Centers for Medicare & Medicaid Services
COVID-19 Office Hours
Moderator: Alina Czekai
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5:00 p.m. ET

OPERATOR: This is Conference #: 1908409.

Alina Czekai: Good afternoon, thank you for joining our May 19th 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 provide an opportunity for providers on the frontline to ask questions at agency officials regarding CMS' temporary action 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.

And while members of the press are always welcome to attend these calls, we do ask that they please refrain from asking questions. All press and media questions can be submitted using our media inquiries form which can be found online at cms.gov/newsroom.

Any non-media COVID-19 related question for CMS can be directed to our COVID mailbox, which is covid-19@cms.hhs.gov. Jessie, let's please open up the lines for audience question, thank you.

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

Your first question comes from a participant's information was unable to be gathered. If you queued from area code 859, your line is open. Please state your name and ask your question.

Bob Labs: Thank you very much. I'm assuming that's myself. My name is Bob Labs. And I'm asking a – thank you for taking the question. I'm asking a question from a week and a half ago to see if there is any update with explaining how we can bill from my professional services, as a doctor of physical therapy on the UB-04 Form in the SNF setting. Can we just place the 59 Modifier with the recognition that the type of bill addresses the POS code?

Ryan: So, again, I appreciate the question. We're hard at work making sure that we're providing the appropriate guidance. I'm certainly optimistic that we'll have that information available readily by way of again explaining just to – just to be 100 percent clear because I understand how important this issue is.

Part of the delay has that the legal authorities are all in line and I know that that's – that that can certainly be frustrating, but we are hard work and we're optimistic that we're – we'll be able to provide guidance in the near future.

Bob Labs: Thank you very much. We're just – there's urgency. We have lots of patients that we are dealing with and we have to make decisions at some point whether we continue certain things or not, so really appreciate that. Thank you. I look forward to it.

Ryan: Thank you.

Operator: Your next question comes from Kline Good Pastew with City of Detroit. Your line is open.

Kline Good Pastew: Yes, thank you. The City of Detroit Healthcare Clinic has been providing and funding drive-thru COVID-19 testing in fair grounds here. The city sends those specimens to a lab in New Jersey who processes the test. The city is funding those tests on behalf of the residents.

The city has been precluded from billing those lab fees because of past rebilling restrictions. The city would like to be able to bill Medicare and other health insurance for the cost of that lab fee which is approximately $50. So, I just wanted to put that out there for a comment.

Demetrios Kouzoukas: Can I ask this is the provision of the drive-thru testing through a hospital or a laboratory that's enrolled in Medicare that you're referring to?

Kline Good Pastew: Well, this is the healthcare clinic. All the patients have a prescription for COVID-19 tests that the residents have been informed that there will be no charge to the patient for those tests. The city is providing – covering the cost of these tests. And then, those tests are being performed in a laboratory, actually, in New Jersey.

Demetrios Kouzoukas: Do you know if anyone in the process has a – has a Medicare enrolled provider or supplier?

Kline Good Pastew: Yes. The healthcare clinic has an NPI. This is being done under the guidance of the physician there under the healthcare clinic.

Demetrios Kouzoukas: OK. Well, we'll – I think that – well, the details will depend on par on the arrangement and who does what, at least. And I think that there are probably – there are likely some options for how to engage in something like that.

And for the Medicare population, I don't know clearly to sort of what's been done up to date whether that will – depending on sort of the details of how you set up the relationship and who does what whether the previous tests have already been administered.

But, if a physician – if a physician enrolled in the Medicare program is performing testing then we do have an IFSC number to some discussion that's probably quite helpful to you about how that physician could bill for that under our Level One E&M Visit. I don't know if you …

Kline Good Pastew: But, just to clarify, this is – this is not billing for just – the collection of specimen. We've research that. We understand how to bill for collecting the specimen. We're billing for the actual laboratory fee itself which was previously precluded under past rebilling restrictions. What I'm hoping that CMS will recognize the need to roll out mass testing in these large cities and will relax that requirement.

Ing Jye Cheng: This is Ing Jye Cheng. What I'm going to suggest is that I think there is probably lot of details here that could help us to better answer your question. So, I don't know if you're – if you're willing to send an e-mail to the e-mail

box that Alina specified then perhaps we can connect over e-mail and schedule a follow-up phone call to help answer your question.

Kline Good Pastew: (Inaudible) you to do that.

Alina Czekai: Thank you.

Kline Good Pastew: Yes.

Alina Czekai: Terrific. And I can give you that e-mail address again. It is covid-19@cms.hhs.gov and we'll be on the lookout for your e-mail and appreciate your question. We'll take our next question, please.

(Kline Good Pastew): OK. Thank you.

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

Operator: Your next question comes from Valerie Eed with Chep. Your line is open.

Valerie Eed: Hello. This is (Valerie). Thank you for taking my call. My first question is related to the COVID swab where we can bill the 99211 and it was indicated that we can use that for new or established, for that particular specific reason.

