Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call
December 22, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 3968359

Operator: Good afternoon and welcome to the CMS COVID-19 Office Hours. My name is Celine and I will be facilitating the audio portion of today's interactive broadcast.

All lines have been placed on mute to prevent any background noise. For those of you on the stream, please take note of the options available on your event console.

At this time, I would like to turn the show over to Stefanie Costello. Please go ahead.

Stefanie Costello: Great. Thank you very much, Celine. Good afternoon and thank you all for joining us on our December 22nd, 2020 CMS COVID-19 Office Hours Call, our last one of this year so we appreciate you taking time out of your busy schedule to join us today. My name is Stefanie Costello, and I'm with the Deputy Director in the Office of Communications, Partner Relations Group at CMS.

Office Hours provides an opportunity for hospitals, health systems and providers to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and healthcare systems to increase hospital capacity to CMS hospitals without walls, to rapidly expand the healthcare workforce, put patients over paperwork, and further promote telehealth and Medicare.

While members of the press are welcome to attend these calls, we ask that they please refrain from asking questions. All press media questions can be submitted using our Media Inquiries Form, which may be found at cms.gov/newsroom/media-inquiries. Any non-media COVID-19 related questions for CMS should go to covid-19@cms.hhs.gov.

We'll begin our call today with one update from our last Office Hours Cal on December 8th. In response to questions asked, we're providing more information on reprocessing RHC and FQHC Claims with telehealth services G2025. MACs will automatically reprocess all claims with HCPCS code G2025 for services furnished on or after January 27th, 2020 through November 16th, 2020 that were paid before we updated the claims processing system to pay HCPCS code G2025 based off on the lesser of methodology.

These claims can be identified on your remittance advice by the claim frequency code, which is the third position of the type of bill. The code will be equal to I. For additional information on how to identify these claims, please contact your Medicare Administrative Contractor.

And with that, operator, let's open up the lines for our first question for today. As a reminder, please keep your questions to one question or one question and a follow-up. Thank you. Operator?

Operator: Thank you. At this time, I would like to remind everyone in order to ask a question, press "star" then the number "1" on your telephone keypad. Again, that is "star" then the number "1" on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

We have our first question coming from the line of Rick Gawenda. Your line is open.

Rick Gawenda: Hi, thank you. In the final rule released on December 2nd, you adjust student documentation in the medical record. Can you clarify that student's document in the medical record so long as it is reviewed and verified by the billing therapist?

And of course, the concern that therapists and business owners have is what if it's a therapy assistant student being supervised by a physical therapist assistant or an occupational therapy assistant. Because assistants don't do the billing in a private practice, their services are billed under the NPI of this therapist or a non-private practice setting under the NPI of the facility. So I guess just clarification, can an assistant supervise an assistant student verify their documentation by this co-sign in their notes or it must be a therapist?

CMS - Ryan Howe: Yes, thank you for the question. I think what the language in the rule attempts to convey is that the CMS is relatively agnostic to who does the literal writing as long as the billing practitioners is reviewing appropriately the documentation itself and that applies regardless of whether or not it's a student or someone else is being paid to do the literal writing.

Rick Gawenda: So I guess just to clarify then, that means – so if a physical therapist assistant is supervising a PT assistant student, the PT assistant cannot verify the documentation. It must be the physical therapist?

CMS - Ryan Howe: It must be the – the verification must be done by the person who is billing.

Rick Gawenda: But I guess in a non-private practice setting, it's billed under the NPI of the facility, so technically there is no NPI of an individual practitioner.

CMS - Ryan Howe: Right. In that case, it would be for whoever would be required to be supervising the procedure would then need to review and sign the documentation.

Rick Gawenda: I guess – I guess I will ask one more time for clarification ...

CMS - Ryan Howe: Sure, sure.

Rick Gawenda: ... maybe I could get a yes or a no. Can an assistant verify and co-sign a note done by therapy assistant student?

CMS - Ryan Howe: So if the assistant is – it depends on the – what the particular rules are and I have to say I don't know them at the top of my head. And so to the extent that the supervision requirement is met by the assistant, then the assistant could be the one who reviews the documentation.

Rick Gawenda: OK. And then the follow-up questions, if I get a follow-up, is in that same language, CMS also clarified that broad policy that allows billing clinicians to review and verify documentation added to the medical record for the (inaudible) by other members of the medical team also applies to therapists.

