Centers for Medicare & Medicaid Services
COVID-19 Office Hours
August 11, 2020
5:00 p.m. ET

Operator: This is Conference #3498643

Alina Czekai: Good afternoon. Thank you for joining our August 11th 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 and 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's temporary action and empower local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote telehealth in 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 – Operator, I think we have a line issue. Thank you.

All press and media questions can be submitted using our media inquiries form, which can be found online 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.

Over the past two weeks, we have made several updates to our Frequently Asked Questions document to assist Medicare providers and we'd like to summarize a few of the updates today. We updated answers to several

questions about appropriate billing for COVID-19 testing including the question, can physicians and NPPs apply the CS modifier to claims for pre surgery examination services that includes COVID-19 testing?

The answer is the CS modifiers should not be used when pre surgery examination services are not paid separately. For example, if particular services are considered part of services with a global surgical period, ESRD services with a monthly capitation payment or maternity package services. We also addressed the question CMS is waiving the entire utilization review condition of participation at 42 CFR 482.30. Does that mean that the use of condition code 44 is waived as well? The answer is no. Condition code 44 still applies.

We also updated our FAQ with graphics outlining billing decisions in response to several questions around hospital billing for remote services, including how to understand billing flexibilities when the beneficiary's home is serving as a provider based department of the hospital, and how to build for outpatient therapy services, such as PT, OT, SLP, furnished via telehealth.

In addition, we have provided answers to questions about reporting a new patient E&M visit code after a visit under CPT code 99211, billing for diabetes self-management training via telehealth and billing for COVID-19 tests provided in the outpatient department prior to an inpatient admission. Please see the updated FAQ under the section billing and coding guidance on our current emergencies page for the comprehensive responses to these and other frequently asked questions.

We have also updated two guidance documents, our COVID-19 Medicare data snapshot, and frequently asked questions COVID-19 testing at skilled nursing facilities and nursing homes. These also can be found under our current emergencies page under the section for all healthcare providers, and for all health care facilities.

And that concludes our updates. For the beginning of today's call, we will open it up to questions from the audience. As a friendly reminder, please do

keep your questions to one question, or one question and a follow up. Grace, we'll take questions from the audience now. Thank you.

Excuse me, this is Charlie the substitute operator. If you have a question at this time, please press star one on your telephone keypad and wait for your name to be announced.

Your first question comes from the line of Rebecca Moore. Your line is now open.

Rebecca Moore: Hi. I have a quick question regarding telephone visits using CPT 99441 through 99443. So if the provider is providing a phone visit in the office or hospital, the patient is a registered outpatient, which is serving as an HOPD during the PHE. Since both are considered to be in the office, I just want to validate in that instance that the phone visit we could still bill the G0463 for the facility.

CMS - Emily: Hi, this is Emily. That, I believe that is correct.

Rebecca Moore: Great, thank you. And just a quick – so, if they were at home, obviously, it would be the Q3014. And just to follow up regarding providers, at home during the PHE providers have not been required to update their Medicare enrollment to list their home addresses. If we continue or providers continue to provide care from their home after the PHE, would we need to enroll their home addresses? I'm asking because we're hearing providers working out of their home on a regular basis may continue.

CMS - Alicia: Hi, this is Alicia, and normally we would require they report their home address on their own application. So, outside of the PHE, that requirement would still exist.

Rebecca Moore: Great. Thank you so much.

Operator: Thank you. And moving on, we have Sandy Sage from Hometown Health. Your line is open.

Sandy Sage: Yes, hi. Excuse me. I just had a quick question about commercial payers and COVID testing. We're seeing denials from insurance, commercial insurances like Anthem if the COVID test is being done at a hospital versus being at one their reference labs. Do you know if there's anything addressed about that for the PHE from CMS?

CMS - Demetrios: So nothing that the Medicare program has put out, then you get mostly the Medicare team on this call since obviously, the Medicare program doesn't get at the commercial regulators. I think we can pass that question on to our colleagues at CSIO.

Sandy Sage: OK.

CMS - Demetrios: And see if there's anything they can advise in that regard.

Sandy Sage: OK, thank you so much. Will you let us know on the call or how do we find that out once you…

CMS - Demetrios: Maybe you can – Alina, if you want to give the e-mail address and then take on this one over to one of our colleagues at CSIO.

Sandy Sage: OK, I'll send it to the COVID e-mail.

CMS - Demetrios: Yes.

Sandy Sage: OK, thank you so much.