Our question then is if the patient returns at a later time to see a patient within this specialty for new patient visit would they bill as a new visit? Or since they've been already billed at one point the 99211 for the COVID swab, would they have to bill it as established?

Ryan: That is a good question. And I think, in general, Medicare would follow the CPT Rules regarding that scenario. We can certainly take that back though and consider what the – what the – what the Medicare policy would be.

Valerie Eed: That's great. Thank you. My other question has to do with the phone call visit. There was some question as to the total time. Providers are wanting to know if they can count some of the time prior to the call where they're reviewing and giving familiar prior to talking to the patient as part of their total time or can they only use time specifically on the phone with the patient?

Ryan: So, again, for Medicare purposes, we would defer to the CPT Rules regarding the billing for time for those. And I don't have those specific instructions in front of me, but I believe that their time directly spent with the patient.

Valerie Eed: Right. Yes, it does say in there medical discussion time, so that would make sense. On that note, the reason that came up is because there was a Q&A or FAQ that we found from another carrier, we're with Meridian that we saw one from NGS that was stating that the non-face-to-face prolong care code, the 99358, could be used in conjunction with the telephone call visit, Telehealth visit.

But, it would have to be related to the highest level phone visit code which is the 99443, for the total of 30 minutes and then it have to extend beyond that for an additional 31 minutes to tack on that 99358, which is the non-face-to-face prolonged service time.

So, with that, we're wondering is it expected then that the provider would be on the phone with the patient for 30 minutes and potentially having that expand beyond maybe to 40 minutes and then afterwards including the time of any follow-up review of labs and such that would be indicated with the 99358.

Ryan: The scenarios that you describe strike me as consistent with the policy. I think one thing to recall is that the – that the coding that we're using, sort of pre-existing coding, in the context of the public health emergency.

And so, I think we can certainly take that back and consider whether or not changes will be warranted. But, to some extent, I just want to reiterate that the – that the coding rules are permanent and they last beyond the public health emergency.

And so, we certainly appreciate hearing the concerns, but also we're glad to hear that the – that the information that you're receiving is consistent with the general coding guidance and we'll take that back. Thanks.

Alina Czekai: Thanks for your question.

Valerie Eed: All right, thank you.

Alina Czekai: And I will please ask our call attendees to keep your questions to one question or one question and a follow-up since we have many people on the phone today. Jessie, we'll take our next question, please.

Operator: Thank you. Your next question comes from a participant's information unable to be gathered. If you do from area code 548, your line is open. Please state your name and ask your question.

Jim Collins: Thank you. This is Jim Collins. And I'm asking a question about remote physiologic monitoring treatment management which has been mentioned several times recently. So, there is – the one code 99454, 62 bucks a month to rent a blood pressure cuff or weight scale basically, 99457 which is 20 minutes, 99458 which is another 20 minutes.

So, those are the codes that we use now for remote physiologic treatment management. There is another set of codes, G-2066 and 93297, and those are the codes we use now to monitor patients with heart failure devices or implanted cardiac devices.

As it stands right now, those codes just pay for gathering the data, analyzing it, and creating a report. If the patient's heart failure status is getting worse, we would bring them into the office and then bill a separate E&M visit.

The 99454 which is the first, I'm sorry, the 99457 which is the first 20-minute chunk of time, is a very good replacement for that in-person office visit, but there is kind of some contradiction about whether or not we can use the 99457, 99458 codes with data that we capture from internal devices.

There was an e-mail from a CMS policy right back on February 6 of 2019 saying that ECG data was derived data could count. On June 19th, the CPT assistant came out and said that we can use implanted devices specifically naming the pulmonary artery pressure sensor.

On November 20th, there was a CPT RBS Symposium in Chicago and one of the AMA presenters said no, you cannot use implanted devices. This is just to

be used for future technologies like watches, is pretty much what he said at the symposium.

So, there are multiple references from CPT and the AMA saying that we can use data captured from implanted devices. And that data is robust, so include impedance which is the measure of how much fluid is in the lungs.

There is – there are devices that monitor the respiratory rate and volume, heart sounds S1-S2 activity level, nighttime activity – nighttime heart rate activity level. So, there is – there is a whole bunch of data that these devices capture and it's more consistent because it's coming from implanted device.

It doesn't require the patient to stand on a scale or put a blood pressure cuff on. So, the question is can we use 99457 and 8 for monitoring – for treatment management services that are based on physiologic data captured from pacemakers, defibrillator, and loop recorders?

Ryan: I certainly appreciate the question. I think overall I want to reiterate that we wouldn't – we're not really in a position to give you specific coding guidance without having the specific circumstances.

I think as a general principle, the – and you can see it in the FAQs on our web site as well as what we've written preamble text related to the rule of physiologic monitoring codes both in the interim rule associated with public health emergency and the physician fee schedule rules over several years that the policy goals associated with remote physiologic monitoring would allow for some flexibility.

