CPT codes for telephone evaluation and management services. And so it sounds to me like in that scenario based just on the information you're presenting that the audio only phone conversation that took place in lieu of what would have been an audio/video visit might be appropriately reported for telephone evaluation and management service depending upon the length and other things. It could be a virtual check-in, but it could also be the telephone evaluation management code.

Dr. Tural: Right, because if it's over – it's like 45 minutes because it's chronic care dealing with all that stuff and going over lots of meds and everything. And you've done very attempt to get the video or you saw the patient for two seconds before their system crashed or one patient's power went out. Do I now – because like in our EMR, then we'd have to cancel that appointment and spend like 30 minutes just putting a new one in to then bill it as a telephone when the provision says a good faith effort to try to do a video.

Ryan: I certainly understand that frustration and with the systems, I would say that in cases where I think in previous references to good faith efforts, I would say that one important caveat would be that the code that best describes the service that was furnished, they'll be reported. And if the video is only sort of active for a very brief period of time and it doesn't meaningfully contribute to the service, it's hard to – I think it would be difficult to say that those codes best describes the service that was furnished.

Dr. Tural: OK, so with that then, how long does the video have to be active for because if you're able to do your physical exams and then the rest is just talking about their labs and what the plan is and everything, but you're able to do your physical exam in the x amount of time the video is present.

Ryan: I think in…

Dr. Tural: Is that not up to like some – so the telephone visit, you're only allowed 30 minutes and prolong for telephone visits aren't being paid.

Ryan: Understood. So I think, again, I think it would be left to the best judgment of the clinician and who's doing the coding regarding the code that best describes the service that was furnished. At present, we don't have time thresholds or particular elements of the service that need to be effectively furnished via video for the direct reporting.

And again, should that become necessary, I think we would take that under advisement, but at the moment there isn't specific guidance to that. And so, obviously hearing your concerns we'll continue to think about whether or not more specific guidance is needed.

Dr. Tural: And the telephone and the video are being paid just like an in-office visit or is that just a video?

Ryan: So, for telehealth services that have audio and video, then generally during the public health emergency, the payment would be the same as the in-person service. And then if the telephone evaluation management codes were reported, then the specific payment associated with the telephone evaluation management service would be reported.

Again, I think we generally understand that there is complexities here and that individual patients and individual circumstances will dictate what the most appropriate coding is. And always trying to sort of balance the need for specific guidance with the recognition that the need to the individual patients in the circumstances are going to have different results.

Dr. Tural: OK, so did you say that, yes, the Medicare patients telephone visits are being paid as in person?

Ryan: The telephone only evaluation and management codes have their own payment rates that are different. They're similar. They're analogous to the level two through four established patient office visits.

Dr. Tural: Well, they're only being paid $30.

Ryan: I think you'll find that the three levels for the telephone evaluation and measurement visits are the same payment rates for the 99212 through four. The payment rate for those codes changed at some point in May I think. And if you're finding that not to be the case for Medicare fee for service, please follow up and let us know.

Dr. Tural: Right, yes. It's only paid $58 for a level four telephone visit.

Demetrios Kouzoukas: I think it's an IFC 2, second interim final, Ryan, where we would direct…

Ryan: Right, right.

Demetrios Kouzoukas: …to deliver an appraisal there and I think you'll find that the rates that Ryan described are going to be in the interim final. I'm not sure what other source you're using.

Dr. Tural: No, that's not (inaudible) paid by Medicare, plus $58 for level three phone visit.

Demetrios Kouzoukas: I think, well, the question whether about the four – I remember the four being higher. I don't remember the rate for the three, but if you're finding that the rate that's in the interim final is not what's getting paid then please send us some information about the particular scenario you're describing.

Dr. Tural: And how do I send that information?

Alina Czekai: Sure. You can send it to our COVID mailbox and that is COVID-19@cms.hhs.gov. And thank you for your question. We'll take our question please.

Dr. Tural: And then where would I find the cost?

Demetrios Kouzoukas: It would be the second.

Operator: Your next – I'm sorry.

Demetrios Kouzoukas: Sorry, the second interim final rule that we put out it would have been in May I believe or you could find that on our physician – you can find that on our COVID material website as well as in our newsroom. You can also Google additional interim final rule Medicare COVID.

Operator: Your next question comes from the line of Norma Nelson from Legacy Health Organization. Your line is now open.

Norma Nelson: Hi, can you hear me?

Alina Czekai: Hi. Yes, we can. Thank you.

Norma Nelson: Thank you. I'm with Legacy Laboratory Services as the department that I bill for and we bill for the actual COVID test on the HCFA 1500. And when I look at the documentation as far as diagnosis code, appropriate diagnosis codes, V11.59 is a valid code to be assigned to either the swab tests or the antibody tests.

And our math is processing those as patient responsibility. And I just want to confirm because everything I'm reading on cms.gov says that's a valid code, but yet they're being processed as patient responsibility and that I am not sure what the disconnect is or am I missing something?

Michael Crochunis: Yes, this is Mike Crochunis from the provider billing group. We're researching a similar issue that was brought up a couple weeks ago on one of these calls. So if you could send that example to the mailbox, we'll look into it.

Norma Nelson: OK. And is that the COVID-19 mailbox?

Michael Crochunis: Correct.

