Centers for Medicare & Medicaid Services
COVID-19 Office Hours
October 13, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 6379959

Alina Czekai: Good afternoon. Thank you for joining our October 13th CMS COVID-19 Office Hours. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the Office of CMS Administrator Seema Verma.

Office Hours provides an opportunity for providers on the front lines to ask questions of agency officials regarding CMS' temporary actions that empower local hospitals and healthcare systems to increase hospital capacity, rapidly expand the healthcare workforce, put patients over paperwork and further promote telehealth and Medicare.

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 questions for CMS can be directed to our COVID mailbox, which is COVID-19@cms.hhs.gov.

Please do keep in mind that the questions discussed on this call are general representative questions. Your specific circumstance may be different. Therefore, the information provided may not always be applicable to your unique situation. You are always welcome to reach out to the COVID-19 mailbox for further assistance.

And since our last Office Hours call which was held on September 22nd, we have updated several CMS publications and guidance. For awareness, since we last connected, the public health emergency was renewed on October 2nd effective October 23rd. General updates have been made to the list of blanket waivers and frequently asked questions to assist Medicare providers, which includes telehealth FAQs.

A memo was posted on September 28th for all healthcare providers around guidance related to the emergency preparedness testing exercise requirements for COVID-19 which details exemptions and guidance for surveyors, providers, and suppliers. The fact sheet on repayment terms for accelerated and advanced payments issued to providers and suppliers during COVID-19 emergency along with the FAQ associated with it have been updated.

The fact sheet states that as of October 8th, so as of last week, CMS will no longer accept applications for accelerated or advanced payments as they relate to COVID-19 public health emergency. CMS will continue to monitor the ongoing impacts of COVID-19 on the Medicare provider and supplier community.

With regards to data reporting, a memo was released to stakeholders on the requirements and enforcement process for reporting of COVID-19 data elements for hospital and critical access hospitals effective last week. There are also a few updates around nursing homes. First, the toolkit on state actions to mitigate COVID-19 prevalence in nursing homes has been updated.

Last week, CMS posted a memo on compliance with resident's rights requirements related to nursing home resident's rights to vote, affirming the continued rights of nursing home residents to exercise their right to vote. In addition, a “Dear Nursing Home Residents” voting rights letter on our website outlines how a nursing home should give residents any assistance and resources necessary to help residents vote.

FAQs on nursing home visitation were also updated. For labs, updates have been made to the laboratory Quick Start Guide to CMS CLIA certification. Additional information about CLIA and CLIA certificate fees can be found through the secure platform link on our website. Finally, two state Medicaid director letters can be found on our current emergencies webpage under Medicaid and CHIP guidance.

The letters outline, claw back phased down state contribution amounts for CY 2020 and CY 2021. That concludes our updates today. Operator, please give the instructions so people can ask their questions. As a friendly reminder,

please do keep your questions to one question or one question and a follow up. Thank you.

Operator: Thank you. During the question and answer period, enter your question in the Q&A field of your event console and click submit. Over the telephone, to ask a question, please press "star" "1." And if you would like to withdraw your question, please press the "pound" key. Thank you. To the participant with a telephone number ending with 4910, your line is now open.

Rick Gawenda: Is it one – 1490?

Operator: Yes, sir. Your line is now open.

Rick Gawenda: OK. Yes, thank you. My question is regarding – this is Rick Gawenda – question regarding safe physical therapy. And there are many assisted living facilities that are limiting the amount of staff that can come in. So my question is, is it possible during a single physical therapy visit, to have both therapy provided direct one on one billed without modifier 95.

But say for the last 15 minutes, the assistant who's doing the one on one for the first 45 minutes, sets up a computer where then the physical therapists who can't be on the premise is doing an assessment via the computer, via telehealth and bill that one unit with modifier 95. So essentially, you might have, for example, three units of say exercise without modifier 95 and then when you – let's say exercise with modifier 95, for the same date of service.

CMS - Male: Hey, Rick, thanks for that question. It's fairly complex. So I think your best bet is ...

Rick Gawenda: It is.

CMS - Male: I'm not sure. Send us e-mail through the COVID mailbox and we'll certainly get back to you.

Rick Gawenda: OK. So, can I know about that, you will say, but I appreciate it. Thank you very much.

CMS - Alina Czekai: We'll take our next question. Operator, we'll take our next question, please.

Operator: I'm sorry for that. Your next question comes from the line of (Eileen Lyons). Your line is now open.