I think where CPT has issued formal guidance I think we will generally expect that guidance to be followed as well for Medicare, difficult to talk through or to respond to things that people have said. But, I think those are the sources that I would – I would look at to help you determine if those were the appropriate codes to bill.

Jim Collins: Everything that they published says that you can, but then somebody at the symposium said you can't. That's just – Medicare has been silent on it. There

hasn't been really any guidance issue. That's been – these codes have been out for like two years and these are things that save Medicare a ton of money.

They keep patients out of hospital. They keep patients from having exacerbations. Emergency department like all of these things stopped when you're monitoring these implanted devices, captured data element. And it's not just trying to get an answer on this call. This has been like over a year trying to get this answer – to get an answer to this question.

Ryan: I think …

Jim Collins: I understand if you can't respond right now, but it's just – it's something I hope we can – we can look at …

Ryan: Sure.

Jim Collins: … and put decision on because it's huge, lifesaving, and cost-saving technology that just sitting there. You're paying 62 bucks to rent a scale. You've got a 30 some thousand dollar device in a patient's chest that can do a 10 times better job, but you're not letting them use it.

Demetrios Kouzoukas: So, this is sort of the conundrum sometimes with answering questions is that we answer them then something in the external environment like coding guidance changes …

Jim Collins: Right.

Demetrios Kouzoukas: … and then we end up needing to sort of constantly revisit but that's something we're painfully familiar with and appreciate you bring in to our attention and definitely we'll …

Jim Collins: OK, got it. Thank you very much.

Demetrios Kouzoukas: Thank you.

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

Operator: Your next question comes from Arlene Wibel Cosar with Heritage Valley. Your line is open.

Arlene Wibel Cosar: Hi, thank you. So, I'm wondering if you're going to consider transitional care management services to be performed audio-only, because right now they're on the Telehealth list as just video-only. And I ask this because I have physician to see patients in a hospital setting and in an office setting.

So, when they follow-up with these patients within seven days, and the patient doesn't have access to video, they have to do a telephone visit. So, coding guidelines state that if the telephone visit is related to an E&M that's provided in the last seven days then that telephone visit is bundled.

So, I am – I am at a loss of how they could report these follow-up office visit phone calls if we can't do a transitional care management over just the telephone only because we are struggling with patient who do not have video access, so I'd appreciate – and you can consider that or if you have been considering that.

Ryan: I certainly appreciate the question and the concern makes sense. We can – we can certainly take that back. One thing that I would suggest, although I am asking that you've already considered, is looking at other care management codes that don't have the visit bundled in to see whether or not those might be appropriate under those circumstances for some particular patients.

Because not all the care management codes have the visits bundled in, so there maybe – there maybe circumstances for some patients where, for example, on audio telephone evaluation management code would be separately reportable alongside a non-face-to-face care management code. But, that said, I certainly understand your question and we can take that back and continue to consider it.

Arlene Wibel Cosar: OK, thank you.

Operator: Your next question comes from Nancy Allory with Northwell Health. Your line is open.

Nancy Allory: Hi, thanks for taking the call. The question is related to hospital outpatient billing and whether or not HCPCS C-98093 Hospital Outpatient Clinic Visit Specimen Collection for SARS-CoV-2 can be used in the emergency room

when the specimen is obtained from an emergency room patient. And the reason I ask is because the description of the code states hospital outpatient clinic visit, so I just want to make sure that that code is also appropriate in the emergency room.

Female: Yes, it's fine to use in the hospital outpatient setting. It's considered to be a visit, but keep in mind, if it's in the emergency room it's likely that there are other services being …

Nancy Allory: Right.

Female: … furnished at the same time, so the code – the C-9803 is conditionally packaged and will be packed into the primary service.

(Nancy Allory): Understood. Thank you. I just wanted to clarify that word clinic included in the description raise some question, so just – thank you for clarifying.

Female: Sure.

Nancy Allory: Thank you.

Operator: Your next question comes from Jennifer Tudor with Project Health. Your line is open.

Jennifer Tudor: Yes. Can you hear me?

Alina Czekai: We can.

Female: Hello.

Alina Czekai: What is your question? Hi, there.

Jennifer Tudor: Thank you. I'm sorry. Thank you for taking this call. We operate a rehab agency that delivers PT/OT and speech therapy services. Bills Part A gets paid Part B and I apologize if this was part of the very first question, but I had a very hard time understanding what the gentleman was saying.

If we deliver Telehealth to patients as allowed for some rehab services is this currently billable via Telehealth since we do bill on a UB-04, but we do get paid Part B rate? And additionally, a second question is do we have to report the patient's home address? Is a rehab agency considered provider-based even though it's not really located at the hospital because it's enrolled with Part A?

Ryan: Thank you for the question. So, this is related to the first question (inaudible) …

(Jennifer Tudor): OK.

(Ryan): … and the – again, just to reiterate, we hope to have guidance in the near future regarding how those services could be reported via Telehealth.