Norma Nelson: OK. Thank you so much, because we were holding a ton of claims and we truly don't want to bill our patients.

Operator: Your next question comes from the line of Chivon Jane from Saint Logistics. Your line is now open.

Chivon Jane: Hi, thank you. Can you – are you able to listen to me?

Alina Czekai: Yes, we can. Thank you.

Chivon Jane: Thank you. Yes. So I have a couple of quick questions with respect to post ICU survivors for COVID-19. I just wanted to understand if there is any initiative – if there are any initiatives in CMS with respect to tracking of COVID-19 ICU survivors? And if there are any particular initiatives with respect to helping those patients out? And if yes, what's the right point of contact for us to basically reach out to those and understand more about those kinds of initiatives?

Demetrios Kouzoukas: So we do have ongoing efforts of varying types to examine claims data and see what can be learned from it with regards to how we run the program and obviously implications for public health and the like as well. That is something that we generally do really behind the scenes and work with based on the claims data that comes and flows through the system on the timelines that it comes in.

So, there aren't specific programs at the patient level that involve patient level interaction. Obviously, our quality improvement organizations are always interested in hearing about best practices and working with providers in different settings with regards to those, but we're looking at that kind of data at a sort of a large scale, not necessarily a patient by patient scale.

Chivon Jane: OK. Just a quick follow up on that because we have seen that there are a lot of mental health and delirium level repercussions, which has been backed by some of our studies at the regional levels. So, we were just thinking of like, sort of seeing if we can introduce this to somebody. So, you are mentioning that it would be the quality improvement organizations, right?

Demetrios Kouzoukas: Yes. And I think if you have observations to share that you think might be helpful to us more generally, certainly, welcome to send them to the mailbox here and we can send them along to our data gurus and see what

their…it may help our own analytics in terms of what we're reviewing as well. Always welcome the input from those who are closer to patients.

Chivon Jane: Thanks a lot.

Demetrios Kouzoukas: Thank you.

Operator: Your next question comes from the line of a participant with the last four digits of 4156. Please state their first and last name and your organization name. Your line is now open.

Kimberly Jamaro: Thank you. This is Kimberly Jamaro, Beaumont Health. My question is about MDS coding for a particular five star measure. Our centers are looking at potential functional decline for residents who have experienced COVID and we're also looking specifically at the ADL measures under G110.

Based on the facilities COVID plan, we're finding a number of residents coded at either seven or eight for item D, E or F because based on isolation for supposed no opportunity would have been provided to walk in the corridor, do locomotion on the unit or locomotion off the unit. Our question relates to those components being part of the five star measure, CMS ID N035.02 percent of residents whose ability to move worsened.

We're concerned that that may be overstated based on a facility's COVID plan and those isolation restriction. Just looking for comments. Thank you.

Demetrios Kouzoukas: Sorry, we don't have the – I don't believe we have the specific people from CCSQ who are conversant on the LPC quality program, but if you consent to the program, we do have some CCSQ representation on this call and i'll see that it gets to the right place.

Kimberly Jamaro: All right, thank you.

Operator: Your next question comes from the line of Fred Algerch from Organization R1. Your line is now open.

Fred Algerch: Hi. First I'd like to say in defense of getting rid of the music on hold, those of us who've been around listening to these calls for three months and who call

in early, we'd really would want a change. Perhaps the Hamilton soundtrack could be considered.

And then my question really is that Seema Verma made a comment to some reporter about physicians billing for telehealth for more hours in a day. Is that really just a warning or were there actual claims that were processed to come up with that data?

Demetrios Kouzoukas: I think that the focus is really generally, and the point was at that we are monitoring claims to identify if this is fraud abuse. Obviously, we're going to get into specific parameters or algorithms that are being used for that purpose, but the frequency and the circumstances under which some claims are looked at more closely or whether it's concern about the physical possibility of a certain things having happened, that is definitely part of how we approach fraud abuse generally as we know from our work and non COVID circumstance as well. So, I guess…

Fred Algerch: Can I just…

Demetrios Kouzoukas: It's probably a little bit of – I would say that it's emblematic and it's also indicative of particular cases perhaps as well.

Fred Algerch: OK. So, can I, just for clarity, this is CMS, you guys yourselves doing the work and not the MACs or the quicks or some other entity doing it.

Demetrios Kouzoukas: No, we use a variety of contractors as you know. So, it's a work that the MACs obviously have a role in at times as (inaudible) and so on.

Fred Algerch: OK, but there's like no targeted probe to educate on this. It's not a routine thing where we should watch for claim denials.

Demetrios Kouzoukas: I think we're – I don't think we have anything particular to share about a specific program or the parameters thereof. I think the administrator though was clear that we're focused on the possibility that the flexibilities can be misused and that we're acting within our authority and the data that we have to identify those circumstances in real time.

Fred Algerch: Thank you so much.

Demetrios Kouzoukas: Thank you.

Operator: Once again, ladies and gentlemen, if you would like to ask a question, please press “star” then the number “1” on your telephone keypad. We don't have any more questions on queue. Please continue.

Alina Czekai: Great. Thank you operator and thank you everyone for joining our call today. Our next office hours will take place next Tuesday at 5:00 p.m Eastern. And in the meantime, you can continue to submit questions through our COVID mailbox. Again, that is COVID-19@cms.hhs.gov. This concludes today's call. Have a great rest of your evening.

End