So regarding Medicare's tenth visit progress report, does this mean now that assistants can write the part they are allowed to write and the therapist can just verify and add their component to it, and then sign off on that note, thereby they don't have to re-write what the assistant wrote for the progress report?

CMS - Ryan Howe: I think – so in general, I would say that the intent of the policy changes broadly is to avoid circumstances where rewriting is required by billing professionals or those that need to supervise. But in the case of – particularly for progress reports, we'll have to take that back to confirm.

Rick Gawenda: OK. Do we need to send that into the – it's a question about this follow-up.

CMS - Ryan Howe: It would be helpful if you would send it in, that way we are making sure that we're getting the specifics of your question and we're able to answer it as thoroughly as possible for the call.

Rick Gawenda: And that would be the COVID-19 mailbox?

CMS - Ryan Howe: Right.

Rick Gawenda: OK, thank you. Thank you all of you for everything you've done in 2020. I hope you have a merry Christmas. Thank you very much.

CMS - Ryan Howe: Thank you. You as well.

Operator: We have our next question coming from the line of (Jan Russell). Your line is open.

(Jan Russell): Hello. I have a question about potential surge – COVID surge situation. We have three hospital systems, but they aren't the same Medicare provider now. So there are three separate hospitals, but one of them is more advanced than the other two. The other two are much smaller.

If the COVID situation gets such that they have to move patients from the bigger hospitals to one of the smaller hospitals, how does the billing get handled? Is it handled to reflect a regular acute care transfer or it is special rule because of COVID?

CMS - Demetrios Kouzoukas: Do we have any of our division acute care colleagues on? We can run that down. I don't know – there's no special treatment away that comes to mind. You say that they were all separate provider numbers?

Jan Russell: Yes, they are.

CMS - Demetrios Kouzoukas: I don't think that we've issued anything that could clarify that.

Jan Russell: OK, I couldn't find anything.

CMS - Demetrios Kouzoukas: Yes, I think – I think that's right. If I find something, we would try to highlight it for you if you send it in email. But I don't – I can't think of anything.

Jan Russell: OK, that's what I thought. OK, thank you.

Operator: We have our next question coming from the line of Brad Willbanks with the University of Texas Medical Branch. Your line is open.

Brad Willbanks: Hi, thank you for taking this question. I'm not sure if this is the correct forum for this question, but you recently – CMS recently changed the resident moonlighting requirements and are now allowing residents to the moonlight at the institutions where they're receiving their training. So long as the services they will be providing while moonlighting are not the same reason they're there for at the institution getting their training.

So my question to you is this gets a little bit gray, so for example, there's going to be some overlap, So, say, you have a cardiology fellow and they're, of course, there for cardiology, but they're going to moonlight in urgent care. There will be seeing all sorts of patients, some which may have a cardiology condition. You may have a pediatric resident who is going to moonlight in the ED and they may see some pediatric patients.

So I guess what I'm getting at is how far apart do the moonlighting services has to be from the training that they're receiving at the institution, if that makes sense.

CMS - Ryan Howe: Yes, thank you. Thank you for the question. It definitely makes sense and I think that's another one where the examples will help us answer the question in a more complete way. So if you could send those into – I guess it's not really a COVID-specific question. I don't know if somebody from OC is on the line that can sort of take that. What's the best email to send that question to? But we can certainly get started on looking into that and get back to you.

CMS - Stefanie Costello: Yes, you can send that to partnership@cms.hhs.gov so partnership@cms.hhs.gov.

Brad Willbanks: Great. Thank you.

Operator: We have our next question coming from the line of Britt Perkins with University of Washington. Your line is open.

Britt Perkins: Hi. In the very recent stimulus bill that's passed, in Section 113, there's a moratorium on payment on the G2211 code for three years. Will CMS be commenting on that and providing guidance?

CMS - Ryan Howe: So ...

CMS - Emily: Hi, this is Emily. No, please go ahead, Ryan.

CMS - Ryan Howe: I was just going to say that I think we're currently taking a look out at and obviously following closely the provisions of law. And historically, when there have been changes to the fee schedule, we have implemented them as soon as we can. Understanding that the changes are effective for January 1st, we'll be taking a look as quickly as we can and we're currently doing so.

Britt Perkins: Can I ask one follow-up question?

CMS - Ryan Howe: Sure.

Britt Perkins: So based on not paying for the G2211, will there be a change to the conversion factor to increase it?