Tiffany Swygert: And (inaudible) ...

Jennifer Tudor: Is that can – is a rehab agency considered provider-based?

Tiffany Swygert: Before we get to that question, under the Hospital Without Walls Guidance if the therapist is employed by the hospital and the hospital is considering the patient's home to be provider-based, the hospital could furnish that as a remote service and bill on the institutional claim form.

So, while there's not the broader – we're still working on broader guidance outside of that context. But, if the therapist is employed by the hospital, the hospital is permitted to bill for those services as they normally would, using the appropriate modifiers and condition code. And then, I'll turn it over to Dave Rife to answer the question about provider-based department that are offsite.

Jennifer Tudor: Thank you.

Dave Rife: Sure. As for the – as for the patient's address as part of extraordinary circumstance – temporary extraordinary circumstance relocation request that is only needed if the – if the provider is planning to bill for services under the OPPS, so if the services are not OPPS services, then that's not needed.

Jennifer Tudor: Thank you very much.

Operator: Your next question comes from Rich Fitzgerald with Baylor Scott and White. Your line is open.

Rich Fitzgerald: Hi. Thank you – thank you for taking my question. Can you – can you speak to if that would be appropriate to capture the originating site fee, the Q-3014, for qualified non-physician providers that are billing on the 1500 that are practicing and then HOPD.

So, if you had a qualified non-physician provider and an HOPD, obviously, their charges would be billing on the 1500, but could that hospital outpatient department capture the Q-3014 for those services that are being provided either via video or audio-only visits?

Tiffany Swygert: I can start and maybe Ryan can add in. The Q-3104 only applies when the patient – when the hospital is serving as an originating site for a Telehealth service furnished by a professional.

And so, it was a little bit difficult to follow along with this scenario you were just describing, but that is the general policy. Ryan, I don't know if you wanted to add anything to that.

Ryan: I think – well, that's absolutely right, and just to be clear, so that would be for professionals, not only physicians, but nurse practitioners and say clinical psychologists, any professional who's billing for their professional services billing Medicare separately on the – on the professional claim as you mentioned that are furnish via Telehealth in those circumstances then the hospital they're serving is the originating site could bill the Q-code, the described, the originating site facility fee.

Rich Fitzgerald: OK, OK. So that makes sense then. So, if we had a clinical psychologist that was working in an HOPD, they are billing for their services on the 1500. The facility could capture that Q-3014 for services performed either via video or audio-only?

Ryan: Right, assuming that the audio-only and the video rules are met in terms of the Medicare Telehealth Services.

Rich Fitzgerald: Perfect. Thank you so much.

Ryan: Sure.

Operator: Your next question comes from Kim Debra Monico with John Hopkins Health. Your line is open.

Kim Debra Monico: Hi. Thanks for taking my call. The modifiers for the hospital provider-based department, the PO and the PN indicate whether it's accepted or not accepted and they drive the payment for either OPPS or the physician fee schedule, should hospitals under the Maryland waiver append those PO or PN even though we aren't reimbursed under either those methods?

Tiffany Swygert: Dave, did you want to take that one?

Dave Rife: Yes. So, it wouldn't be necessary to add the PO or PN modifier if for any system that isn't paid under the OPPS, so the Maryland Waiver would fit into that category.

Kim Debra Monico: Great. Thank you so much.

Operator: Your next question comes Bruce Kingfield with Valley Wise Health. Your line is open.

Bruce Kingfield: Hello. I just wanted to confirm with my assumption that where it says that the price – the cash price for the virus testing has to be published, is that satisfied by having our CVM published on our websites?

Demetrios Kouzoukas: This is the website posting for the cash pricing talking about – asking whether or not it should be – whether or not you need that by posting it on the website?

Bruce Kingfield: Right. We already posted our CVM which includes the Coronavirus test and the cash, the base price I guess you could call it. I just want to make sure I saw it mentioned in the CARES Act that it's not expecting us to do something separate from that.

Demetrios Kouzoukas: The statute refers to make the cash price public with the provider. So, the – that's – that sounds like what you're saying would be sufficient. We could – you could also look to the rules we have regarding public posting and charge master prices before the hospital transparency rule that we finalize last year, but the year before, if you wanted just sort of a guide a thumbnail for how we previously interpreted a similar requirement for public posting. We've got …

Bruce Kingfield: OK.

Demetrios Kouzoukas: … the regulatory requirement kind of like that, if that – if you wanted sort of some more flesh and bone, if you will on an approach to take. But, the statute refers to a posting on a public internet website.

Bruce Kingfield: OK, good. I just wanted to make sure it was one and the same because I got the daily digest email that kind of gave a reminder and made me wonder if there like a different expectation to that. I thank you for thinking the same thing. We're good.

Demetrios Kouzoukas: Yes, thank you.

Bruce Kingfield: OK, thank you.

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

Operator: Your next question comes from Christy May with Tennessee Orthopedics. Your line is open.

