Centers for Medicare & Medicaid Services
COVID-19 Office Hours Call with Hospitals and Health Systems
Moderator: Alina Czekai
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5:00 p.m. ET

OPERATOR: This is Conference #: 6793622.

Alina Czekai: Good afternoon, thank you for joining our call today, CMS Office Hours on COVID-19. This is Alina Czekai in the Office of the Administrator at the Centers for Medicare and Medicaid Services.

Today's call is the first in a series of opportunities for hospitals, health systems and providers to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and health care systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote telehealth and Medicare.

I'm joined today by a number of subject matter experts from CMS who are here to answer your questions. I'd like to note that this call is open to everyone, and today's call is being recorded. If you're a member of the press, you may listen, but please send your questions directly to the CMS Office of Media Affairs at press@cms.hhs.gov.

With that, we will open up the lines and take our first question. Operator, please open the lines.

Operator: As a reminder, to ask questions, you will need to press “star,” “1” on your telephone. To withdraw your question, press the “star” key. Please stand by while we compile the Q&A roster. Your first question is from online. Please speak your name and then ask your question. Your line is now open.

Leslie Narramore: Hello.

Alina Czekai: Hi, what is your question?

Leslie Narramore: Hi, my name is Leslie Narramore, and I am with the American Gastroenterological Association. Can you guys hear me?

Alina Czekai: We can, thank you.

Leslie Narramore: Excellent, sorry. So, I was wondering if I could get clarification on a letter to clinicians that the CMS Office of Communications sent out today. Is that an appropriate forum for this, or is this an appropriate forum for that, sorry?

Alina Czekai: Sure, happy to take your question.

Leslie Narramore: Excellent. So, the letter appears to present new rules for reporting audio only E and M, but the letter is kind of presented as an overview of what the agency has already done. So, that maybe that's what's kind of throwing me off a little bit.

So, I don't know if you have it available, but I was just wondering, is it correct to interpret CMS' language on Medicare telehealth visits on page three of that letter in the "Please note" paragraph to be new rules that allow providers to report E and M codes 99201 through 99215 for audio only telephone calls when two-way audio and video technology isn't available, but when the service can still be provided using audio only communications. Is that accurate.

CMS Staff: Brian, do you want to take that? Liz, do you want to take it?

CMS Staff: So, I can answer it. So, under the current rules, the codes that should be used for audio only evaluation and management would be the telephone evaluation and management codes, which are not the 99201 through 15 codes, but specific CPT codes for telephone or audio only evaluation and management.

Leslie Narramore: OK, that's what I thought, but I call your attention to the "Please note" that was stuck in there, because it says, "In a case where two-way audio and video technology requires to furnish a Medicare telehealth visit might not be available, there are circumstances where prolonged audio only communication between the practitioner and the patient could be clinically appropriate, yet not fully replace a face to face visit."

And that may cause some confusion and make some providers think that, you know, if they're unable to establish that two way audio visual communication with the patient, either because the patient declines it, or because they tried for 30 minutes and just couldn't get the platform working, that they might be able to use the 99201 through 99215 as telehealth.

So, I just, I mean, and certainly, that is something that the provider community, you know, has been, has been asking CMS to do. So, I guess, thank you for giving me this opportunity for that clarification.

Alina Czekai: Thank you, we'll take the next question please.

Operator: Your next question is from online. Please state your name and then ask your question. Your line is now open.

Female: Hello.

Alina Czekai: Hi there, we can hear you.

Female: OK. I'm calling from the California Hospice Association, and our question is regarding Medicare telehealth and the waiver that was approved for flexibility, which is that we can provide telehealth under the routine home care, or a face to face encounter with a nurse practitioner or an MD or a DO. And I want to confirm that it can be a voice to voice mechanism for telehealth.

We do not have, and most of our patients in families' homes do not have the capacity to do any video. They mostly use landlines. So, can you confirm for me that hospice providers can use voice to voice in the routine home care telehealth as well as the face to face encounter?

