Centers for Medicare & Medicaid Services
COVID-19 Office Hours
September 08, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 6196045

Alina Czekai: Good afternoon and thank you for joining our September 8th 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 front line to ask questions of agency officials regarding CMS's 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.

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.

Please 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. You are always welcome to reach out to the COVID-19 mailbox for further assistance.

We'd like to begin our call today with some updates on recent CMS publications and guidance. Last week in our frequently asked questions document to assist Medicare providers, we updated answers to several

questions including how PRS payments and SBA loan forgiveness amounts will be reported on the Medicare Cost Report.

Whether hospitals should report charges reimbursed through PRS uninsured program on worksheet S10, claiming employer share of Social Security tax as an accrued liability. Please see the updated FAQ under the section billing and coding guidance on our current emergencies page for the full text of all responses.

We also uploaded several documents outlining new testing and reporting requirements under the Interim Final Rule with comment three or IFC3 including an outline of our new COVID-19 testing and reporting requirements and updated FAQs around point of care antigen testing and university laboratory testing. These and the full IFC3 documents can be found in the section for health care facilities.

We have also updated our toolkit for states to mitigate COVID-19 in nursing homes, which can be found in full under the section survey and certification guidance. I also like to note that we have a call later this evening at 6:30 p.m. Eastern that is a National Nursing Home Stakeholder Call, and we invite you to listen in on that call as well.

You can find information for that call on our CMS current emergencies page. So with that, operator, we'll open up the lines for questions. As a friendly reminder, please keep your questions to one question or one question and a follow up today. Operator, over to you.

Operator: To ask the question, please press "star" then the number "1" on your telephone keypad. We have a question from Sherry Mahoney. Your line is open.

Sherry Mahoney: Hi, thank you for taking my call. I have a question I'm seeking clarification. I've reviewed the IFCs and FAQ's, even the most recent one and current waivers regarding the Hospital Without Walls initiatives and the allowances for PVD temporary expansion site. Most of that guidance at least from what I can tell focuses on relocation to off campus sites.

And so the clarification I'm seeking is regarding existing on-campus, provider-based apartments relocating temporarily to another on-campus site. And what are the reporting requirements would be other than condition code BR on those claims, on those facility claims?

CMS - Diane Kovach: So, this is Diane Kovach, and I'll start though. I hope others will certainly jump in as needed. Just in terms of entertaining that it is and emergency claim the BR condition code would be necessary. Otherwise, I don't know if there are other depending on the services being sold, if there are other modifiers or indicators that are needed on the claim. Is there anyone else on the line that can give any more information on that?

CMS - Male: Sure, and you're saying this is an on-campus department relocating to another on-campus location, is that right?

Sherry Mahoney: Correct, but another on-campus location that isn't generally regarded as a clinical site. So, that's why we would be operating under the waivers and flexibilities currently in place solely for the PHE. That's both on-campus.

CMS - Male: Could you clarify? By on-campus you mean within 250 yards of ...

Sherry Mahoney: Absolutely.

CMS - Male: ... in case of a (inaudible) in-patient?

Sherry Mahoney: Correct.

CMS - Male: So, I don't think you would have ...

Sherry Mahoney: So, do we need to – OK, go ahead.

CMS - Male: I was going to say that I don't think you have to apply any modifiers for the off-campus piece because it would be an on-campus location. Let us get back to you if we can. Maybe you can send an e-mail to the COVID-19 mailbox and we can respond on the modifier question of whether or not because it is relocated from where the – it is a registered department whether or not we need a relocating modifier on the claim.

Sherry Mahoney: OK. So, can you give me that address to make sure I have it correct?

CMS - Alina Czekai: Sure, I can provide that. It's COVID-19@cms.hhs.gov.

Sherry Mahoney: Thank you. And what's the turnaround time that you guys have on those currently?

CMS - Alina Czekai: Usually its one to two business days is our standard turnaround.

Sherry Mahoney: OK, thank you again for taking my call.

CMS - Alina Czekai: Thank you. We'll take our next question, please.

Operator: We have a question from Dee Staley. Your line is open.

Dee Staley: Hi, thanks for taking my question. My question is a follow up question to a question that was submitted for consideration two weeks ago and for which we were hoping to just get an update from you if possible.

The question is regarding the applicability of CMS policy on virtual presence during the PHE to services requiring "direct personal supervision" such as certain radiation therapy services. This relates to the fact that chapter 15 of the benefit policy manual defines direct personal supervision for these services in a way that is substantively identical to the standard for direct supervision.