Christy May: Hi. I just wanted to follow-up regarding the BPCIA Program. I'm still seeing some information out there on ACOs and some of the comprehensive joint, but still I'm not seeing any decisions on how to – how the BPCIA is going to be handled.

Kris: Hi. This is Kris. I can take that question. We understand that there is a lot of interest in seeing something forthcoming and the innovation center has been looking at trying to save the ACO Program, the actual program itself, to

rollout all of the information on the models together. So, I would just keep an eye out. We're hoping to have something out sooner rather than later.

Christy May: OK. Thank you so much.

Operator: Your next question comes from Gareth Clause with CO School of Medicine. Your line is open.

Gareth Clause: Hi. Can you guys hear me?

Alina Czekai: Hi. Yes, we can.

Gareth Clause: Hi. Thank you for taking my call. Thank you for everything you guys are doing. I'm hoping you can help me regarding CPT Codes 99441 and 99443, the telephone evaluation and management services.

Do the COVID-19 pandemic CMS stated that for evaluation and management services providers are allowed to bill based of either MDM or time. I have a provider asking for formal written confirmation or just verbal on CMS definitely stating that these codes are time-based and are not included in that rule that can allow them for evaluation and management codes being based on medical decision-making.

Ryan: That's right. The policy changed as articulated in the interim rule that was released at the end of March allows the medical decision-making are time to be used for the office outpatient visit codes, the 99201 through 99215.

Gareth Clause: But, it won't qualify for 99441 or through 99443 …

Ryan: Right, 99441 and – through 3, are generally reported according to their code descriptors based on time of the med book discussion.

Gareth Clause: OK. That's all I needed. Thank you very much. I appreciate your time.

Ryan: Sure.

Operator: Your next question comes from Beth Gillis with Baptist Health. Your line is open.

Beth Gillis: Good afternoon. I need some clarification on billing for patients who are in a hospital, acute care hospital based swing bed, who received dialysis treatments. The acute care hospital has a dialysis department; however, the dialysis department is not an ESRD designated provider.

The hospitals are also going to set up acute care swing beds. Would the hospital be able to provide dialysis as services to the swing bed patients and bills with them?

Dave Rife: Thank you for the question. I do not know that answer off-hand, but we can take a look and see if we can get you some information about that.

Beth Gillis: OK. Thank you very much.

Operator: Your next question comes Kelly Wolfe with St. Claire Nephrology. Your line is open.

Kelly Wolfe: Hi. My question is I have been hearing rumors that there might be the possibility of CMS paying for offices that are providing masks to their patients when they come in the office. Is there any word of that or any discussion of that possibly happening?

Demetrios Kouzoukas: You mean masks for use during the medical appointment?

Kelly Wolfe: Yes. They give a patient comes in to the office without a mask and we provided one for them that there is possible reimbursement for Medicare for that. Is that …

Demetrios Kouzoukas: In the physician office?

Kelly Wolfe: … true or it's just a rumor? Yes.

Demetrios Kouzoukas: So, I mean Ryan can sort of fill this a little bit more, but the approach of PFS is that it includes all the practice expense and other things that would go into a visit. I think what you're asking for is separate payment. No, we don't have a separate payment.

Kelly Wolfe: OK.

Demetrios Kouzoukas: But, I think we would take the approach that is included in the price that we pay.

Kelly Wolfe: OK. That's what I was thinking myself, but I figure I ask the question since the rumors are going around here. Thank you.

Operator: Your next question comes from Ina Bender with Mt. Sinai Hospital. Your line is open.

Ina Bender: Hi. Thank you for taking my call. I had a question about antibody testing to identify potential donors for Convalescent Program. We seem to be functioning under a Mayo Clinic Bar Clinical Trial to clog the patient's blood.

And then, if they are positive and they are willing to donate, they go to a New York's Blood Center to donate the blood and then we transfuse the blood to the patients during their admission. There seem to be some lack of clarity whether how can we get reimbursed for the cost of the processing the blood that these patients donate.

Under the agreement, we're not allowed to charge patients for the actual blood product, but we are paying for that blood product for processing fee to the New York Blood Bank quite a large sum of money.

And we were told there are some methods of submitting or requesting reimbursements from, I guess CMS, but I have not been able to find any guidance what and how can we get reimbursed for that product.

Or is that something that the hospital has to submit as part of their FEMA or any other one of those programs where the government is providing assistance? That's kind of question number one. And then, I have related question.

Demetrios Kouzoukas: Is the activity that you're talking about part of participation in the clinical trial or is it something else?

Ina Bender: A convalescent – there is a convalescent transfusion of blood – expanded use convalescent blood project on the BARDA. And then, it's managed by Mayo Clinic and a lot of hospitals throughout the country are participating. They basically having patients come in they do an antibody testing.