(Eileen Lyons): Hi, thank you very much for taking my question and thank you again for having these calls. So, our question is regarding on the facility side. So, if an RN who is in the hospital provides education over the phone in a facility only nurse visit that day as ordered by a physician as part of the established patient's follow up treatment plan, would this be billed as if done in the clinic with the G0463 and modifier PO or PN?

And alternatively, if the RN were placing the same call from their home to the patient's home, would that still be covered the same way as a G0463 with the PO or PN or is the hospital employed person, the RN, billing through UB required to be located in the hospital at the time of the call? And I know that was a lot.

CMS - Male: Yes. So to take the second part first, where you're asking about – I think the breakdown really falls along the lines of if there is a distant site provider providing the service. If you're describing something where there is not a distant site provider providing the service, that would be on the telehealth list.

Then, sort of the next question you ask is if there is a – if the service can be furnished remotely to the patient in the patient's home. If that's the case, then the hospital can bill for the – can bill for the service on a UB04 as if the care was furnished in the hospital. Does that answer your question?

(Eileen Lyons): Thank you for that. It does partially and to – there was follow up so, can the RN's call also the G0463, also be performed audio only or is audio and video required?

CMS - Male: So for services provided in the hospital setting, they communicate – it's basically communications technology. So, I don't know that I can give you more details than just telecommunication technology at this point.

(Eileen Lyons): OK. Well, thank you very much.

Operator: Your next question comes from the line of (Maureen Davis). Your line is now open.

(Maureen Davis): Yes, hello, I know this question has been asked many times, but I'm going to try again. So, I'm speaking about facilities. If we decide not to submit the individual patient addresses to relocate our provider based departments, and instead, we plan to report the PN modifier. Is there something specific that we have to do to make the patient's home a new provider based department?

CMS - Male: The ...

(Maureen Davis): Which means all applicable conditions of participation to the extent not waived are met. That's all I see. So is there something physical, something specific that the hospital must do other than to add a PN modifier to our charges?

CMS - Male: So the temporary exception requests only applies if you plan to bill with the PO modifier.

(Maureen Davis): Right.

CMS - Male: If you're making – you don't need to submit that if you plan to bill using the PN modifier.

(Maureen Davis): OK. So, then does that – does that mean we can't bill for example, if there's a physician by the telehealth service, does that mean, we as a facility cannot charge the facility site fees of the 23014? Or for example, like the G0463 when both the – even though the patient's at home providers is at the facility, so they're both considered at the facility and we would normally then be able to charge the normal codes is if it's in-person. Are we still allowed to do that?

CMS - Male: So your question is if the practitioner is at the hospital and is billing to the patient's home, which has not received a temporary relocation request, and you're billing using the PN modifier, can you bill the G0463?

(Maureen Davis): Yes. Are those two different things because one of them is called the extraordinary circumstances relocation request, which will allow you to relocate your department to the patient's home? And if you don't do that, then the patient's home is considered just a new provider base location, correct?

CMS - Male: Correct.

(Maureen Davis): But is that what – do you have to go through that extraordinary circumstance relocation request in order to fill any of these other types of codes in this situation, like the one I just mentioned that if the physician is at the hospital, patient's at home?

CMS - Male: So, you would not need to do that to bill with a PN modifier nor would you need to do that to bill it as a telehealth visit with the originating site fee. You'd only have to do that if you were billing it with a PO modifier as an accepted off-campus provider based department.

(Maureen Davis): So we can add – so the only difference is we would add the PN modifier instead of the PO modifier?

CMS - Male: Correct.

(Maureen Davis): But I guess, yes, I guess my – so, but like the 23014 is the facility fee only? So, I don't know. Does that make sense? It's only paid under apps, so.

CMS - Male: You're talking about the originating site fee?

(Maureen Davis): Yes, if we were allowed to bill that, did we have to do this extraordinary circumstances relocation request in order to do this ...

CMS - Male: No, you would not have to for an originating site fee.

(Maureen Davis): And the same can be said about, like if it's a telecommunication service, but they're both, I mean, the patient's at home, but we're considering them a new PVD, we can still bill those codes.

CMS - Male: So you would need to do the temporary extraordinary circumstances relocation request if you plan to bill for services using the PO modifier. You

would not have to submit that request if you plan to bill for services using the originating site fee under telehealth or if you were applying the PN modifier signifying that they are a non-accepted provider based department.