CMS Staff: Hey there, I can jump in. You can use a landline for routine home care visits in lieu of an in-person visit, but it's for the face to face requirement right now, we're requiring the two-way audio/visual communication, but I can definitely take your concerns down and see if there's any potential for revisiting that in the future.

Female: OK, so can you can confirm that we can use voice to voice?

CMS Staff: You can – you can use voice to voice for RHCs …

Female: OK.

CMS Staff: … but not for face to face encounter requirements (

Female: OK. Thank you so much for the clarification and we look forward to getting some flexibility around the face-to-face encounter. Thank you.

CMS Staff: No problem, thank you.

Alina Czekai: Thank you, we'll take our next question please.

Operator: Your next question. Please state your name and then ask your question. Your line is now open. Press the "star," "1." Your line is open.

Jonathan Gold: Hi, this is Jonathan Gold from MRPA. Can you hear me?

Alina Czekai: We can. Thanks for joining.

Jonathan Gold: Great, thank you. My question pertains to the hospital without walls, and as well as a few other hospital specific waivers you've issued. And for those instances where you just state it applies to hospitals, does that apply to a rehabilitation hospital or as CMS refers to them, an in-patient rehabilitation facility?

Jason Bennett: So, this is Jason Bennett. Let me try to address that. I think with regard to – are you specifically thinking about a freestanding IRF or are you talking about units, excluded part units within a hospital?

Jonathan Gold: Sure. For example, if they – if a freestanding IRF needed to treat a patient at an external location, or if a unit needed to treat a rehabilitation patient at a location outside of the – either the unit or outside of the hospital itself.

Jason Bennett: OK. So, I think what you're describing is a scenario where the IRF is actually expanding beds beyond what its normal footprint would be, and considering those to be patients for purposes of IRF payment. Is that right?

Jonathan Gold: That could be right, or if, say if there's an IRF unit and within an acute care hospital, so it's a distinct part unit, and the hospital – the acute care hospital has to begin using that rehab unit, could then the hospital start treating those distinct part unit's patients at a location outside of the four walls of their hospital with – using the hospital without walls waiver?

Jason Bennett: OK, I think I understand the scenario that you're talking about. I'll need to confer with our colleagues and get back to you in more detail. But what you definitely can do with an excluded distinct part unit is that you can move patients between the IPPS apportioned to the IRF and vice versa, and then pay – and then bill according to the type of patient that they are. So, if the IRF move the patient in an IRF excluded part unit moves into an IPPS bed, then it's appropriate to still bill that patient as an IRF patient under the blanket waiver.

But we'll get back to you as to whether or not that patient could be moved to, say, an IPPS bed that's been set up in a more remote location or new, sort of, facility that's been built to help address the larger surge capacity.

Jonathan Gold: Thank you, we really appreciate that clarification.

Alina Czekai: Next question please.

Operator: Your next question. Please state your name and then ask your question. Your line is now open.

Male: Hello, can you hear me?

Alina Czekai: We can, thank you.

Male: Thank you. My question is related to hospice visits in routine home care for services provided in the last seven days of life. I understand that for telehealth nursing visits, they can satisfy visit requirements, but shouldn't be reported on the claim. How are hospices, or are hospices, able to report in some way the SIA adjustment visits through telehealth. Is that something CMS can consider. As it stands right now, without being able to report telehealth visits

on the claim, I don't believe there's any way for a hospice to receive an SIA adjustment.

Hillary Loeffler: Sure, hi. This is Hillary Loeffler, we can definitely take that back for consideration. As you know, the SIA is paid for visits in the last seven days of life, and so the current thinking is telehealth would be part of a routine home care rate, it would not rise to the level of, you know, requiring us to pay an add-on payment for that, but that's something that we can, you know, take back and think about further.

Male: Wonderful. And then one follow-up question. There are some facilities that are just blanket-ly not allowing hospice providers to get in their walls and care for patients. I understand, you know, "hysteria". However, for those patients, can you – can you talk to and/or consider initial nursing assessments via telehealth and whether or not you would allow any expansion of the telephone only for face-to-face in those instances? I know someone just asked about telephone only, but you know, there's an issue with being able to even access patients.