And we were hoping to follow up with CMS and see if you could confirm that the policy authorizing a physician's virtual presence for direct supervision also applies to the equivalent standard for direct personal supervision. And this is specifically in regards to superficial radiation therapy delivered in an office setting just described by CPT 77401. So, any update you have on that would be most helpful.

CMS - Gibbs: Hi, this is Gibbs. I can provide an update there. So yes, the requirements are the same as we laid out in our policy for what would be applicable to the direct personal description that's in chapter 15 of the manual. We should have an FAQ that says that shortly, but the requirements are the same, the policy does apply.

Dee Staley: Great, thank you. Good.

Operator: And next question comes from the line of Brad Wilbanks. Your line is open.

Brad Wilbanks: Thank you. So I had a question about the new requirement to have a COVID – positive COVID test result in the record in order to get the extra 20 percent for the MSR (inaudible) DRG (wait). And as you know, patients go and receive these tests all over the place. Many of these locations are pop up sites.

They don't get a copy of a test result. They're often given a phone call or a text result and told to self-quarantine and positive and get it to the ED if they're negative. And of course, when they show up at the ED, they don't have a test result in or they don't really remember who gave them the test or where they got the test. And trying to track down that test result is a huge hurdle for providers.

And I was wondering CMS' position as having to one, have an actual copy of that result and/or if we decided if we are admitting a patient who does not have a positive result with them, but they've indicated that they did test positive and/or they had signs and symptoms of being positive to test those people upon admission. Any thoughts in that regard? Could you all hear me?

CMS – Diane Kovack: Yes, we did. I was going to ask if – I know that there are some of our regular attendees who were not able to be on the call today from CMS. I wanted to ask if anyone from our inpatient team is on the call and able to address that question. OK, unfortunately, I don't think we have the right people on the call today. So, we will have to ask you to send that question into the mailbox and then we'll have to get back to you on that.

Brad Wilbanks: OK, thank you.

Operator: Our next question comes from the line of Lauren Davis. Your line is open.

Lauren Davis: Yes. Thank you for taking my call. So prior COVID, our patients on long term Coumadin would come to our anti-coag clinic, get their PT INR lab test and then they would meet with the pharmacist to discuss their lab results, talk about medication regimen, any misdoses, adjustments, any new related health

issues, et cetera, et cetera. And we would bill a level one E&M code to G0463 in addition to the lab code.

And now during COVID, the patients are getting their blood tested but for safety purposes, they're not meeting face to face with the pharmacist but instead, the pharmacist was calling patient back over the phone to discuss their current lab results and essentially having the same discussion that they used to have with the patient over the phone instead of face to face.

I know some of them have been billing the G2012, which of course is denied since pharmacists are not allowed to bill that. So, are we allowed to bill the G0463 for this service?

CMS - Male: I'll start and Dave, definitely hop in. The G0463 is an office visit but from an outpatient perspective, and you're talking about the patient going to see a pharmacist to talk about their Coumadin levels or – I'm sorry – their Coumadin levels and to get additional information on a plan that's been laid out by a billing practitioner because the pharmacist can't build directly so I'm assuming there is a billing practitioner.

Lauren Davis: Yes. Exactly. They're the ones that are – yes, obviously, it's whatever incident to the physician but, they're the ones that are in the anti-coag clinic, and pharmacists are the ones that are speaking with the patient about their most recent test and any issues they might be having and what have. I mean, this is ...

CMS - Male: OK.

Lauren Davis: ... what we've always billed, again, when this was a face to face service. And essentially, so the patients are (inaudible) so I don't know how – they're just going to drive by here or whatever, but getting their blood tested, but not meeting with the physical person. But like I said, the pharmacy then gets the blood results and calls them back when they normally would have done the same thing at the clinic with the patient sitting in front of them.

CMS - Male: Got it. Got it.

Lauren Davis: So, it's performing the same exact service, but it is of course over the phone and pharmacists are not allowed to bill that code.

CMS - Male: Right. So that's why I bring up the billing practitioner. Billing practitioners should be able to bill for 99211, right, a level established office visit for that interaction given that the pharmacist that is auxiliary or working incident to the billing practitioner as long as there is a relationship there. I can't speak to the G04 – I'm sorry, I'm forgetting that.

Lauren Davis: The G0463.

CMS - Male: The (inaudible) specifically – 463 – which sounds to me like an E&M in an outpatient setting for (inaudible).