(Maureen Davis): And so we could still bill the G0463 with a PN modifier?

CMS - Male: You could bill the G0463 with the PN modifier in appropriate circumstances, yes – with the PN modifier.

(Maureen Davis): OK. All right, thank you.

Operator: Your next question comes from the line of (Theresa Campbell). Your line is now open.

(Theresa Campbell): My question is in relation to the BioFire respiratory panels and the fact that Medicare administrative contractors are making the decisions on whether that's a covered code or not for the PLA that's assigned to it. Is there any plan for there to be an overarching CMS decision on coverage?

Demetrios Kouzoukas: Tamara, you want to speak to that?

Tamara Syrek Jensen: Sure. So, right now, we haven't – we are certainly talking internally right now. I don't know that we are going to be doing an overarching national policy. I think the contractors, they're closest to what is going on and they can be most flexible in handling the situation currently, but we are closely monitoring it to make a determination whether that should change or not.

(Theresa Campbell): But until the contractor will cover it, then we can't get any reimbursement.

Tamara Syrek Jensen: So I guess I'm not sure I'm understanding your specific question. You have a specific test you want covered.

(Theresa Campbell): The 0202U is the PLA code assigned to the respiratory panel.

Tamara Syrek Jensen: So currently, I think the contractors have to make a determination on whether – not the code, but whether the panel is medically necessary for that specific patient. So, I mean, that – go ahead, Demetri.

Demetrios Kouzoukas: I was just going to add, and that's something that she can work with the contract, with the local MAC on. I don't know that necessarily need an affirmative coverage decision, but the MAC would be in a position to walk you through what their coverage policy is. Get that right, Tamara?

Tamara Syrek Jensen: Yes, exactly. Thank you. Yes. So I think working with your MAC on that to determine whether that test is coverable or not is the best place even if there isn't a code. And also I would say the MAC are currently looking at their policies now and whether they can update them. And they certainly can if there is an individual situation. They certainly can cover those situations. But it is up to the MAC at this point.

(Theresa Campbell): OK, it's just the technology to be able to do the respiratory panel including the COVID test and our MAC will not cover it, but other MACs are so.

Tamara Syrek Jensen: So I would encourage you to work with your MAC because I know many of them are reviewing these policies currently.

(Theresa Campbell): Thank you.

Operator: Your next question comes from the line of (Amber Cruiser). Your line is now open.

(Amber Cruiser): Good afternoon. Our question is in regards to hospital services – excuse me, and they're seeing the patient via audio/video to save on PPE though in the same facility. What we're wondering is, is it acceptable for the nurse who's located at the patient bedside to perform the physical exam?

Demetrios Kouzoukas: Who did perform it? I'm sorry.

(Amber Cruiser): The RN, because we're trying – these are COVID positive patients. So we're trying to save on PPE. So, the RN is at the bedside. The physician is connected via audio and video, but the hospital codes have an exam component. And so the question is whether or not the RN who is assisting that physician can complete that exam component or how would we meet those components for those codes?

Demetrios Kouzoukas: And the billing would be the under the (inaudible) schedule or are you talking about a facility bill?

(Amber Cruiser): No. It would be the (inaudible).

Demetrios Kouzoukas: OK.

(Amber Cruiser): So (inaudible) 221, 223, or (inaudible) 231 (inaudible)?

Demetrios Kouzoukas: I'm not sure if we have our physician (inaudible) ...

Gift Tee: Hey, Demetri.

Demetrios Kouzoukas: There you are.

Gift Tee: Hey, sorry about that. I'm driving and trying to listen safely, of course. I think this is one where we need a little bit more context. So, if you wouldn't mind submitting the questions to our mailbox, we will definitely get back to you on it. But could you just repeat the question one more time.

(Amber Curiser): Yes. I did. I did put it to the mailbox and I got a really great non-answer, which is why I'm asking here So what it is, is this COVID positive patient and we're trying to save on PPE. And so instead of having the physician to don and doff different PPE for all of these patients, there is a nurse assigned to that COVID positive patient.

And so the physician is connecting via audio and video to the patient to room and the hospital codes do require an exam component. And so the question is whether the RN can perform in documents that exam component and have it count towards those hospital code?

Gift Tee: OK, go ahead.

(Amber Cruiser): He or she was assisting the physician.

Gift Tee: Assisting the physician, they're performing the PE and you're asking if they can bill for the 99211 or whatever via telehealth. Go ahead and ...