CMS - Demetrios: Any time.

CMS - Alina Czekai: Sure. And I can repeat that again. It's COVID-19@cms.hhs.gov, and we'll take our next question.

Sandy Sage: Thank you.

Operator: Thank you. And moving on, we also have Ronald Hirsch from R1. Your line is open.

Ronald Hirsch: Well, that was fast. Just going back to Emily's answer there. If it's a telephone call, the physician is in their office and the patient is in their home, which is a provider based clinic, would you not put the 95 modifier on the claims because it's not telehealth because it's an in-person visit technically?

CMS - David: So, if the telehealth – if a service is not a telehealth service being billed as a telehealth service and including the originating sites fee, then you wouldn't include the 95 modifier because it's not a telehealth service. It is a service being provided remotely using telecommunication technology in the patient's home as a registered outpatient.

Ronald Hirsch: OK. So, will there actually be edits in the system that if it sees a GO463 and it sees a 95 modifier that it's going to reject the claim? Because it doesn't change payment. It just seems this is all so confusing.

CMS - Demetrios: No. I think we don't generally speak to the edits in the system, and you can imagine why, but whether it's through edits or otherwise, we do always seek to ensure that that payment is made in accordance with our policies. I don't know if our provider billing group has any more to add to that. Diana?

CMS - Diana: No, nothing more to add. Thank you.

Ronald Hirsch: Thanks. I tried.

Operator: Thank you. And moving on, we also have Susan LaPadula from ICMRS. Your line is open.

Susan LaPadula: Hi, good afternoon. Thank you for the call. I have a follow up question for you please regarding the point of care COVID-19 testing devices that were shipped to the skilled nursing facilities. We have them in our facilities, however – and we do have CLIA waivers by the way, in order to build a COVID test, and we would be billing Medicare Part B as Medicare Part A is a bundled item for the COVID test.

My question is, will CMS be assigning a new HCPCS code for specimen collection that is done by our nurses within the nursing home that do not have to travel and we're billing as a clinical lab to Medicare Part B? Currently, the

two codes that do specimen collection are defined without keeping in regard this new situation that happened in July.

CMS - Ryan: The new situation in July, if I could just ask you to elaborate on that a little.

Susan LaPadula: Certainly. The point of care devices that were sent by CMS directly to the nursing home so that we can do the test ourselves within our own facilities.

CMS - Ryan: I see. So, generally speaking, when the specimen collection and the lab tests are happening on the same premises, our general approach to the payment has been that those things are considered to be part of the price of the test.

Similarly, to when a specimen collection happens along with a visit in other settings of care that the specimen collection is generally considered to be priced into the payment for those visits. I think in the cases where the specimen collection is separately available, is when there's a separate entity in the example that you've provided where the lab is going into a facility to collect the specimen and that's happening in a separate location.

And so that's why those payments are as the suggestion that there, in other words, there wouldn't be a separate payment for specimen collection in the case where the test is – where payment for the test is being made to the SP in this same location.

Susan LaPadula: So the G2023 and 24, obviously, have travel issues calculated in them for the lab technician to travel either to someone's home or to a skilled nursing facility.

CMS - Ryan: Right. Those are the circumstances under which those codes would be billable.

Susan LaPadula: OK, so if we're using our own staff, we're using the point of care device that you shipped us and we're doing that collection on site ourselves, there's no additional code to be on the claim for specimen collection.

And then just to elaborate one more phase, because this is a COVID-19 test, are we allowed to use the CS modifier to waive the cost sharing because we believe we would be able to for the actual COVID test?

CMS - Ryan: I think maybe others on the call can confirm that whether or not you could place the modifier on, but the lab tests under Part B wouldn't have an associated patient cost sharing. And so you wouldn't need to put the modifier on to not have patient cost sharing be applied.

Susan LaPadula: Even if we're using our provider number, that's the skilled nursing provider number because we're billing Part B directly as the Part B provider?

CMS - Ryan: Right. Under Part B, for those kinds of tests, they're generally isn't patient cost sharing associated.

Susan LaPadula: OK. So, would your colleagues suggest the CS modifier to be added or to be not used?

CMS - Ryan: I don't know if anybody else wants to take that.

CMS - Vera: Sure, Ryan. This is Vera. I would just add that under Medicare Part B for payments for the clinical lab fee schedule, there is already no cost sharing involved. And so if you're billing Medicare Part B, I don't believe that the CS modifier is needed. The system already doesn't apply co-insurance for laboratory tests.