Lauren Davis: Well, I get it and that's why maybe I should clarify. I am talking about the hospital.

CMS - Male: Got it. It is why invoked to Dave's name. So Dave, I don't know if you've got any thoughts.

CMS - Dave: Yes.

Lauren Davis: This is all so confusing to me. I just – I've been listening to every single one of these phone calls and I know every single call gets a – there's a question on the G0463, but go ahead.

CMS - Dave: Yes. I think it would be best if you submitted a question to the mailbox and we can respond to you through that.

Lauren Davis: OK, will do. Thank you.

Operator: Our next question comes from the line of Jay Stevens. Your line is open.

Jay Stevens: Hi, thank you. I just wanted clarification of a question that was brought up last week. When hospital clinical staff who were fully employed by the hospital for whom the hospital does not do any separate professional billing, for instance, an LCSW who performs counseling using telecommunications

technology to the patient who was registered outpatients and the patient is at home and in the relocated site.

The hospital can bill for the service, for instance CPT 90832 on the UB-04 with modifier PO or PN. My question is does this provider need to be on site in order to utilize that billing?

CMS - Male: Yes. If you're if you're billing for the service under the Hospital Without Walls to the relocated department that is the patient home. The practitioner has to be at the hospital department site in order to do so.

If not, the distant site practitioner in their billing code is provided under the telehealth service with a 95 modifier, they should be billing that service as a telehealth rather than under Hospital Without Walls for the G0463 because the providers distant sight and not at the hospital location.

Jay Stevens: OK. So if the provider is say for instance an LMSW who is not a Medicare provider and they need to provide the services incident to a physician, they would then do professional – they could provide that service incident to a physician as a telemedicine service, meaning they would bill a 90832 on a 1500 professional claim as a (inaudible).

CMS - Male: Yes. I can't speak to the physician bill.

CMS - Male: Yes. Now, working incident, they could bill that service as long as the staff furnishing the service was not in the same location, right, at a distance site versus the originating site or the patient's home or wherever that was related to or considered part of the hospital they could bill separately.

Jay Stevens: And the incident to billing would be done under the actual physician's name as opposed to on a non-Medicare practitioner.

CMS - Male: That's right. Well, when we say non-Medicare, let me say it differently. Practitioner or staff that couldn't bill Medicare directly for the service that was being furnished. So, there would have to be a billing practitioner that was enrolled and allowed to bill for that service.

Jay Stevens: And the facility can bill the 23014 in addition.

CMS - Male: Yes, the originating site fee.

Jay Stevens: OK, thank you.

Operator: Our next question comes from the line of Rick Delenda. Your line is open.

Rick Delenda: Hi, thank you. Back in FAQ's that you post for physician services, you do talk about physician services and the new definition of how you advise the definition of direct supervision to include with a physician won't have to be on site. They could be available by audio visual or even you mentioned just via phone and/or text.

The question I'd ask is, in private practice for both physical therapists and occupational therapists, they have to be on the premise when supervising a PT assistant or an OT assistant. Does the revision of the direct supervision for physicians also apply to physical therapists and occupational therapists and private practice?

Meaning, they can be available either by audio visual or just audio only telephone or text messaging when a PT assistant or an OT assistant is treating a Medicare beneficiary.

CMS - Male: Thanks for that question, Rick. You should certainly send us an e-mail. I promise we will get through it as a (inaudible) ...

Rick Delenda: I did send it a couple of weeks ago.

CMS - Male: OK. It hasn't made its way to us just yet, but I will I will ask and try to get that so we can respond.

Rick Delenda: OK. I can send – I'll send it again to, I guess, the COVID-19 mailbox, is that correct?

CMS - Male: Yes. And I believe you also have my e-mail address as well, too, just to make sure I have an eye on it. So, if you wouldn't mind just CC me and that would work.

Rick Delenda: And I'm sorry for asking because I don't ...

CMS - Male: Yes. I'm sorry. I'm sorry. That's OK. It's OK.

Rick Delenda: Yes, I would do that. Thank you very much. Appreciate it.

Operator: There are no questions at this time. Presenters, please continue.

Alina Czekai: Great. Well, if there are no further questions on today's call, we can give everyone a solid 30 minutes back in your day. I'm sure everyone could use it after the holiday weekend. In the meantime, you can continue to submit any questions you have to our COVID mailbox. Again, that email address is COVID-19@cms.hhs.gov.

Thanks again for joining our call. Have a great rest of your day.

End