Hillary Loeffler: Sure. And we can consider thinking about the face-to-face requirements further. Is there anybody from CCSQ on that wants to jump in about the initial assessment?

David Wright: This is David Wright. I believe that we've allowed this to be done, yes, telehealth as well. Was that the question?

Male: OK, just double checking. So, the initial assessment for hospice admission can be done through telehealth?

David Wright: Right. I don't believe that we have a requirement that it has to be face-to-face, and so we're including that within the telehealth rubric as well.

Male: Wonderful, thank you.

Danielle: Hi David, this is Danielle, I would just want to add onto that, that is correct that hospices may use telehealth to do this, to the extent that the use of telehealth is actually capable of providing a full assessment of a patient and

caregiver's needs, and that's really what it comes down to as far as compliance with the CoPs is concerned. Were you able to fully assess the patient's needs in a way that allows you to develop an accurate care plan and deliver services.

Male: Absolutely. Thank you so much.

Operator: Our next question. Please state your name and then ask your question. Your line is now open.

Sarah Warren: Hello.

Alina Czekai: Hi there, we can hear you.

Sarah Warren: Great. This is Sarah Warren with the American Speech-Language-Hearing Association. I just want to thank you guys for all of your hard work over the last several weeks, and I know that your job is not anywhere near complete, you've got a lot to do. And so, I just want to give kudos to you all for that, and I appreciate it.

And I appreciate what you guys have done so far for non-physician practitioners, like audiologists and speech language pathologists who, under statute, typically aren't allowed to provide or get covered for services provided via telehealth. In the interim final rule that was issued last Monday, so the 30th, you allowed for the billing in the certain speech-language pathology CPT codes. For example, 92507.

But you made it clear in the rule that those services weren't allowed to be billed by speech language pathologists, that they had to be billed by a physician. The fact sheet that accompanied that rule referred to speech language pathology services, and it's created a great deal of confusion in the provider community about whether speech language pathologists are allowed to bill for those codes via telehealth at this time.

And I know that you guys – after that rule was pretty much written and ready to go, you guys got some additional waiver authority that you're looking at in terms of expanding telehealth possibly to additional categories of providers, like audiologists and SLPs. But I was just hoping that you could just clarify

that yes, certain CPT codes that might be billed by SLPs are allowed to be billed via telehealth, but only by physicians based on the provisions of the interim final rules to help try and clarify that confusion.

Obviously, we're disappointed by that, but we recognized your statutory limitations at the time the rule was written. But I did feel it would be very beneficial to have that clarity.

Ryan: Sure, you're absolutely right to make that clear that your interpretation of the way the rules work now is accurate. And as you also noted very well, that there are new authorities under the CARES Act and we're really actively working on those. We certainly appreciate the reason for the confusion and we're anticipating being able to make clear some of that in the near future as we continue to take a look at what authorities we have.

Sarah Warren: Thank you. And I appreciate that you're working on the new stuff that you got through the CARES Act and we're really looking forward to that. And if there's anything we can do to be helpful, please do not hesitate to reach out to us. I know we've been talking a little bit, and I know there's limitations on what you can say, so I appreciate that. I just wanted to say thanks again for all of your hard work.

Ryan: Thank you very much.

Operator: Next question. Please state your name and state your question. Your line is now open.

Female: Hello.

Alina Czekai: Hi there, we can hear you.

Female: Hello.

Alina Czekai: Hi there, what is your question please?

Female: Can you hear me? Hi there, I represent a large hospitalist group, and we were looking for some clarification. When our hospitalists are in the same facility

as the patient and they provide a virtual service to the patient, specifically using, an iPad or other, what's traditionally considered telehealth equipment.