Susan LaPadula: And you believe that will follow through even though the claim is going in under a skilled nursing provider number? Keep in mind the NPI is registered to the skilled nursing and we have the CLIA waiver certificate allowing us to bill. However, in the system, we're set up as a skilled nursing provider not as a lab.

CMS - Female: It should. The cost sharing would still not be applied.

Susan LaPadula: OK, wonderful. Thank you. We don't believe that.

CMS - Female: Sorry there would be no need to have the CS modifier for the lab test.

Susan LaPadula: OK, wonderful. Thank you so much to all of you and thank you for these calls.

Operator: Thank you. Next we have Harlene Cozar from Heritage Valley. Your line is open.

Harlene Cozar: Hi. I'm calling to ask you questions about the provider reimbursement that's now available for counseling patients to self-isolate for their COVID-19 testing. And I'm wondering is this counseling only at the time when they are getting their testing done?

CMS - Ryan: I'm sorry, could you ask that again?

Harlene Cozar: Sure. So, the announcement that CMS had made about provider reimbursement for counseling patients to self-isolate when they have their COVID-19 testing, I'm wondering if this announcement was just in regards to at the time of testing. So, if they were getting their test at this time, that then this counseling is available and the provider can be reimbursed for it. Was it just at that time of that test that's being …

CMS - Ryan: Sure. So, understood and I appreciate you asking again. So, I think the announcement really was an emphasis on what the existing policies are surrounding patient counseling that could be applied to things like exposure risks and waiting for test results. And so I don't think that there's a specific requirement that would only allow for those services to be provided or to be billed, for example, as part of an evaluation and management visit at the time of a test.

In other words, if a test were to happen subsequent to such a visit, but the counseling associated with the test was happening the day before or the day after, if it was still medically reasonable and necessary for those services to be furnished then the same rules in terms of allowing counseling to contribute to the code selection for an E&M code, et cetera, would continue to apply.

Harlene Cozar: OK. What if for just example, let's say that a patient went to a drive thru and they didn't have an order. They just – they went to get a test done. They were worried and say a nurse was doing that test for that patient and they were

working incident to a physician. Could they go ahead and do the counseling and that would be – can be billed into the (2), that physician?

CMS - Ryan: So in cases where the counseling is furnished by clinical staff under incident 2, then I believe for the most part, that kind of service would typically be reported as a level one visit, which would be similar, which would also be the case for the specimen collection itself.

And so I think the bill – the conversations that associate – that are associated with the specimen collection by clinical staff under the supervision of a physician would probably be considered part of the payment for that visit.

I think the information that you're referring to regarding counseling associated with the COVID testing really applies for the personal counseling of the billing professional or the billing practitioner. And that's where that's more directly applicable.

Harlene Cozar: OK. Thank you.

CMS - Ryan: Sure.

Operator: Thank you. And your next question comes from the line of Robin Sora from Michigan Private. Your line is open.

Robin Sora: Hello. I'm calling because I have a few – two follow ups from ones that I e-mailed and then new questions. So the new question is, if I have a patient that has Medicaid, that's Michigan Medicaid and they are in a different state because they travel for work for a telemedicine visit, like you're not supposed to see somebody in a state that you don't have a license with, does that apply there because it's going to be billed to a Michigan insurance as if it's occurring in Michigan?

So, I'm just trying to decide do I have to tell them I can't see you because you just crossed the line of a different state or?

CMS - Demetrios: It is Michigan Medicaid your – does that – that's a payer here or …

Robin Sora: Yes. Michigan Medicaid …

CMS - Demetrios: Is it a dual with Medicare?

Robin Sora: No, just Michigan Medicaid. Patient lives in Michigan, address is in Michigan, but he traveled across state lines for work and that's when his telemedicine visit was.

CMS - Demetrios: OK. Yes. I don't think we're in a position to answer that because you have the Medicare folks on this call, but we can definitely pass it on to our Medicaid colleagues and it probably will ultimately depend on what the contours of the Michigan Medicaid program. I think there is some guidance. I know there's some guidance that CMCS has put out around testing and licensing. They've been getting some of these questions and so they should be in a position to answer it, but we can go to those folks.

Robin Sora: So, if it was a Medicare patient who had Michigan Medicare …

CMS - Demetrios: Yes.

Robin Sora: … like, what would be the answer to the question if it was Medicare since you're the Medicare people.