CMS - Ryan Howe: So I think we're still taking a look at the particular provision. But I would generally say that in cases where the budget neutrality assumptions that we'd

make in setting the conversion factor assume the utilization of particular code when something like the law would change to prevent use of that code, then ordinarily we would then recalculate to offset the reduced anticipated payments because of the – not use of the code.

So that's a long-winded way of saying, generally speaking, yes, we would anticipate less of a negative reduction to the conversion factor to account for the budget neutrality. And so, that's how that would ordinarily work, but again we're taking a look so I don't want to be entirely definitive at this point.

Britt Perkins: Perfect, thank you so much.

CMS - Ryan Howe: Sure.

Operator: We have our next question coming from the line of Janel Gleeson with DeBrunner & Associates. Your line is open.

Janel Gleeson: Hi, thank you. A question about place of service for telehealth, in this scenario, the patient is in their home receiving telehealth services from a physician located in his or her office. I'm wondering if that physician has discretion to bill for the visit as an office visit with Place of Service 11, with modifier 95, or can that physician bill it as a home visit using Place of Service 02 telehealth without the modifier?

I read in that first IFC that there were some options still available to bill using Place of Service 02 so I wanted to get some clarification on that.

CMS - Emily: Yes, thanks, this is Emily. That is a great question. So as you point out, what we did say for telehealth visits is that the practitioners should put the place of service on the claim where the service would have been provided had the patient been seen in person. So if this is an instance where the patient would have come into the physician's office sort of under normal circumstances, then the physician could – would put the Place of Service code 11 on the claim.

However, if this is an instance where the beneficiary would have received a home visit and understanding that the services of home visit versus an office visit as they described, they have some different sort of service elements that

distinguish them. And so you should use whatever code most accurately describes the service that you're furnishing. And in the instances when the beneficiary is at home, then you could use the telehealth place of service code.

Janel Gleeson: OK. And if I'm using the Place of Service 02, is that reimbursed the same way that would be as if we're outside of the public health emergency?

CMS - Emily: Yes, that is correct.

Janel Gleeson: OK, thank you so much.

CMS - Emily: Thank you.

Operator: We have our next question coming from the line of Margaret Napoli with Novant Health. Your line is open.

Margaret Napoli: Yes, hi. I have a question, this is visit facility-related. If a patient presents to the emergency room and has a Medicare Advantage plan and has E&M visit with a COVID test that comes back positive, the patient meets the criteria to receive the infusion treatment. Are all the services billed to original Medicare, or do we bill an E&M test – lab test to the Medicare Advantage and then the infusion directly to Medicare?

CMS - Demetrios Kouzoukas: So here there are three components – lab test, infusion, and E&M. Is that three pieces?

(Margaret Napoli): Yes.

CMS - Demetrios Kouzoukas: And the infusion is ...

(Margaret Napoli): There could be more but, yes, basically those three.

CMS - Demetrios Kouzoukas: So we would treat this – we're treating this like vaccine administration, and so maybe our HAPG folks can help me out in terms of what would be normally paid under the vaccine, if these were like a regular vaccine? I think it's the infusion ...

CMS - Ryan Howe: Sure.

CMS - Demetrios Kouzoukas: ... and the – I think it's the infusion.

CMS - Ryan Howe: Right.

CMS - Demetrios Kouzoukas: Tell me more if the lab test and E&Ms are covered. Certainly the infusion.

CMS - Ryan Howe: As I understand it, it would just be the vaccine administration, in this case, the infusion for the monoclonal antibodies, that would be paid under the preventive vaccine benefit. And the other services would be billed normally. Although I'm sort of asking a question to make sure if that makes sense to you. I think that's my answer.

CMS - Demetrios Kouzoukas: It does. It does because I'm just thinking out loud here that we wouldn't pay for E&M associated with the vaccine. And as part of the vaccine payment, that would be just be regular fee or (advanced) payment.

CMS - Ryan Howe: Right.

CMS - Demetrios Kouzoukas: And really this is true about the lab test vis-à-vis the CLFS. So I think, sorry for all the words, but the answer is we would – in that scenario described, with the three components you described, the administration or the infusion should be billed the fee-for-service and the other two to the MA plan.

Margaret Napoli: OK. And can I just ask like a second part of that, if the patient has a hypersensitivity treatment, that would go to the Medicare as well, if they're having a reaction?