(Amber Cruiser): No, no, I'm asking if the provider who's in the same facility as that physician is in the same facility as that patient, if that provider – if we can use the nurse exam as part of the components for the hospital care code?

Gift Tee: For the hospital care code?

(Amber Cruiser): Correct. These are hospitalists that are seeing these COVID positive patients that are in the ICU or in the critical care unit.

Demetrios Kouzoukas: So they'd be billing a physician service through the supervision of the nurse, remote while on site.

Gift Tee: Right.

(Amber Cruiser): So, the physician is doing all the work with the exception of the exam.

Gift Tee: OK. Go ahead and submit your question to our mailbox and copy me.

(Amber Cruiser): OK, and who is speaking please, I'm sorry, I didn't catch your name.

Gift Tee: OK. It's gift.tee@cms.hhs.gov and I'll follow up on it.

(Amber Cruiser): OK, thank you very much.

Gift Tee: OK. You're welcome.

(Amber Cruiser): All right.

Operator: Your next question comes from the line of (Susan Chapman). Your line is now open.

(Susan Chapman): Hi, thank you. Again, my name is (Susan) and I represent the Connecticut Massachusetts Orthopedic Surgeons. And they are inquiring about code 99072, which is for additional supplies, materials, and clinical staff time over and above those usually included in an office visit when performed during a public health emergency.

Their question and concern is that currently, Medicare does not have a fee or description attached to this code and the public health emergency is set to

expire. So, I'm just wondering, I did reach out to our carrier advisory committee and I also reached out to a representative in the Massachusetts – Boston, Massachusetts office of CMS. But according to them, there is no further clarification or information. So I'm wondering if somebody can direct me in the right direction.

Demetrios Kouzoukas: So we're aware of the CPT code, obviously, and the AMA's recommendations or suggestions regarding it. We're reviewing that. I don't – as of now, we do not have a separate payment for that in the Medicare payment scheme, and so that's the current status. The public health emergency by the way has been renewed and so that is going to go on a bit longer. But the answer with regards to the code for PP – separate PPD payment is that we do not currently have a separate payment for that.

(Susan Chapman): OK, I should advise them not to bill for that code then, obviously,

Demetrios Kouzoukas: Right, for Medicare. Other payers may be doing other things.

(Susan Chapman): OK. I'll check with the commercial insurers as well. Do you have any idea or anticipate any further clarification or activation of this code, I guess, if you will?

Demetrios Kouzoukas: I think – no, I can't – I don't know that I can give you a timeline right now, but until we speak to it, the default is that we're not paying separately for that, but we are taking a look at the request and considering whether we ought to make a change.

(Susan Chapman): OK. OK, thank you very much. Appreciate that.

Demetrios Kouzoukas: Thank you.

Operator: Your next question comes from the line of (Maureen Davis). Your line is now open.

(Maureen Davis): Hello, it's me again. I had asked on previous call about the CS modifier and which services they should be added to and it was my understanding that the CS should be placed on the E&M code, as well as the COVID related testing codes. But a new edit, OCE edit was just – just took effect on October 1st, and as a result we've got a bunch of denials.

And it looks like, because I went to the file that shows what code you're allowed to add it to. And it looks like the only code you can add it to are E&M codes, the originating site facility fee, and the lab specimen fee. I need to go back and report this to the powers that be. So can you please explain if that's correct and if we need to rebill all of these claims going forward I want to make sure we're doing this correctly.

Diane Kovach: Hi, this is Diane Kovach. So I can start and at least say that yes, we did have edits that were added to the system. I do not believe that we have said that anyone needs to re-submit claims, but we will have to verify that.

(Maureen Davis): OK, because I mean, there's many, many of them. And the edit was, yes – when I have it here, one I thought I had it written down. I don't, but anyway, its OCE edit 114. Yes, "item or service not allowed this modifier CS is the reason." So, yes, I mean, it would be great if we didn't have to resubmit everything, but is that something you can address in a publication or do I need to e-mail or how can we find out what to do about them?

Diane Kovach: No, you don't need to e-mail it in. We've taken the question down so we will check on that and we will – (inaudible) certainly address it up the next call, but then we'll also discuss whether there's any additional information we can provide either in our FAQs or for some other publication. I do believe these are prospective edits that you would not need to resubmit, but again, I want to verify that for you.