CMS - Demetrios: So if the patient resided in Michigan, went to another state to get tested the …

Robin Sora: No, that's not what's happening. So, I am their primary care doctor in Michigan. Patient is from Michigan we have a telemedicine visit set for today, but patient happens to be on vacation in a different state while the telemedicine visit is occurring.

CMS - Demetrios: Yes, we wouldn't really get into that from a Medicare perspective. I mean, the Medicare program is nationwide. It doesn't have geographic boundaries, necessarily. Obviously, there's a need to comply with the state telemedicine laws.

Ryan, I don't know if you are going to get in on some of that?

CMS - Ryan: Yes. I was just going to say a very similar thing. So, our long standing policy has been to that there aren't separate requirements for Medicare, but we do

defer to applicable state law so, to the extent that the state would allow that arrangement, then that would also be payable for Medicare.

But there's also been some changes to increase the flexibilities during The Public Health Emergency that are applicable to some of the state rules. And so I would recommend looking at individual states. But as a general matter, I think a lot of those rules have been lifted under the Public Health Emergency.

Robin Sora: So, because I'm just trying to say like if patients on vacation, I can't do any medicine for them even through MyChart, even through a patient portal if they're in a completely different state that I'm not licensed in?

CMS - Ryan: No, I think – so, in terms of Medicare rules, Medicare would defer to the state as a matter of permanent policy, but I think during the PHE, and, and different states have different rules in terms of whether or not they would allow for the practice of medicine in that way across state lines. Some certainly do.

And during the Public Health Emergency, I think many of those rules have been waived. And we – I think there is – I just don't have it off top of my head, but I think that there are FAQs on our website related to practice of medicine using telehealth across state lines during the Public Health Emergency.

All of those waivers I think are handled out of the department, they're not necessarily CMS regarding Medicare specifically. But for Medicare purposes because we defer to the applicable state law and whatever the national guidance is, there aren't separate rules for Medicare that would prohibit that. And so I would recommend looking at not only that website, but for your state, whether or not there would be applicable state law that would apply.

Robin Sora: Yes, I have and it just is not very clear because the patient is not a state resident. It's not a resident of the other state. The insurance is the Michigan – the patient address is in Michigan. They just happen to be on vacation for that telehealth visit out of Michigan, not in Michigan anymore.

So, like, if a patient calls me and they're like, hey, I'm in Florida. I need you to send my medicine to Florida, is that now breaking a law to send a refill request to a Florida pharmacy when I'm not a Florida doctor?

CMS - Ryan: I think in that case, both potentially the laws in Michigan and Florida would apply, but I'm not sure that we have the right folks on the call to answer what the individual rules would be.

Robin Sora: OK.

CMS - Ryan: But for Medicare, there wouldn't be particular rules that would prohibit that.

CMS - Demetrios: And I'm not sure we have – that those folks exist in the agency, necessarily. Those are sort of questions of Michigan and Florida law that we should – that we would probably leave to the – we'd be looking really to the states to tell us how they apply their laws to the extent they're incorporated apart of Medicare's policies.

I will say that right now for ordering a test, we eliminated the requirement for an order altogether for Medicare payment purposes. So, if it's about test ordering, then maybe that's – and it's Medicare, maybe that makes it somewhat simpler, at least for that bucket of situations at least for Medicare.

But obviously you still have – a primary care physician would still obviously be worried about maintaining their licensure and not violating your state's telemedicine laws and licensure laws, of course, and we wouldn't speak to those, but maybe that's one area that we've spoken clearly on.

Robin Sora: Yes. It's just interesting that, like a patient is a resident of a state, but then they happen to be on vacation and so they're still seeing their primary care doctor telehealth wise because they're now in the state, the doctor can't be a doctor for them anymore because they're not licensed in the state that they're vacationing in, but they're seeing them virtually.

CMS - Demetrios: Yes. I think a lot of that has been, I mean, obviously it would depend on the state, but like Ryan said, a lot of that has been relaxed by different states that's certainly what we've seen. And we've encouraged, I think the department and

CMS, have encouraged governors to relax as many of these restrictions as possible just to increase the supply of providers that are available in any particular hotspot or situation. And I feel like the government had been fairly responsive from the sort of high level observations we've had and the interactions.

Robin Sora: So will it continue afterwards because I mean, it's a scenario that happens often that you have a patient on vacation and they need medical care so you talk to them on the phone or you do a video visit with them, like they're not a resident of that state. They're just there for a day or so.