CMS - Demetrios Kouzoukas: That – I don't think we pay for those under the vaccine benefit either, so that would normally go to the MA plan.

Margaret Napoli: OK.

CMS - Demetrios Kouzoukas: Yes.

Margaret Napoli: OK, thank you very much.

Operator: We have our next question coming from the line of Jennifer DeVore with Compass Health. Your line is open.

Jennifer DeVore: Hi, this is Jenny. I just have a question regarding the COVID vaccine. I want to clarify is the physician order required for the COVID vaccine?

CMS - Demetrios Kouzoukas: Do we have CPI on? So this is a question we've gotten – I think it's an FAQ. I don't remember if it's out or not. Does one of our HAPG folks remember?

CMS - Ryan Howe: I don't know if the FAQ is out or not. But as a general – to the extent that the COVID vaccines are following the model for the flu vaccines, they wouldn't necessarily be a physician order required. But I think we'll take a look. We're clear -we're working on – we haven't written the guidance that addresses that question so we'll definitely address it definitively on the next call as well.

Jennifer DeVore: OK, thank you. And then one other question regarding the COVID vaccine. I know for hospitalized inpatients, Medicare still pay for the COVID shots separately from the DRG, but this is allowed on 11X type of bill. So we should then bill our COVID shots or vaccine on the 12X hospital inpatient type of bill, is that correct?

CMS - Demetrios Kouzoukas: Diane, do we have some – Diane?

CMS - Mike Campbell: So this is Mike Campbell. It has to be reported on a 12X on the date of discharge of the 11X.

Jennifer DeVore: OK, thank you.

Operator: We have our next question coming from the line of Sandy Sage with HomeTown Health. Your line is open.

Sandy Sage: Hey, thanks for taking my call. Since the monoclonal antibodies are being treated like they're under the vaccine program, what revenue code should we

put that infusion in to get it paid? We're having a little bit of difficulty. But that should be in the 771 or place of service revenue code? Gentlemen?

CMS - Demetrios Kouzoukas:
Go ahead.

CMS - Mike Campbell: This is Mike Campbell. This is 771 revenue code.

Sandy Sage: OK, good to know. All right, thank you very much. I appreciate it.

CMS - Mike Campbell: Thank you.

Operator: We have our next question coming from the line of Gretchen Case. Your line is open.

Gretchen Case: Hi, thank you. This is a facility billing, a hospital billing question with regards to the vaccine. On our last call, there were some discussions towards the end and what was explicitly stated then was that for vaccines that we receive for free, we should bill for the administration of the vaccine and the vaccine, and the vaccine with the ones been charged in the non-covered column.

We since followed up with both of our MAC as well as other partners in the community, and there seems to be still gray area with regard to this. Some of the fellow providers are billing for the vaccine with the ones been charge on the regular part of the claim, not even in non-covered, stating that they couldn't get the claim through without that, which is what we were concerned about. And then others, including the MAC have directed us back to the CMS guidance which explicitly state on the CMS website "Do not bill for the vaccine when it's free."

So are we to follow that, or what was said last, or what other providers are doing? We're just really confused on what to do.

CMS - Mike Campbell: Yes, this is Mike from Provider Billing. We would prefer that you just bill the administration code and not the vaccine based on what was discussed in the last call. It sounds like some provider billing systems require that you also bill the vaccine so that is allowed to bill that if it would be the token charge, the 1 cent charge.

Gretchen Case: OK. Can that or will that be updated somewhere in writing like on the web page or even in the FAQs?

CMS - Mike Campbell: We can look into that. Given what's coming on site, I think that might be a good idea.

Gretchen Case: Yes, thank you very much. I appreciate it.

CMS - Mike Campbell: Sure.

Operator: We have a follow-up question coming from the line of Rick Gawenda with Gawenda Seminars & Consulting. Your line is open.

Rick Gawenda: Thank you. Sorry, I kind of beat this dead horse, but I just want to make sure back to the assistant supervising and assistant student. So I just want to clarify also in the private practice setting that the assistant could verify the documentation, could co-sign the note as long as the assistant was under the appropriate supervision of their therapist which right now that direct supervision has been eased through December 31 of 2021 instead of being (tracked) on the premise, it can be achieved through two-way audiovisual. As long as the assistant is being supervised appropriately by the therapist, the assistant can verify, co-sign, the note of an assistant student.

