Centers for Medicare & Medicaid Services
COVID-19 Office Hours
July 14, 2020
5:00 p.m. ET

Operator: This is Conference #: 2550919.

Alina Czekai: Good afternoon. Thank you for joining our July 14th 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 frontline to ask questions with 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.

And please do keep in mind that the questions discussed on this call are general representative questions. Your specific circumstances may be different; therefore, the information provided may not always be applicable to your unique situation. You are always welcome to reach out to the COVID mailbox for further assistance.

And today, we do not have any agency updates at the top of the call, but I did want to call attention to one question we received a number of times. And that question is, please clarify the use of CPT codes 98966 to 98968 by registered dieticians during the public health emergency based on CMS' decision to change these codes from non-covered to covered status. And our

update is our CMS experts are still researching this question and we hope to have an update to share with you all shortly, but we did want to provide a status update on that question.

So, operator, let's please open up the lines for questions. Everyone, please do keep your questions to one question or one question and a follow up today. Operator, over to you.

Operator: That is noted. And ladies and gentlemen, we are about to start the question and answer session. To ask your question, you will need to press star one on your telephone. To withdraw your question, just press the pound key.

And our first question for today comes from the line of a participant that has a last four digit of phone number of 3667. Your line is now open.

Marie: Hi. My name is Marie. Thank you for taking my call. Can you hear me?

Alina Czekai: Yes, we can. Hello Marie.

Marie: Oh, OK. Hi. Yes. My question is, I have a directive off of the NGS website and it's supposedly from CMS. So, that's what's very confusing. This question was asked on a previous call about 94141 to 43, the telephone calls, and the fact that they have the seven-day rule and they were at one point or for CPT supposed to only be able to be used once per seven days.

The directive on the NGS site says they can be used once or if it's medically necessary. So, that's my confusion. I believed you deferred to the MACs specifically, but there is no more direction from any other MACs that we are able to obtain. Is that something CMS is going to deliver a conclusion on? It's not in the latest FAQs.

Ryan: So, that's right. We would generally defer to the MACs from the interpretation of the coding rules. It may be that the – it may be that the MAC is pointing out that the services can only be reported when medically necessary, which would always be true. Of course, in some cases, like those codes, the bundling rules or the packaging rules would not allow necessarily

separate payment and those codes will be bundled. But I think that's something that we have to take a particular look at.

Marie: May I just read you this quote from their alert?

Ryan: Sure.

Marie: It says, since these telephone services have been designated by CMS as representative of EM services for patients who do not have capability to telehealth visualization, the only associated frequency limitation is the longstanding rule of no more than one service being billed per day when repeated services are medically necessary for patient follow up or care for new problems. These services may be performed as frequently as is necessary.

Ryan: OK. I appreciate you reading that. But I think we will take that back.

Marie: Yes. I appreciate that.

Ryan: Yes. Thank you.

Marie: Thank you. My only follow up is has there been a decision about extending the telehealth that – extending the date.

Demetrios Kouzoukas: The public health emergency?

Marie: The public health is – yes, of the public health emergency and the use of this expansion.

Demetrios Kouzoukas: I think we haven't made a formal announcement, but there has been some activity in some of our leadership's social media pages that indicates an expectation that this will be renewed.

Marie: OK. Thank you so much. I appreciate these calls.

Demetrios Kouzoukas: You're welcome. Thank you.

Operator: Your next question comes from the line of a participant that has a phone number with the last four digits of 3571. Please state your first and last name and your organization name. Your line is now open.

Slavika: Hi. This is Slavika. Can you hear me, please?

Alina Czekai: Yes, we can.

Slavika: Hi. Thank you so much for taking my call – my question. I have a question regarding the COVID testing for skilled nursing facility. When there is a skilled nursing facility staff that is performing specimen collection for the COVID-19 test, are they allowed – is the skilled nursing facility allowed to bill G2024?

Ryan: So, that is the G-code for the independent lab specimen collection. And so, the nursing – that wouldn't be appropriate for the nursing facility itself to report that code unless the nursing facility itself was enrolled as an independent laboratory.