(Maureen Davis): OK, thank you. So we'll just hold on to them for now. OK, thank you.

Operator: Your next question comes from the line of (Teri Soldemando). Your line is now open.

(Teri Soldemando): Hi, thank you for taking my call. My question is regarding telephone codes 99441 through 99443, and if they are allowable for place of service 21. And I can give an example- as we have a patient admitted to the hospital in the COVID unit, and they're expected to be put on a ventilator within the next 24 hours. And we have a supportive care physician who's asked to speak to the patient and the spouse and we only have the telephone available to address their code status.

So, the patient doesn't currently have any advanced directives than the physician is discussing with the patient about their high oxygen requirements and went on – going over the details of the differences between code and DNR status. So, the only way to communicate with the patient is via telephone only, but they are in-patient.

Demetrios Kouzoukas: In-impatient and you're seeking to – and the question is whether – which physician service to bill for?

(Teri Soldemando): Yes.

Demetrios Kouzoukas: Gift, is this coding advice or something we think we can answer?

Gift Tee: It falls right down the middle. I think the way I would think about it is that there are certainly codes that are covered currently and codes that Medicare would pay for, but I stopped sort of telling you that those are codes that you should bill to capture what you just described.

(Teri Soldemando): So, I guess, ultimately, would a telephone call be allowed for any in-patient or is that something that we couldn't – that we would have to find other codes that fit the requirements?

Gift Tee: The question is, is that a physician that's furnishing the service, like, what is being captured? What service is being captured that would require that service to be billed that way?

(Teri Soldemando): OK. So, as long as it's a service that can be captured by another code that would be telephone only, it would be allowable.

Gift Tee: I think I would say whatever you deem to be appropriate, given the service that's being furnished is a service that could be billed.

Demetrios Kouzoukas: In other words, the fact that it's in-patient doesn't ...

Gift Tee: Yes.

(Teri Soldemando): It doesn't matter.

Gift Tee: That just happens to be the setting.

Demetrios Kouzoukas: Yes.

(Teri Soldemando): OK. Thank you very much.

Operator: Your next question comes from the line of (Ronald Hirsch). Your line is now open.

(Ronald Hirsch): Hi, there. A few things. First of all, Demetrios said that we should not bill 99072. Can't that code be billed? And then if it's not paid, just written off since CMS has a wonderful habit of making things payable and then retroactive to the beginning of the public health emergency? So, can't we submit the code, let it get rejected, and then when you guys go back and approve payment, you'll reprocess all the claims and then pay us?

Demetrios Kouzoukas: I think, I guess – I suppose it's a question of the representations implicitly or explicitly with respect to the submission of a bill. So, I think the thought was, the question – or the thought that I sort of confirmed to or spoke to is whether or not it would be advisable to not fill it, which I agree that it would be advisable to not, but I think you're maybe trying to draw a finer line around what could be done and versus what's flat out prohibited.

And I think that the caution warrants, perhaps, especially in a situation where we know that we're not billing for it, paying for it, that to not bill it in the first place given the implications that come along with submitting a bill.

(Ronald Hirsch): OK. Next question is, just to add on to the CS modifier issues, is that since these edits are only put in place recently, there are a lot of past claims that may have been paid with the CS modifier at 100 percent. And so now that the edit is in place, the concern is, will you go back to the beginning and then ask for the 20 percent back on all of those claims or is that something that hospitals should do proactively or do we wait until the MACs or the RACs come after hospitals for that money?

Diane Kovach: Hi, this is Diane Kovach. As we had said for the last question on this, I believe that we will not be going back and reprocessing those claims, that

these were perspective edits or from the date we put them in forward. They apply but I do want to verify that so we will come back with that information at the next call.

(Ronald Hirsch): OK. And again, because the law really – you're just clarifying the law that said it's only applicable to E&M services. So, if I could see that if you don't recoup the money that someone is going to come after it later on. That would be the concern.

Diane Kovach: I understand and we would certainly make sure that we communicate that with our colleagues so that if the decision is that it is straightforward, that pages have not been interpreted, that it should be recouped from that payback.

(Ronald Hirsch): Great. Thank you all.

Operator: And presenters, we don't have any questions over the phone. Please continue.

Alina Czekai: Thank you, operator. And thank you everyone for joining our call today. We'll give everyone a little bit of your time back this afternoon. As a reminder, you can continue to submit questions to our COVID-19 mailbox and that is COVID-19@cms.hhs.gov.

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

End