And I guess if you have sufficient amount of antibodies, then the patient will donate their blood which is then used – that should be transfused into COVID patients in their – during the hospitals administration. So, there are two parts. One, it seems everybody think that we shouldn't be charging anything for doing the testing itself. And as you know, we just expand resources and testing kits and all that should do that.

And two, we do pay for the actual processing of the blood that was donated. But, under these various arrangements or contracts, there's no provision, no budget for getting any kind of reimbursement for the actual blood product.

And it's still good and clear whether we are allowed to bill for the actual antibody at least to third party payers pairs, those patients kind of – they're finding donors who our eligible to donate the blood. Are we allowed to bill for antibody testing at all? And what is the mechanism to get reimbursement for the blood products we're actually paying for?

Demetrios Kouzoukas: OK. So, what you might be looking for is Medicare's Clinical Trial Policy. I think that might be the – what you reach beyond on the – forward to see how it applies to your particular situation. I'll say that as a general matter what we – what pays under that policy is the routine cost of medical care even if they are under context of a clinical trial or other research endeavor.

But, not usually the incremental treatment itself and/or costs that wouldn't be part of routine, what would be defined in that policy is routine cause. So, you might find that to be a helpful resource. I suggest you go there.

And then, of course, there is always the possibility or option of working with those who are working on the – engaged in the clinical trial and the like. I understand that the former agreement may not provide for that, but there is

always that possibility too. But, I think what you are looking for is that clinical trial policy. Hopefully, that's helpful.

Ina Bender: So, do you think the antibody could be considered routine, because it's not really routine care. You're just doing testing to find patients who could donate the blood. I'm familiar with clinical trial policies, it's just the question whether this particular test falls under this routine category and we can at least bill through third party payers because patients are basically donating their blood they don't even care, but their blood is useful – that can be used to save other patient's lives.

Demetrios Kouzoukas: I think that the – this particular circumstances as it plays out for any particular patient or situation might vary, but it doesn't sound from what you're describing that it would necessarily be routine cost as a general matter or routine care. But, I don't want to be definitive about that because that could be – even a case-by-case determination.

So, I think that if you're comfortable with the clinical trials policy that's really the guiding principle. And if you don't think that it applies there and you're asking if there are some other vehicle or collection or payment for something like this, then don't – we don't – I don't have anything that really comes to mind as being available for what you're seeking.

Ina Bender: Is there another agency that can provide guidance in terms of what we should be doing? Because with testing, literally, thousands of patients I'm collecting antibody tests from them to find donors, so is there some policy or something you can consider or issuing some clarifications.

Because we're not the only the hospital in the country doing this work, so I think it would be helpful if we have some kind of guidance of what to do with these tests where we just literally looking for patients who may have something that we can use for other patients.

Demetrios Kouzoukas: If it's a BARDA sponsored research project and really we should – the best place to go would be BARDA – yes.

Ina Bender: OK. Thank you.

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

Operator: Your next question comes from Joana Bennett with Baylor Scott and White. Your line is open.

Joana Bennett: Hi. Thank you for taking my question. It relates to podiatrist and phone visits. So, which set of phone E&M codes with doctors of podiatric medicine be using, 99441 through 99443 or should they be using 98966 through 98968 the code set for qualified non-physician healthcare professional?

Ryan: So, I think again, getting into coding details, it's a little bit probably beyond the scope of what we're trying to answer. But in general, for podiatrist who would ordinarily report evaluation management services, they would then report their telephone evaluation management codes that are – that are described as being reported by professionals who report evaluation management services.

Joana Bennett: So, we are thinking the same thing. And we thought 99441 through 99443 however NOVA Tech is telling us that they should be using that code for the non-qualified healthcare professional. So, we don't know really what to do about it. And we know that the reimbursement is much different for – between their two codes (test).

Ryan: Sure. Understood. We can follow-up. If you can send that information to us, I'm not sure.

Joana Bennett: OK.

Alina Czekai: And I can provide that e-mail (inaudible) …

(Bryan): Alina, what's the – that would be great. Thanks.

Alina Czekai: Absolutely. Thanks, (Bryan). I can provide that e-mail Joana. It is covid-19@cms.hhs.gov. Thank you for your question. And we'll take our next question, please.

Joana Bennett: Thank you.

Operator: Your next question comes from Destiny Turner with Cornerstone Medical. Your line is open.

Destiny Turner: Hi, good evening. Thank you for taking my question and we definitely appreciate the ability to do these calls. It's very helpful. My question is actually related to HCC reporting and Telehealth.

Prior to audio-only visits being approved as a Telehealth service, it was determined that the HCC value codes were reportable for credit under the Telehealth visits but not under the audio-only visits.

Since then, CMS has approved the telephone codes as a Telehealth service and have approved the AWV visits to be performed as audio-only. Is there any change being discussed to allow those phone audio-only visits to allow credit for the HCC reporting?

Demetrios Kouzoukas: No, is the short answer. The changes that you're describing are in the fee for service program and reflect the purpose of fee-for-service to pay for services provided, and in MA, there's flexibility to provide the Telehealth or telephone visits and pay for those services.