Slavika: OK. Because we actually have seen some claim processed for the skilled nursing facility using these specific HCPCS code. And now, we're wondering whether that has been paid in error or what the (inaudible) is.

Our understanding was that under the public health emergency that the expansion really was that if the lab is not sending the staff to the skilled nursing facility to collect the specimen but rather it is the skilled nursing facility staff that is really collecting that, the SNF would be allowed for the collection under the public health emergency waiver. Are we interpreting that incorrectly?

Ryan: So, those codes are created specifically for the labs to bill, not the nursing facilities themselves.

Slavika: So, is there – is there any situation where skilled nursing facility would be really doing this part of the testing where they're collecting the sample. Is there anything – and really the lab is perhaps billing for the kits that are sent to the nursing home. Is there any way a skilled nursing facility can get

reimbursed anything for doing this job? I mean, besides what was published on those G – on those two established G codes, I have not really seen anything else that would kind of apply to this situation.

Ryan: So, I should say, first of all, we certainly appreciate the changing clinical circumstances of the public health emergency are requiring different approaches to care than some of the preexisting rules account for. I would say that there are mechanisms for both independent labs and for physician offices to bill for specimen collection scenarios.

And it may be that they're in some cases depending upon the business relationships between the nursing facilities and other entities. There may be approaches that more directly account for the work that's being done and the separate payment for that work. But the codes that you specifically mentioned would be reportable by labs and not by nursing facilities under Part B.

Slavika: OK. So, I guess if the nursing facility actually got reimbursed for this specific code, you're saying we should reach out to the MAC and just really have them answer to that, because we did receive a payment.

Ryan: I think that's probably an advisable approach.

Slavika: OK. All right then. Most of the time, we follow your direction. Thank you so much.

Ryan: Thank you.

Operator: Your next question comes from the line of the participant with the last four digits of 4155. Please state your first and last name and your organization name. Your line is now open.

Sandy Sage: Hi. This is Sandy Sage with Hometown Health. I just wanted to ask about the specimen collection in clinics where we've been advised if there's no other E&M service to bill the 99211, does that also apply to RHCs in addition to regular outpatient clinics? Are they able to bill that as well?

Ryan: So, there were no changes in the qualified visit rules under the RHC or FQHC specific for specimen collection.

Sandy Sage: OK. All right. Great. Thank you so much and I appreciate the calls.

Ryan: Sure. Thank you.

Operator: Your next question comes from the line of a participant with a restricted phone number. Please state your first and last name and your organization name. Your line is now open.

Susan LaPadula: Hi. Good afternoon. My name is Susan LaPadula with ICMRS. My question is different, but maybe I can follow on your previous question from a caller for skilled nursing facilities. It's been actually practiced that a skilled nursing facility file for a CLIA waiver certificate that maybe consideer providing those laboratory services for the COVID test. Is that a possibility?

Alina Czekai: Would it be possible to repeat your question, please? We had some difficulty hearing you. Thank you.

Susan LaPadula: Yes. Thank you. Is this better?

Alina Czekai: That's great. Thank you.

Susan LaPadula: You're very welcome. For your previous caller regarding the skilled nursing facility, previously in practice skilled nursing facilities have filed for a CLIA waiver and that CLIA waiver would allow them to perform some services that would belong to the laboratory. Is that appropriate for a COVID test that the skilled nursing facility would file for the CLIA waiver application and certificate?

Demetrios Kouzoukas: I think the prior answer assumed that the SNF was billing as a SNF. If the SNF is actually billing as a lab and has sort of an alter ego as a lab, those are circumstances that we have seen and that circumstance the answer – the part of the answer that dealt with how a lab bills would be the applicable one.

Susan LaPadula: So, the CLIA certificate would entitle the nursing home to bill as the lab for that specimen?

Demetrios Kouzoukas: It would go more to how they're enrolled in the program on their 855 or otherwise and if they enrolled as a lab.

Ing Jye Cheng: OK. So, generally, in the context of that particular code, G2024, that the code itself, the descriptor presumed that the lab is having the staff travel to a SNF in order to perform the specimen collection. So, again, the SNF certainly – maybe enrolled as a lab and may bill as a lab, but they would need to be billing for the service that the code itself described and the code does not describe the service where the SNF staffs are collecting a specimen onsite at the SNF.