Like, do I really – does a doctor really have to go through all the licensors just to see a patient that they're established with and that they see and they've always seen, so it's not like they're taking care away from a Florida doctor because they were never going to go to a Florida doctor, so they're going to their primary care doctor for something that they already deal with.

So, it doesn't make sense that a license is needed to take care of my patients when they're on vacation for two days. So, like changing like the overhead rules to have that additional thing in there, so it makes sense if it's a Florida resident, I can't put like, it's a Michigan resident who just happens to be in Florida for this visit.

It was like, no, it's like we could see states anything about that. So it's all about the Florida residents and Florida insurances, but this specific scenario, no FAQ has been, like specifically brought up so, like bringing that as something that needs to be looked in to with the agency for the future and all the different states, but it's just a particular one that hasn't been discussed or brought up.

CMS - Demetrios: No, not that largely reflects that it's a state issue as Ryan described.

Robin Sora: OK. And then I still haven't heard back from the email I sent in May. So, like, is there a timeline because I still haven't heard back from e-mails that I've sent in May.

CMS - Demetrios: We obviously, getting into many of the questions that have been asked to over time, there are – I imagine that I don't know if it's been answered by other FAQ's in the meantime, but I think that if you go on and go ahead and resend it, we can see where it is in the queue or to try to be responsive there, we should.

Robin Sora: OK.

Operator: Thank you. And your next question comes from the line of Vanessa Barren. Your line is open.

Vanessa Barren: Thank you. This question was already asked, but I think I just want to ask it one more time to get the final clarification on it. For telehealth visits for hospital-based clinics with a modifier PO, if the physician is in the hospital-based clinic calling the patients home, then the facility is to bill the G0463, correct? If the physician is not in the hospital-based clinic calling the patients home, then we'd bill the Q3014. I just wanted to get a final clarification on that.

CMS - Female: Yes. So I can speak to the – I can't speak to what sort of modifier that you would need to place on the claim, but if there is a professional claim for the service, then the hospital would bill for the Q code as an originating site. If there is no associated professional claim, then the hospital would bill for, in this example, the visit code.

CMS - David: Yes. So, to phrase it another way, and there's helpful addenda in the FAQs that are on the COVID website in Section LL. There's a helpful graphic that will sort of walk you through the process, but the first step in determining how you should bill it is if there is a different site practitioner who would be providing a service on the telehealth list.

And if that's the case, then it should be built as a telehealth service. If not and it is a service being provided remotely for hospital outpatient, then it would be billed as a visit code on the facility claim.

Vanessa Barren: OK. Thank you so much.

Operator: Thank you. And your next question comes from the line of Christina Marciano. Your line is open.

Christina Marciano: Yes. Good afternoon. Hi, my question is in regards to the panel reporting. I understood that in the CARES Act, the panel reporting that is due January 1, 2021 through March 30, 2021 has been deferred to 2022. Can anyone on the team confirm that? The CMS website still has 2021, but I'm seeing other correspondences as suggesting that that deadline has been moved out.

CMS - Sarah: Hi there, this is Sarah and yes, you're correct. It is moved to January through March of 2022. And thank you for pointing out the website. We'll be sure to take a look at that. I know we've issued some sub-regulatory guidance where we've updated the date, but we'll go back and check the website for sure. Thank you.

Christina Marciano: OK, great. And I did send the contact on the page an e-mail. And that – so I did notify them as well and with the question, so hopefully that will help. And then for appropriate use criteria, that's my other question, it's related because it's regulatory reporting that goes into effect January of 2021.

I understand that that has been extended too, so we have an extra test year due to COVID. We have 2020 with our original test here. So now that will overlay into 2021, the way I understood the update, is that correct, for appropriate use criteria?

CMS - Demetrios: I don't know if we have any of our CCSQ colleagues on the line. There was a change that was either announced or proposed in the rule, but I don't know the details of it. If our CCSQ colleagues are on please answer if not we can get back with you on that.

Christina Marciano: OK. And if you like, I can send an e-mail to the COVID-19 email box, if that would be helpful because I was curious to see if there would be an update to the MLN for additional guidance and support.

CMS - Demetrios: I think those usually trail after the rules get out, but we can – you should send the e-mail and we can go from there.

Christina Marciano: OK, sure. I'll do that. And then is there any, lastly, is there any adjustments to the pricing transparency rules? It seems like a lot of the reporting due January 1, 2021 is being deferred to, just the extra emphasis on COVID this year. So I was curious to see if there's any discussions around deferring the price transparency rules as well.