I know you're asking about something really different which is the extent to which diagnosis collected from certain visits can be used for purposes of risk adjustment but against – and the – I think what we have said so far are – in a few forum have been – has been that at this point in the year, we don't plan to make changes in our methodology for – significant changes in our methodology for risk adjustment when asked this question.

So, I hope that's clarifying at least.

Destiny Turner: Yes, definitely clarifying, appreciate the answer. I just wanted to make sure that there wasn't something more into the works because, obviously, as a very heavy risk-based practice, something important for us to capture those. So, if we're doing audio-only visits, but we're not getting that risk adjustment, we're really not helping anybody.

So, we just need to make sure that we understand that there isn't anything more in the work, so that we don't improve those processes, so we can make sure that that's captured. So, definitely, appreciate it.

Demetrios Kouzoukas: I'll note that we did put our guidance that explains that beneficiaries can be – plans can provide beneficiaries with laptop pads – I'm sorry, with iPads or tablets or phones that are locked down to enable Telehealth visits so the kind of – for which diagnoses are accepted and also that we've been provided a number of flexibilities about how in different ways that plans can engage with beneficiaries in terms of different kinds of sending some into the home or other things like that even if it's not a problem.

But that's – so, there are some other options in terms of creating ways to provide care and those mainly the diagnosis or not, so.

Destiny Turner: Definitely. Thank you very much.

Operator: Your next question comes from Danda Williams with Bronson. Your line is open.

Danda Williams: Hello. Thank you. I was calling about the telephone services when a patient has an E&M visit with the same provider and/or a telephone service within the seven-day but the condition for the initiation of that telephone call or E&M visit is for a separately identifiable medical condition not related that we are seeing denials for those services.

How would you suggest that when it is a separate condition not related within another E&M or telephone call within that seven-day period? How do we process those claims to show the separation?

Ryan: I think that is probably a good question for your local Medicare administrative contractor. Again, these codes are – or change for Medicare purposes on an emergency basis, and so while we generally are following the CPT rules that would apply, the specifics related to how you would note that in your claims processing with the better answered by the – by the MACs at the local level.

And you are certainly – we would appreciate it for sure if there's broader concerns that we need to address then we can certainly do so, but that would be the place to start.

Danda Williams: OK. So, since CMS has only approved this during the PAG that this will not necessarily be something that would be normally listed in the Claims Processing Manual. So, our MAC would have clarification guidelines on that for these PAG only services?

Ryan: Right. I would – I would look to the MAC because the way that you would note similar circumstances for other codes might be different, and so the MACs might individually have different approaches to addressing those kinds of scenarios during the public health emergency.

Danda Williams: OK. Thank you for the information.

Ryan: Sure.

Operator: The next question comes from David Glacier with Patrickson and Ira. Your line is open.

David Glacier: Howdy. So, I want to ask about the instruction related to the temporary relocation of Hospital Outpatient Department. So, you guys have been extremely creative in taking steps to adapt the rules to work well in a stressful time and thanks for that. But I want to push on the idea of submitting addresses for this temporary relocation.

Past Office Hours, you've stated that the hospital needs to provide every patient's home address for every encounter that happens. And obviously, that's going to require a great deal of work for hospitals. It is hard for me to understand why the regional office would want all of those addresses and what they would do with it.

And a smart client pointed out to me that in the paperwork section of the IFC, you indicated that it would take about 15 minutes to meet this portion of the requirement and, obviously, submitting every single address for every home encounter is going to take more than 15 minutes.

So, I recognized this only applies for hospitals that want to get paid for an outpatient hospital service, but I guess this is more a comment than a question but what – why – what's the use of every single home address? Why is not a notice to the RO that says, "Hey, we're doing this" sufficient?

Dave Rife: Hey, so I'm not sure I can say much more than that the hospitals do have 120 days to – from the date of services provide – services have been – that provided their location to provide that temporary extraordinary circumstances relocation request to the regional office. So, one possibility to reduce the burden is to submit that after a period of time with the addresses in which services have been provided.

And if that would help to reduce the burden for the provider in providing the addresses at which the relocated department is providing services.

Demetrios Kouzoukas: I will add just a little bit more from the policy perspective which is kind of what you're getting at and just suggest that while – I understand what you're saying from sort of common-sense standpoint. We've had this during the rules a little bit – we had this sort of work within the confine of the statute, and you can see how much we're doing to try to work with the – with the statute in terms of what we have available to us.

And so while these things may seem like a formality in some respects, they are important to ensuring that we stay within the confines of what our legal authority is.

David Glacier: I'm not sure I totally (trap) with that thing. I do appreciate what you guys have done. I'm not sure the statutory site that's the hang up here. But thank you guys so much for doing it.

Operator: Next question comes from Keith Erqua from CCI. Your line is open.