CMS - Ryan Howe: I think I understand the question. I think the rule that is being changed is that the – in any case where previously the supervising professional would need to have re-documented, but instead of that, the review and sign would be acceptable in its place.

And so in a scenario where that assistant would have previously been documenting and would not – it would not be required to be reviewed and signed by a therapist in private practice. Then the rule change would now allow for the assistant to be the person as reviewing and signing.

Rick Gawenda: Correct. OK, thank you very much for the clarification. I greatly appreciate it.

CMS - Ryan Howe: Thank you.

Operator: We have our next question coming from the line of Kathy Bold. Your line is open.

Kathy Bold: Yes, thank you for taking my call. I just wanted to reaffirm, I've been listening to the past audiocast you've been offering and in regards to the billing of the vaccine when it is free, if – and maybe you've clarified that the 1 cent charge in the non-allowed column is going to be the way to go. Because all the time I was hearing about not allowing the 1 cent charge and putting the administration on. I was wondering what sort of codes would indicate or give light to that billing of drug was vaccinated if you didn't have a drug charge on there and you only have the administration.

Through the history of time, in the 30 years I've been doing it, if you didn't allude to what the drug charge was, you wouldn't know what was administered, it could have been insulin for all we know. So I guess my first question is, is there agreement now that we could put the 1 cent charge in the non-allowed column? And if I'm incorrect on that, my second question would be what indication on the UB will let MACs know and those – the auditors know what the drug was that was administered. So if you can help me paint the picture, that would be great.

CMS - Mike Campbell: Yes, this is Mike. I can answer that and see if others want to chime in. Yes, on the 1 cent charge, and as I mentioned before, we will revisit that issue and provide some – and provide education materials to the MACs on that.

But as far as the admin code, it is product-specific so we would know the type of vaccine that was administered just by that admin code.

Kathy Bold: OK, OK, thank you. And thanks for doing this phone calls, it's really helpful. Thanks.

Operator: We have our next question coming from the line of Anna Dander. Your line is open.

Anna Dander: Yes, hi, thank you for taking my call. So just to get some clarification, are we treating the monoclonal products the same as vaccines in terms of billing and the 121 bill type? And part of that is a typical monoclonal product in CMS

documents in the past were identified to be billed with 335 revenue code as a chemo type of product. Would 335 be the right code or are we supposed to just follow 771?

CMS - Ryan Howe: Yes, it should be just like the influenza, which would be 0636 revenue for the drug and then 0771 for the administration.

Anna Dander: So that would apply both directly in the monoclonal bodies, and then both of them would qualify for the 121 bill type on top of DRG. How does that work with the add-on payment with – for the DRG? So CMS also issued the add-on payments for some of these products on top of DRG. So are we supposed to still bill separately for the vaccine in monoclonal body on the 121 bill type and get the DRG plus the add-on payment?

CMS - Mike Campbell: Again, this is Mike from the Provider Billing. I can't speak about the add-on, I don't know if others can or that's one that we would want to maybe take in writing through the mailbox.

CMS - Ryan Howe: Yes, I ...

CMS – Tiffany Swygert: This is Tiffany. Go ahead.

CMS - Ryan Howe: No, I was just going to ask maybe a clarifying question. Are you asking about a scenario where let's say under a circumstance where a hospital is treating a patient with a positive COVID diagnosis both through conventional treatment and then also infusion of monoclonal antibody, is that the scenario there?

Anna Dander: Yes, during the admission, you're doing both. So, typically, like you said, if it follows the virus like a flu vaccine methodology then the patient typically get a flu vaccine. You can bill 121 bill type on date of discharge.

But on this scenario, there was also an add-on payment that was created for some of these products if you're doing that during the admission and you code with appropriate PCS code. Does that mean – are we allowed to still bill the vaccine or the monoclonal antibody on the 121 bill type? And still qualify for

the add-on payment, or the add-on payment basically subsumes the 121 bill type? Does that clarify the questions?

CMS - Ryan Howe: I think so. I don't know, Tiffany, do you have a thought on that?

CMS – Tiffany Swygert: Yes, just a couple of thoughts. So, one, the monoclonal antibodies are expressly not authorized for patients who need to be hospitalized due to their COVID diagnosis, So, in general, we would not expect that the monoclonal antibody would be used under the hospital inpatient program.