CMS - Demetrios: No, we haven't made any change or announcement in that regard.

Christina Marciano: OK. Thank you, sir. Appreciate it.

CMS - Joe Chen: Excuse me. Hello. This is Joe Chen. To answer the question prior to this on the appropriate use criteria.

Christina Marciano: Yes.

CMS - Joe Chen: On our website, the appropriate use criteria program, we have posted an update actually that does say that the operational period has been extended. So if you can – if you would check onto the AUC webpage, you would have that information.

Christina Marciano: OK. Perfect. Thank you so much.

CMS - Demetrios: Thanks, Joe.

Operator: Thank you. And your next question comes from the line of Sheila Greta. Your line is open.

Sheila Greta: All right. Thanks for taking my call. My question is also regarding provider reimbursement for counseling patients to self-isolate. I just wanted to confirm that this is not separately billable with another office visit given a scenario if they have, the patient is, let's just say an audio only visit with a patient that's following with congestive heart failure, but now fears may be exposure from a neighbor who is COVID positive.

So the physician might conduct a separate review or whatever for the congestive heart failure, plus orders the tests and counsels the patient for COVID. Is there an opportunity to bill both the audio only visit, the 9944X as well as the COVID counseling if it were an office visit type of a scenario

given the time that they spent with counseling or is that going to be all integral to the audio only visit?

CMS - Ryan: So, if I understand the scenario and the question that you're asking, I think that the general answer is that the counseling associated with such services with would typically be a part of the – would be considered part of the evaluation and management visit just as if a patient – that often happens of course – patients present with more than one issue for discussion or consideration in visiting with their practitioner, and so the same thing would be true here.

Certainly, we understand the point that the counseling may be more extensive and that there is the telephone audio only E&Ms have sort of a more limited duration compared to the fuller range of the E&M codes. Of course, if the telehealth visit happens, audio and video, then the fuller range of evaluation management codes could be built for the additional counseling.

Sheila Greta: OK. So then these codes are more or less for those drive up visits that occur in their counseling after or maybe the contact tracing visits performed, not really when it is during a billable visit.

CMS - Ryan: Right. When there is a billable visit, there wouldn't necessarily be a separately billable visit, but the time spent counseling could be used to change the level of visit reported. So if the additional counseling takes more time, for example, you might have with, otherwise, it would have been a level three visit, become a level four visit, et cetera.

Sheila Greta: Thank you very much for the confirmation.

CMS - Ryan: Sure.

Operator: Thank you. And your next question comes from the line of Erin Gentry. Your line is open.

Erin Gentry: Hi, thank you. I think actually my question might have partially just been answered there, but just wondering if there is any specific guidance for hospital reporting, say a patient comes into the ED, they get their testing, they get the counseling and the provider can charge their E&M level and

encompass any additional time spent counseling the patient within that level, is that applicable to the facility reporting the E&M level as well?

CMS - Ryan: So to the extent that a facility would be reporting the E&M visits, then based on time, then yes, but I think for – under the hospital outpatient PPS, for example, the clinic visit code isn't delineated by time and so in that case, there wouldn't be a difference in the code that's reported by the facility.

Erin Gentry: Thank you.

Operator: And your next question comes from the line of Carrie Keller. Your line is open.

Carrie Keller: Hi, this is Carrie Keller. Thank you for taking my call today. I wanted to ask a question in regards to the new PCS codes that were released on October 1st, and I wanted to know if there's any further guidance on those or if we were to just go ahead and bill them as of October 1st discharge date.

Our concern was is that we're holding accounts until we can get that information in our system and we don't want to re-bill a claim that's already technically been billed just to put these tracking codes on. So, any further guidance, I would appreciate.

CMS - Ryan: Are these new codes under CPT?

Carrie Keller: No sir. They're the PCS codes that were released on, I think it was July 30th. It's in regard to the ICD-10 MS-DRG Version 37.2 that was effective October 1st. Yes, sir, that's our question.

CMS - Demetrios: These are the ICD-10 procedural codes.

Carrie Keller: Yes, sir.

CMS - Demetrios: Ing Jye, I know you're in a new role, but do you remember from your old head. I put you on the spot here.

CMS – Ing-Jye: Sorry, which codes were those specifically again?