So, they'd be using their iPad and Skype or Apple FaceTime, and they're removed from the patient. So, not in front of the patient. Removed from the patient in another part of the hospital, and they provide an E and M service, an initial or subsequent or discharge service to that patient via virtual service, but in the same facility. Is that payable as a regular E and M service? Does that take the place of your typical in person face to face visit?

CMS Staff: Ryan, I think you answered that one before.

Ryan: Happy to answer it again. So, I think, under our current rules, the telehealth services only applies to when the patient and the practitioner are in different locations. So, in the circumstance when they're both in the institutional setting of a hospital, even if they're in different rooms or on different floors, for example, and the service is fully described by the codes that are reported, then telehealth rules wouldn't be applicable.

In other words, to the extent that the services that are reported and described by the codes can be done using communication technology or otherwise, the telehealth rules don't apply. And so, I think in the description, so far as I understand it, that you've given, the codes could be billed without the telehealth modifier.

Female: OK, and that's exactly what was my question. Can they be still billed even though we're using virtual, not in person face-to-face? They can still be billed, we just don't use that modifier 95, because it doesn't meet the criteria for telehealth. I just wanted to make sure we're OK to submit those regular E and M codes.

Ryan: Yes, right. And I would point out that where the code descriptor says "face to face" that sort of gets at where, say, for example, a video component would be really important in the delivery of the service.

Female: Absolutely.

Ryan: Yes.

Female: OK, thank you so much, that has just helped probably thousands of hospitalists who are out practicing in their hospitals to try to minimize exposure and PPEs, so thank you for clarifying that for us.

Ryan: We're looking at whether we could provide that in more formal way as well.

Female: That would be fantastic.

Alina Czekai: Thank you for your question. We'll take our next question please.

Operator: Your next question. Please state your name and then ask your question. Your line's now open.

Alina Czekai: Hi there, what is your question? Operator, can we take our next question please?

Operator: Yes, ma'am, one moment please.

Operator: I'm sorry about that. Your next caller, please state your name and then ask your question. Your line is now open.

Female: Hello.

Alina Czekai: Hi there, we can hear you.

Female: Hi, I'm calling to question about the telephone CPT codes 99441 through 99443. Since many of the elderly patients with Medicare don't have access to video, will Medicare be recognizing those CPT codes?

Ryan: So, under the new interim final rule they're payable CPT codes for telephone evaluation and management services that are payable under the physician fee schedule. Much like the standard E and M visits are. But they have specific CPT code numbers.

Female: And where can those be found?

Ryan: Those are on the same place. They are both in the CPT book, as well as anywhere where there's a listing of Medicare physician fee schedule codes. So, on the – on the websites for the Medicare minutiae of contractors, as well as on CMS' website. So the physician fee schedule files. I'm happy to …

Female: It's not the G2012 code, right?

Ryan: No, that's the virtual check-in code which is also separately payable. But the CPT codes are 99441 through 99443, and they describe telephone evaluation and management services.

Female: OK. So, in the new bulletin or new Act, you guys are going to be setting a reimbursement rate for those CPT codes, because currently there isn't one?

Ryan: Those codes should have a payable payment amount. And depending upon where you're looking, it may take some time before the payment files are updated. But they are payable services as of the date of the PHE.

Female: OK. If I could ask one more question in the same relation. If a provider is doing an audio visual service, and in the midst of the audio visual service, the patient has an issue with the video either freezing, or it being dropped, is the telehealth service still billable as the E and M with the 95 modifier?

Ryan: So, I think if enough of the service was furnished with audio and video, that the code continues to describe the service that was furnished, then generally that code would be appropriately reported. If the service that was ultimately reported is better described by the telephone evaluation and management, because that's where the bulk of the service was, then the telephone evaluation and management would generally be reported.

And I say that as a general note for coding policy, not specific. I think, in an individual case, you'd want to – there'd probably be a lot to take a look at. But I think, merely the presence of some sort of interruption wouldn't necessarily mean that telehealth, that the audio and video code wouldn't be appropriate. Likewise, any use of video alone when it wasn't, sort of, a central part of the service, probably wouldn't be appropriately reported either.