But if there was some anomaly where the patients perhaps have been admitted for something else and were later determined to have a positive COVID diagnosis and met all of the requirements of the EUA to get a monoclonal antibody while they were in the hospital, that could be administered in the inpatient setting under that very, very limited circumstance.

The 20 percent add-on for the IPPS is still applicable, assuming that all other requirements are met and that is that they are hospitalized for inpatient or for having COVID in inpatient setting. The DRG will have that 20 percent add on. So it's not mutually exclusive, but we wouldn't anticipate seeing the monoclonal antibody billed for a hospital inpatient except for under very rare circumstances. Does that help?

Anna Dander: Yes. But the vaccines – OK, so I'll have to go back to look at the list of the add-on payment. Because the PCS codes cover the vaccine codes and they also cover this new technology there so mono – those various antibody products ...

CMS – Tiffany Swygert: Right, but any – yes, so the extent that the monoclonals are being treated as vaccine, just like other vaccines are paid separately under the inpatient system, these are as well including the administration. So you still – I'm saying that for the regular DRG amount, that still gets the 20 percent add-on. And the for the monoclonal administration, in the rare circumstance that it would be administered in that setting, would be paid just like any other vaccine and we get that separate payment on top of the DRG plus the 20 percent.

Anna Dander: OK, thanks. And then the – another quick question I have regarding the labs and rapid test reduction in payment. There's a requirement that the hospitals have to run reports on a monthly basis to indicate a certain percentage of testing done under this rapid methodology and results are – there's a turnaround in 48 hours.

If the hospital was able to do that on every single test where we track how long it should do the test and result in – for every single test, do we still need to run these monthly reports and have them available for any – what has been purposes to indicate the six to eight or whatever the number is of test were done in 48 hours? Do we still need to do that if we can substantiate on every single case on what the turnaround time was? Is that still the requirement?

CMS - Demetrios Kouzoukas: Can you – can you repeat the question for us because I think we've ...

Anna Dander: I'm sorry. So on the new regulations for the rapid test, the Medicare is reducing the payment for the high-speed test and you have to run reports every month or I guess based on a prior month activities that if you return the results in 48 hours certain percentage of clients, then you can bill the additional code for the extra $25 payment.

If the facilities can identify this on every single case like if they run report – they run tests and they could say for every test, yes, it is 48 hours or no, it's not, do we still need to run monthly reports to come up with that average?

CMS - Demetrios Kouzoukas: Yes.

(Anna Dander): It's still a requirement which they have to run to run them every month and just store them, or just have them be available in case of an audit?

CMS - Demetrios Kouzoukas: Well, the requirement to bill the extra code is not just with respect to the individual test but also the extent to which the tests were run within 48 hours on average in the previous month. So that's why there's a need to run the analysis.

We do have some FAQs that we're working on that might be out soon if they're not already that relates to what our suggestions about documentation. But I don't think we addressed the issues directly and even issued a ruling.

Anna Dander: OK, I think FAQ would be helpful and I think if you could also come up with these FAQs about the revenue growth and then the vaccines and the antibody treatments to be treated like vaccines, I think that would be also helpful because I think it's a little bit over gray area when you read the original rules.

And just to confirm, both of them are billed to fee-for-service for Medicare patients and just – because I thought it was just vaccines, but you said it was both. So both of them are treated like vaccines, so both the antibody and vaccine are supposed to billed to fee-for-service for Medicare or managed care patients?

CMS - Demetrios Kouzoukas: Correct.

(Anna Dander): I think it would be just helpful to have them in FAQs also.

CMS - Demetrios Kouzoukas: That we do have – so we have a whole page on the monoclonal antibody discussion. It’s got a graphic and it says explicitly that you're billed as vaccines.

Anna Dander: OK, thank you very much.

Operator: Again, in order to ask a question, simply press "star" then the number "1" on your telephone keypad. We have a follow-up question coming from the line of Sandy Sage with HomeTown Health. Your line is open.

Sandy Sage: Hey, yes, thank you. I'm sorry, as a follow-up on the monoclonal antibody discussion, thank you for clarifying on the EUA that it's not for inpatient. But the question is about patient that are in observation, would – do you think they would meet the EUA if they were not on oxygen but were positive COVID in observation versus inpatient? Could they bill those appropriately under the EUA for observation versus in?

CMS - Demetrios Kouzoukas: I think that's a question for the FDA and so I won't weigh into that one.