CMS - Male: They're the new tracking codes in for ICD-10 that are for IPPS, but …

Carrie Keller: It was the PCS codes that were released on and it was a document that was released on July 30th in regard to the ICD-10 MS-DRG group or version 37.2, and they were all new technology codes, new PCS codes around Remdesivir and convalescent plasma and two other medications, the total of 10 PCS codes that were released. We were just wondering if you could elaborate or give us any further guidance because we haven't found anything else out on the web since this was released a week and a half ago.

CMS – Ing-Jye: OK. I know that the codes are effective on August 1st and we'll have to check with our experts to see if there's additional coding guidance. Typically, the agency doesn't release coding guidance per se, as you know there are a number of documents such as coding clinic that provide often the type of detailed guidance that people look to, to understand different scenarios on when to bill …

Carrie Keller: Yes, ma'am.

CMS – Ing-Jye: But the addenda and the files should be online at this point and they're available for billing. If there are any additional pieces of guidance that we are made aware of, either that we're working with the HIMA and the cooperating parties to issue by a coding clinic or that CDC or others have made available, we'll certainly make that available, a follow-up in Office Hours next time.

Carrie Keller: OK. Our concern was is that we're holding claims until we can get the information into our systems and updated, and that if a claim would have dropped and we missed a patient and we go back and bill that again as just a corrected claim, then nothing's going to happen to our payment that would have come because needs do not have any DRG bearing at all.

There's no financial gain or anything from them and they're just new technology codes that you all have us put on the claim. We just want to make sure we're not going to mess anything up if we have to send a corrected claim of a patient that might've been missed.

CMS – Ing Jye: So the question is really – so, for a patient who received the treatment after the August 1st effective date, if you needed to resubmit that claim to add …

Carrie Keller: Yes.

CMS – Ing Jye: … one of the treatment codes would that affect the payment? I don't believe it would. It shouldn't create sort of any additional beneficiary issues or any additional payment issues. I don't know if we have any of our billing folks on the phone who might be able to confirm that though.

CMS - Female: Yes, that's correct. They can correct the claim to add the PCS code and it won't impact the payment.

Carrie Keller: OK. Thank you. That's all I needed to know. I appreciate your time.

CMS – Ing Jye: Sure.

CMS - Demetrios: I know we're not used to having a field on the claim that aren't used a necessarily in the fashion that have an impact. So, this is a new venture for us, having these codes, but obviously given the nature of the pandemic. It seems appropriate as an agency to go out on a limb.

Operator: Thank you. And moving on, we also have Edwin Espinosa. Your line is open sir.

Edwin Espinosa: Hello. Thank you for taking my call. My call is concerning the store and forward code, like the G2010 code. I was wondering if we're having, say, a patient's caregiver who isn't able to come into the clinic, send pictures of the patient's home to get safety, kind of like a safety assessment and recommendations for alterations for the home to prevent falls as that is a fairly time consuming number of images to review by a clinician.

Currently, I think I saw that the G2010 code has a MUE of 1, but it does have a MAI of 3 where if it's medically necessary, it can be billed more than once. So I guess my question is, is that specific code, like, able to be billed more than once or is it just billable once per patient?

CMS - Female: So, I believe that there are sort of – there's restrictions involving whether or not a visit takes place within a certain timeframe, but I don't believe that we made any restrictions regarding how frequently the code could be billed. I have to confess I'm not super, super familiar with MCCI, so I don't know, Ryan, if you want to speak to that or if you could send a question into the resource box so we could get you a more definitive answer.

CMS - Ryan: Yes. I think given the particular coding advice aspect of it, definitely feel free to send the question in so we can take a look about the intention in terms of the policy surrounding that particular code.

Edwin Espinosa: Got you. So what would be my procedures to do that? I'm sorry.

CMS - Demetrios: Alina, the e-mail address. I should have it memorized by now, but …

CMS - Alina Czekai: Yes. No, I've got it. It's COVID-19@cms.hhs.gov.

Edwin Espinosa: Thank you very much.

Operator: Thank you. And your next question comes from the line of Karen Raider. Your line is open.

Karen Raider: Hi, this is Karen. I just have a question regarding the G0438 and G0439, the initial annual wellness visit and subsequent annual wellness visits. They are listed on the CMS Excel spreadsheet as being allowed to be done by telehealth. And in column D, it says that it can be done as audio only.

My question comes because there was an issue brief from the ASPE on July 28th. And in that, on appendix B, which is page 12, it says that these codes can only be done in-person. So this seems in conflict, and I just want to make sure that my direction to providers that these can be done audio only is correct.