Female: OK. Can I ask one more question or am I timed out?

Alina Czekai: We'll allow one more question for the greater good. I know there's a lot of questions on telehealth. Thank you.

Female: Yes. So, I have a primary care physician asking if there is anything he can bill, as he was the admitting physician for a patient into the hospital who is now in the ICU, positive COVID, and the hospital restricts only one provider to see the patient a day, which in turn becomes the ICU provider, the interventionist.

However, the primary care physician, the admitting provider, is taking lead in coordinating care with the interventionist, and also monitoring the medical records of the patient daily and also speaking with the family. Is there any reportable billing for the PCP as the admitting physician?

Ryan: So, I think we'd need to know a lot more about the specifics before giving specific coding advice, but I would suggest that there are several non-face-to-face codes that might be applicable to that kind of situation, including there are CPT codes for inter-professional consultations that describe the time of both the primary care and the specialist physician in terms of interacting for care management purposes, and there's also several care management codes for monthly services provided to a patient, some of which could be reported potentially in that scenario, and those would be the – but again, I would think you'd need to look at the specific circumstances and the way the codes are described to know for sure.

Female: OK, perfect. Thank you very much for all your help and your answers, they were very informative and I appreciate it.

Ryan: Thank you much.

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

Operator: Please state your name and then ask your question. Your line is now open.

Female: Hello.

Alina Czekai: Hi there, we can hear you.

Female: You can hear me?

Alina Czekai: We can, yes. What is your question please?

Female: OK, thank you. Yes, my question has to do with accelerated payments. We have gotten a quote from our MAC of what our maximum is that we do not think is right. And I know this has happened to other hospitals, their maximum hasn't been what they expected. Is there any specific remedy for this or ways we can find out how the calculation was made?

Alina Czekai: Sherri, would you like to address this question?

Sherri McQueen: Sure. Hi, this is Sherri McQueen in the Office of Financial Management. Can you send your particular facility's information to the mailbox, and I'll make sure that I'll look into your particular concern directly.

Female: OK.

Sherri McQueen: But to answer your second question in terms of the calculation, so for Part A and Part B providers, other than those covered by the CARES Act, what the agency has done to streamline the advance and accelerated payment process is to take a look back at claims history for a provider or a supplier, when determining the payment, and looking at history that preceded the coronavirus public health emergency.

Female: Correct.

Sherri McQueen: So what we've done for the providers that are covered by the CARES Act that could receive six months' worth of payments, we're looking at claims history from July 1, 2019 to December 31, 2019, and all–

Female: And that's why we're confused. We're a PIP hospital, and when we look at our PS&R, and we look at our PIP payments, what they're telling us doesn't make sense.

Sherri McQueen: If you could send the information to the mailbox, and I will look into exactly what the concern is for your particular facility. OK?

Female: Thank you so much. Can you tell me what the mailbox address is, or where to find it?

Sherri McQueen: I'm sorry. I can give you that, sure.

Alina Czekai: It is covid-19@cms.hhs.gov, and I'll repeat this at the end of the call, as well, but in case we lose folks, it's covid-19@cms.hhs.gov. Thank you.

Female: Thank you so much.

Alina Czekai: We'll take our next question.

Operator: Your next question, please state your name and then ask your question. Your line is now open.

Alina Czekai: Hi, there, what is your question? Hello? Hi, there, we can hear you. What is your question, please?

Melinda Renshaw: Hello, my name is Melinda Renshaw, and I'm calling from Missouri Long-term Care, and I was wanting to know your documentation requirements, to utilize the 1135 waiver.

Evan Shulman: Hi, this is Evan Shulman from the Division of Nursing Homes. Could you be more specific? Utilize the 1135 waiver for what purpose?

Melinda Renshaw: Well, to waive the three midnight stay before a patient or resident can come in on skilled Medicare. What documentation are you going to require be in place to utilize that?

Evan Shulman: Can someone from the Center for Medicare answer that one?