Sandy Sage: OK, OK. But it would be outpatient so I think they were talking about inpatient acute hospitalization, but we weren't sure. Thank you very much.

CMS - Demetrios Kouzoukas: I think we have ...

Sandy Sage: Do you know what I'm saying?

CMS - Demetrios Kouzoukas: Yes, that point is true that there are going to be cases where you might be billed as inpatient but it's not truly inpatient in a clinical sense.

Sandy Sage: Right.

CMS - Demetrios Kouzoukas: Because of the Medicare billing requirement, some outpatient care might be billed. Some small outpatient care, if you will, care that is provided in outpatient, what is considered in outpatient setting is billed under the IPPS or impacted into an IPPS. So that's the case and I think we did talk about that in the last call and we acknowledge that that could be happening, yes.

Sandy Sage: OK.

CMS - Demetrios Kouzoukas: So maybe you're asking about how the FDA applies their rules.

Sandy Sage: Right. No, no, but – all right, well, thank you. Merry Christmas.

CMS - Demetrios Kouzoukas: Thank you. Merry Christmas.

Operator: We have our next question coming from the line Lisa Caldwell with UC Health. Your line is open.

Lisa Caldwell: Thank you for taking my question today. I have a question about the cost sharing that patients would have in adverse reaction to the vaccine administration and need urgent/emergent care, will cost sharing a private

services could be an emergency room business, possible hospital observation services, inpatient admission?

CMS - Demetrios Kouzoukas: I don't know if any of our HAPG folks have thoughts about how we treat them in case of a normal vaccine benefit.

Lisa Caldwell: Again, we understand there's no cost sharing applied with the vaccine administration themselves, just wasn't sure what we should do with playing – should we have any – should the patient have adverse reaction to the vaccine administration.

CMS - Demetrios Kouzoukas: Then it's not a question around the modifier Q because it's sort of a – but if it's particularly – specifically into that bucket, you're just asking a generic question of whatever the circumstance if there's some kind of adverse reaction, is care for it covered? Somehow it's been exempt from cost sharing because it was associated with the vaccine.

Lisa Caldwell: Correct. I mean, typically, during our claims processing we add those (207.1) or the (28.28), (0.828). Those are more helpful during that claims process in identifying claims which cost sharing would not be applied or be assessed. But, I didn't know if cost sharing would not apply to the emergency services, how would we indicate them on the claim that it should be assessed?

CMS - Ryan Howe: So I'm not sure if anybody else in the call knows. But I think the same rules would apply as would apply if they were an adverse reaction to flu vaccine in terms of the subsequent treatment.

Lisa Caldwell: So would cost sharing apply in that scenario? I mean, that totally got a different (inaudible) because it's not COVID-related. The cost sharing would typically be assessed if the patient had an adverse reaction to the flu vaccine. So since this COVID vaccine, I wasn't sure how ...

CMS - Ryan Howe: I don't there's a particular provision. No, I don't think if there's any – we can certainly get back to answer that definitively. But I think it's not – I'll speak for myself, I don't think there's any apparent provision that would change the cost sharing for the treatment following that such a scenario.

Lisa Caldwell: OK. All right, thank you very much. Have a merry Christmas.

CMS - Ryan Howe: Thanks. You too.

Operator: We have our last question coming from the line of Anna with Hoag Hospital. Your line is open.

Anna: Thank you. Thank you for speaking about the monoclonal antibodies today. I just want to clarify one final question. I know we're going to treat it as a vaccine, but for the administration charge, the HCPCS M0239, that's the one that will go into revenue code 771 so it will not interfere with any other infusion hierarchy in those situations, correct?

CMS - Ryan Howe: So those codes are treated the same way as the vaccine administration codes – the other vaccine administration codes, and so they shouldn't interfere with the infusion any different. There shouldn't be a different interaction with the – any other infusion services that would apply for – or that's similar to vaccine administration, either COVID, or flu, or any other vaccine administration codes.

Anna: Thank you.

CMS - Stefanie Costello: Great. Thank you. We don't have any more questions. So with that, I want to thank everyone for joining us today for the Office Hours. Additional questions may be submitted by email at covid-19@cms.hhs.gov.

A recording and transcript of the call will be posted very shortly on the CMS podcast page which you can locate by going to CMS, clicking on the coronavirus image and scrolling to the bottom of the page. We hope you have happy holidays and be well. Thank you.

Operator: This concludes today's conference call. You may now disconnect.

END