Keith Erqua: Yes, hi. Just a question on the urban swing bed waiver, are there – are rehabilitative requirements the same as for rural swing beds in terms of the patient having a rehabilitative need?

Dave Rife: Yes, that's correct. There still needs to be a skilled need that would qualify the patient for the benefit under the skilled nursing facility's benefit.

Keith Erqua: Thank you very much.

Operator: Your next question comes from Moshe Arnold with Premier. Your line is open.

Moshe Arnold: Hi. I have – so with regards to the future reporting on Nursing Home Compare, are there any guidance yet on how that's going to look? Meaning will it be broken out between residents that the facility admitted that were positive versus patients that became positive while in the facility?

Edmond Showman: Hi. This is Edmond Showman. Are you talking about the data that is required to be submitted through the CDC NHSN platform?

Moshe Arnold: I mean, I'm assuming – this is the CMS Administrator said the other day that they're going to start posting this COVID numbers on Nursing Home Compare. I'm assuming the source is going to be from NHSN but it wasn't clarified.

Edmond Showman: Yes, we're planning on posting the COVID-19 data that's submitted through CDC, and it will be at the facility level and it will include the same data element outlined on the CDC module that's on the website.

Moshe Arnold: So, it will be parsed out then between patients that were acquired as COVID in-house versus patients that were admitted in the hospital with the COVID diagnosis.

Edmond Showman: We're still – we literally just received the first week's data last week. So, we're still working out all of the details, but essentially the data element – the modules on the CDC website, we intend to post them as unique elements just as they're collected.

Moshe Arnold: OK. Perfect. And then – and just quick separate question with nomcs, is there a potential for a waiver notice for Medicare non-coverage for residents

who their – due to their COVID diagnosis business office will not be going into their rooms due to the diagnosis?

Can that be done via – if they're self-responsible, could someone else do it for that – could just like – could that be explained but not necessarily actually signed? This is there, anything in the waiver that would help with that?

Edmond Showman: I think if you wouldn't mind submitting that to the waiver e-mail address, I think that probably be – but I'm OK, I have someone on line that can address that specific question right now.

(Moshe Arnold): OK. Thank you.

Demetrios Kouzoukas: And I know we did put out some guidance on (ABNs) and some of other notices that might be delivered in the weeks in other settings, and I don't know off hand whether it was broad enough to include that specific one, but if you – if you look there first and then let us know that also helps, too.

(Moshe Arnold): (Inaudible) …

Demetrios Kouzoukas: We will look there soon, yes. It's a guidance, so we put out around ABNs and just to make sure we have them in person in hospitals, but it was written more broadly than that. I know – I know it covered at least that, but I don't know is if it covers the nomcs.

Moshe Arnold: Oh, thank you so much.

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

Operator: The next question comes from Tom Norton with Geologics. Your line is open.

Tom Norton: Yes, I'm calling about the Q3014 originating site fee. I want to make sure I got all the pieces of the puzzle here. So, is it true that if the hospital does not register the patient's home as part of the Hospital Outpatient Department, that the hospital can still bill the Q3014 for the telehealth visits. They would just use the PN modifier.

Tiffany Swygert: No. It – that can only be furnished for a registered hospital outpatient and there's no change in payment regardless of the PO or the PN modifier being used for the originating site fee.

Tom Norton: So, the hospital does have to go through the – they have to go through the step of registering – of sending the addresses to CMS?

Tiffany Swygert: No.

Tom Norton: (Inaudible) …

Tiffany Swygert: No. The – sending of an address to make your provider based is for a temporary extraordinary circumstances relocation so that only applies for that circumstance where the hospital is registering an accepted department to maintain the accepted status. If all the hospital is doing – is billing as an originating site, it's not necessary to submit a relocation request.

You would just determine that to be a provider-based department as a temporary expansion location of the hospital. Register the patient as a hospital outpatient and that's it. But in that scenario, you're not requesting – if there are no other services that you anticipate billing for the patient during the public health emergency, then there's no need to request a relocation.

Tom Norton: OK. And would we use the PN modifier in that case if we did not do that or PO? Because I'm confused

Tiffany Swygert: It would be the PN modifier but just to clarify …

Tom Norton: OK.

Tiffany Swygert: … it would not change the payment for the originating site fee.

Tom Norton: Right. What – is it at (inaudible) …

Tiffany Swygert: The Q34 (inaudible) …

Tom Norton: … is it $26.65 or something like that I think? So …

Tiffany Swygert: I don't have the exact dollar amount. So, I won't say what it is but …

Tom Norton: OK.

Tiffany Swygert: … it's in that ballpark.

Tom Norton: OK and it's the same payment either way. OK. That's exactly what I needed. Thank you.

Tiffany Swygert: OK. Great.

Alina Czekai: Thank you for your question, and thank you, everyone, for joining our Office Hours today. Our next Office Hours will take place this Thursday, May 21st at 5:00 p.m. Eastern, and in the meantime, please continue to direct your questions to covid-19@cms.hhs.gov.

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

End