Jason Bennett: Yes, this is Jason Bennett. This is a blanket waiver, so the waiver is available in all cases when a discharge may be under three days. What we recommend is that you always have documentation as to when you exercise these waivers. We're not specific about necessarily what that is, what degree of

documentation that is, and we provide you some flexibility there, but I do recommend that you note that.

And it could be because the patient is COVID positive. It could be because the patient may be suspected of being COVID positive. It may also be just because the hospital is concerned about its own operations, and needing to make sure that beds are available for patients who may be presenting as COVID positive, and are working to free up their bed capacity as quickly as possible.

Melinda Renshaw: OK, so just some documentation, maybe from the discharging hospital, or the accepting physician?

Jason Bennett: Anything like that would be satisfactory. That would be good.

Melinda Renshaw: OK, thank you.

Alina Czekai: Next question, please.

Operator: Next question, please state your name and then ask your question. Your line is now open.

Christy: Hello.

Alina Czekai: Hi, there, we can hear you. What is your question, please?

Christy: Hi, this is Christy. I'm calling regarding documentation requirements on the new guidelines that were put out on the 30th or 31st, regarding documenting telehealth, and actually documenting telehealth via the time guidelines that are given for the 2021 E/M, and advise if you require that something be put in the documentation as far as 15 minutes was face-to-face time, this was preparation time, and this was end time, or are you looking for anything that specific?

CMS Staff: I don’t think we can give particular answers about the level of specificity, but I think we would expect the same level of documentation that would ordinarily be required for coding those services based on time, so that can

happen now for counseling, and so it would be generally similar, I would think.

Christy: OK. Also, I've been looking for guidelines on BPCIA. Our practice participates in those. In the proposed federal rule, I was able to locate documentation on CJR, but did not see anything on the BPCIA program. Has there been anything published that will guide us as far as that goes, participation in the bundled plans?

CMS Staff: I don't know if we've got the right folks on the line to answer that one.

Beth: This is Beth, I can actually help you with that. CMMI is currently evaluating flexibilities for all of our models, including BPCI Advanced, and we will be providing information as soon as it is available.

Christy: OK, thank you.

Alina Czekai: Thank you for your question. We'll take our next question, please.

Operator: Next question, please state your name and then ask your question. Your line is now open.

Arlene: Hello.

Alina Czekai: Hi, there, we can hear you. What is your question?

Arlene: Hi, I have two questions. My name is Arlene. Thanks for taking my call. The first one is regarding the relaxation of the documentation requirements, and I wanted just to make sure, is it specific only to the office outpatient key codes established, the 99211 through the 215, and the new patient, 99201 through the 99205 codes, so I wanted to see if it was, you know, just specific to those, and would that apply to Medicaid, and the Medicaid products, and commercial payers, would they need to follow those, as well?

CMS Staff: I can answer. In terms of Medicare, that change is related to the change that is slated to go into effect for January 2021, and so that's for the office outpatient visit codes, so the 99201 through 215, as you mentioned, and it is specific to those codes. In terms of other payers, including Medicaid programs, I think

they would have to make their own determinations, and I don't think we're in a position to know whether or not they've made similar adjustments.

Arlene: OK. Can I just ask one more question, if you don't mind? I did see, also, that Annual Wellness Visits were on that list for eligible telehealth services, and I'm just wondering how our providers are supposed to obtain those required exam elements such as weight and blood pressure. Maybe the patient can self-report those, but maybe they can't, so I'm just wondering, you know, would this requirement be waived, or how CMS would be looking at this.

CMS Staff: I don't think the requirements for any particular service, including Annual Wellness Visits, have changed. Certainly, I don't know that the requirements couldn't be met by a patient capable of taking some of their own vitals, for example, but I think it's probably also worth pointing out that telehealth isn't limited to when the patient is at home. That certainly may be the most relevant, given the current context.

The rules are also designed in such a way to also allow for telehealth when it's from one healthcare setting to another, including a circumstance where the physician or other practitioner might be in the home setting, but the patient might be in a healthcare setting, so for some services, it's probably more likely that they would be more reportable or more likely to be able to be done when the patient is in a healthcare setting. But that is a question that we've gotten, and it's something that we're looking at, as well.