CMS - Female: So from a Medicare payment policy perspective and from that perspective only, these services as we have sort of issued guidance suggesting can be provided as audio only telehealth services. I can't really speak to it. I don't know if anybody else on the line can speak to what the report that you

referenced was sort of the specific intersection between that guidance and the CMS guidance.

CMS - Demetrios: I know that ASPE's report was meant as an analytical report, just as a general matter, ASPE, that part – it's a part of the department that does evaluation of policy and the like, and we wouldn't expect them and nor would they expect themselves to be issuing guidance. And when they issue their reports, they're meant to be observational and analytical.

So, I don't know if there was some more context around the way that they use the term or if they maybe meant it in some other fashion beyond the Medicare program. But I think I would rely on the CMS guidance for the Medicare program use if that helps.

Karen Raider: You know what, thank you. That's very helpful. I just had a provider who was questioning the seeming contradictions. So, thank you for your clarification. I appreciate it.

CMS - Demetrios: Thank you.

Operator: Thank you. And the next one we have Teri Harmon. Your line is open.

Teri Harmon: Yes. Hi, good afternoon. I'd like – my question is relative, I'd like to go back to the point of care testing, the antigen testing. I'm understanding about the diagnostic piece of that. However, in guidance that came out from the federal government, and it's not – they have not stated when this is effective, but the guidance came out on August 1st, that any SNFs that are in a community where the spread is 5 percent or higher, we must begin. And again, there's no timeframe for this set yet, but we must begin surveillance testing.

Now, I had asked this question a few weeks ago and I was sent back to your MLN Matters number SE20011, and I've looked through that and it clearly states that surveillance testing is not covered under the Medicare guidelines.

So, I really would like to get some clarity then, and how will or where do the providers look to coverage or reimbursement for surveillance testing when that begins?

CMS - Demetrios: I can answer that. I don't know if Joe, if you have anything more to add to my answer, but there is a program that I think it's a cooperative agreement. It's kind of like a grant that CDC, the Congress appropriated monies for surveillance testing and some screening testing as well that CDC is implementing.

I know that they have – I think they put out the announcement and the states are working with CDC, the various states are applying for the monies and the like. So that's – I know that that's at least one source. I also know that there are obviously a number of public health programs that are run outside of Medicare, outside of CMS, outside even HHS and the federal government at the state levels too, but also at the federal levels.

And that there is a role that that FEMA is playing in some of this activity as well. Some of that involves reimbursement or payment, but some of it also involves other kinds of support or sort of facilitating our involvement in the testing process itself. So, I know that's not a categorical answer of go to this website, sign up, and you'll get a payment.

Teri Harmon: Right. Right. Right. I understand.

CMS - Demetrios: Which is probably what you're looking for, but the constraints on us and the Medicare program are that the statute says we pay for those things that are reasonable and necessary. And so surveillance is sort of definitional out of the picture there.

I think we have defined those things that in the MLN that you mentioned, defined – try to give some definition to what's reasonable, necessary, and diagnostic in the context of a pandemic in a way that perhaps recognizes the unique nature of the situation that we're in. But going further to cover those things that are surveillance wasn't something that we felt like we were in a position to do.

Teri Harmon: Well, let me ask you this then, and because I do understand exactly what you're saying, and that was my understanding, and thank you for validating that. So, let me just then follow up with this question. Would you then say,

and I think you kind of are saying, because you're saying, hey, there are other programs.

I can say – what I can say to you is the provider community as a whole, really is going to go back to their states quite frankly and knock on the doors and say, hey, we now have to do this in certain arenas. Where's the money that the federal government gave you? I mean, that's basically was our take on things.

CMS - Demetrios: Yes. And I don't think those checks have been cut. I feel like – I think the – I …

Teri Harmon: Right. They are not cut yet.

CMS - Demetrios: Yes.

Teri Harmon: Yes. And that $5 billion that came out, I think that that's part of that. So, thank you very much. You totally clarified for me. Thank you.

CMS - Demetrios: Happy to help.

CMS - Alina Czekai: Thank you. And we are at the end of our call today. Thank you everyone for joining as always. In the meantime, you can always reach us at our COVID-19 e-mail box, and again, that is COVID-19@cms.hhs.gov. Again, thanks for all that you are doing on the front lines as we continue to address COVID-19 as a nation.

This concludes today's call. Have a great rest of your evening.

End