Arlene: OK, thank you so much.

Operator: Next question, please state your name and then ask your question. Your line is now open.

Cherie McNett: Hello.

Alina Czekai: Hi, there, we can hear you.

Cherie McNett: Hi, this is Cherie McNett with the American Academy of Ophthalmology. I have two questions related to the advance or accelerated payments, if I could.

Alina Czekai: Please.

Cherie McNett: OK, so the first question deals with the flexibilities around the time period for when the recoupment will begin. I know that in all of the information, it has said 210 days would be the amount of time before the recoupments would begin from the initial payment, but there was an article today in Politico that stated that hospitals were going to be allowed one year to repay. Is that same consideration being given for physicians?

Sherri McQueen: Hi, this is Sherri McQueen again. So, to clarify, 210 days is the maximum amount of time that's given to the provider to repay the advance or accelerated payment for certain hospitals, so what happens is, at 120 days, Medicare will not be making any type of recoupment between the day that the provider receives their payments, to day 120. At day 121, Medicare will begin recouping from any claims payments that are made, up through 90 days from that date, and if there is a balance that's remaining at that point, then the provider, or supplier, will be able to make a direct payment to cover that amount.

There were certain hospitals that were part of the CARES Act that have a different timeframe for repayment. Those hospitals will receive up to 365 days to repay their advance or accelerated payment, but the recoupment will begin, as with the others, at day 121, but the provider will have up until the 365th day to repay the full amount.

Cherie McNett: OK, great, thanks. I think the concern is, though, that if practices don't get up and running – this is for physician practices – until June or July, but they've already received an accelerated payment, that's going to be very difficult for them to repay in that 90-day time period.

And then, on the second question, on the remittance advice for when those payments are being recouped, can you tell us what the code is going to be, so that our doctors can recognize when those payments are coming out, for their accounting purposes.

Sherri McQueen: So, I don't know the specific code. I know that there will be a statement on there. It's my understanding that in the case of COVID-19, as the reason for

the recoupment that's occurring, but I can find out what specific code it will be, and I can share that.

Cherie McNett: Great, and how would I get that from you?

Sherri McQueen: So, if you can send your question to the mailbox, I will send a response to that.

Cherie McNett: Great, I'll do that. Thank you very much, appreciate it. And again, echoing what everybody has said, we really appreciate everything that CMS has done.

Operator: Next question, please state your name, and then ask your question. Your line is now open.

Kate Beller: Hi, can you hear me?

Alina Czekai: We can.

Kate Beller: Great. My name is Kate Beller. I'm with the American Medical Rehabilitation Providers Association. I also want to thank you for holding this call and taking my question. I wanted to touch on an issue tied to Patients Over Paperwork. In late March, I saw that CMS announced that it was waiving the requirement of IRF quality reporting program data, from January 1 through June 30 2020, along with quality reporting program requirements and other PAC settings and provider settings.

And CMS guidance indicated that this waiver included data that is normally submitted through the IRF Patient Assessment Instrument, or the IRF-PAI. I want to see if I can get more specific information as to which specific sections of the IRF-PAI would not be needed to be submitted under this waiver, given that the IRF-PAI is also used for payment, as well as the fact that providers would normally face a penalty for failing to submit a completed IRF-PAI. Any additional guidance would be much appreciated. Thank you.

Michelle: This is Michelle, and I can take that one on. We'll be addressing the IRF-PAI in upcoming rules, so we'll have more information on that shortly.

Kate Beller: OK, I appreciate that. Thank you, Michelle.

Alina Czekai: We'll take our next question, please.

Operator: Your next question, please state your name and then ask your question. Your line is now open.

Alina Czekai: Operator, can we take our next question, please. Thank you.

Operator: Your next question, please state your name and then ask your question. Your line is now open.

Jane Alteveda: Hi this is Jane Alteveda. I have a question regarding the physician supervision. Lately, I have read in one of the more recent publications, that, in recognition of the fact that physicians are not in the office, especially during infusion like chemotherapy, et cetera, that the direct supervision requirement would be met if the physician was available via telehealth.

What was not clear to me, even though there was a pretty good example there, but still didn't really answer the question is, does the physician – to meet the direct supervision requirement, so that he or she is immediately available should there be a need, do they need to be on a consistent open line via telehealth, or is it sufficient if the physician might be available – you know, in an instant, right, that they know that they're supervising infusion. Can you comment on which is acceptable?

CMS Staff: Yes, so, I think the use of virtual presence was intended to replace the need for the in-person presence, and so, to the extent that the in-person presence wasn't personal supervision, so it wasn't necessarily in the room during the entire course of the service, but rather, immediately available in person, the same thing would be true of the virtual presence.

Jane Alteveda: Wonderful. That's what I was hoping, because I understood the intent, but it's very good to hear that. Thank you so very much.

Operator: Next question, please state your name and then ask your question. Your line is now open.

Alina Czekai: We'll take our next question, please.

Operator: Next question, please state your name and then ask your question. Your line is now open.

Marie Alexander: Hi, can you hear me?

Alina Czekai: We can, thank you. What is your question?

Marie Alexander: Hi, this is Marie Alexander. I have question about the hospital without walls. I'm wondering if there were more details on what conditions of participation are specifically being waived, and more specifically, I'm wondering whether a patient's home would be an acceptable alternative.

CMS Staff: So, with regard to what CoPs are being waived in particular, we have a list of the blanket waivers on our website. If you go to the current emergencies website, or within that, a link to coronavirus emergencies. The list is in both places. We just made sure that, in any case, people were on one website or another. With regards to the question of whether a patient can be at home, I'm assuming you mean for an outpatient clinic visit. Is that the question?

Marie Alexander: No, I'm wondering, under the expanded hospital without walls initiative, whether we can use that waiver to treat a patient that otherwise would have been in the hospital, in their home, but bill it as a hospital DRG.

CMS Staff: Hospital at home. Some of the others may want to chime in here, but I think that's something we're still looking at in terms of inpatient. I think we've gotten – it was a request I just saw today from a hospital system about that, and we're taking a look at it. I don't know if David or Mary – do you have other things to add to that?

David Wright: Hey, this is David Wright. I think this is something that we've had some inquiries about. We're actively looking into it, and we expect to issue some initial guidance shortly.

Marie Alexander: Great, thanks very much.

Alina Czekai: Thank you. We'll take one final question, operator. Thank you.

Operator: Your last question, please state your name and then ask your question. Your line is now open.

Karen: Hello.

Alina Czekai: Hi, there, what is your question, please?

Karen: Hi, this is Karen, with Bill Dunbar & Associates.

Alina Czekai: Thanks for joining. What is your question?

Karen: I'm sorry, I wasn't sure if you could hear me. I've seen information about the CR modifier for, I think it's a disaster. I'm sorry, I had it pulled up here a second ago. For a catastrophe, disaster related service, and it's for items that fall under the blanket waiver. I know that telehealth services are exempt from the use of that CR modifier, but what about, for example, the telephone calls? Is that part of the blanket waiver, and so, is the CR modifier required on those?

CMS Staff: Those changes are not part of the blanket waiver, so for the telephone call codes, they would not require the use of that modifier.

Karen: That's what I needed to know. Thank you very much.

Alina Czekai: Thank you for your question. And that concludes today's call. I would like to take a moment and thank all of you for joining our call this afternoon, and more importantly, to thank you all for the work that you're doing in response to COVID-19. Before we conclude, I'd like to make sure that you all have the email address for the CMS COVID-19 box, and again, that is covid-19@cms.hhs.gov.

Thanks again for joining our office hour. You can look forward to more of these sessions as we continue to answer and address your questions. We will have another office hour this Thursday at 5:00 p.m. Eastern. Thanks again. Take care.

End