Demetrios Kouzoukas: Yes.

Susan LaPadula: That's an excellent point, excellent. With that in mind, if the nursing home has the CLIA waiver certificate and their nurse is doing the COVID test. Would they be allowed to bill using the appropriate code?

Demetrios Kouzoukas: So, there are some circumstances where an entity that is – that performs less than a certain volume or type – number of tests can enter into another arrangement kind of situation with a non-lab and – or with a lab and bill. I don't know if that's the situation that's being described here, but I think that the focus – the point perhaps to get away from the specific circumstances that could vary is that if the SNF is billing as a SNF then the code that was asked about isn't the right code to be billed and there isn't necessarily a separate code for that circumstance.

But if the SNF is also a lab or falls under one of these under arrangement situations then a different set of rules apply and they could do whatever it is that a lab does or otherwise work under arrangement practice sort of arrangement that allows them to proceed as a lab as well. Does that help?

Susan LaPadula: It helps a lot, yes. And I do believe like your previous caller that the MACs are paying the claims. So, if it is something you would take back and look at,

it may be something for the FAQs. Now that we're really ramped up, it's a common occurrence. So, that would be my request if you consider it.

I actually was calling for a follow-up on skilled nursing facilities and that was regarding the three-day prior stay and the benefits renewed if you have any new updates on those two issues.

Demetrios Kouzoukas: Just a follow up on your first question, by the way, just one last bit of – Jason, I'll let you go, but if the under arrangements provision is in the Medicare claims processing manual at Chapter 16 Section 40, that has to do with referred test, so that might be a helpful reference for some that are thinking about how it is that a laboratory test under arrangement can be provided by a hospital, CAH, or SNF with payment made to the hospital or SNF under those circumstances.

Susan LaPadula: That's excellent. Thank you.

Demetrios Kouzoukas: OK. Sorry, Jason. Go ahead.

Jason: I think your second question is in regard to whether there was any new information that has been published with regard to the three-day waiver. And the last information that I believe was published was in a MLN article about three weeks ago. And our FAQs are up to date with regard to the information that's currently available.

Operator: Your next question comes from the line of a participant with the last four digits of 3354. Please state your first and last name and your organization name. Your line is now open.

Male: Hi. Can you hear me?

Alina Czekai: Yes, we can. Thank you.

Male: Great. Thank you for taking my call. I actually have a question about taking that hospital targeted distribution. Is this the appropriate forum to ask that question or should I be asking that somewhere else?

Demetrios Kouzoukas: Those are questions that are outside of our purview at CMS, but we can certainly pass them along to the entity – folks at HRSA, who are the administrator provider relief fund.

Male: Great. So, in that case, just send the questions to COVID mailbox?

Demetrios Kouzoukas: Yes, please.

Male: OK. Thank you very much.

Operator: Your next question comes from the line of a participant with the last four digits of 8308. Please state your first and last name. Your line is now open.

Terry Harmon: Hi. Good afternoon. This is Terry Harmon with Genesis. And thank you for taking my call today. I think that my question was already answered by an earlier caller who asked regarding the PHE and if that was going to – we know that it is to expire on 7/25, but we have heard that there has been discussion and probability that the secretary will re-sign and I do believe that you folks answered that question. So, thank you very much.

Demetrios Kouzoukas: You're welcome. The statement that was on our HHS spokesman's Twitter account says that HHS.gov expects to renew the Public Health Emergency due to COVID-19 before it expires. We have already renewed this Public Health Emergency once. And then it provides the link to the phe.gov website where they're posted so you'll have it.

Terry Harmon: Yes. We do. We do. And I'm – we're – I'm hoping or expecting that there will be something updated maybe perhaps next week. Thank you very much.

Demetrios Kouzoukas: Thank you.

Operator: Your next question comes from the line of a participant with the last four digits of 4372. Please state your name and your organization name. Your line is now open.

Annie: Hi. My name is Annie. I'm calling from Southwest Montana Community Health Center. I'm hoping for clarification on telehealth coding for FQHCs. The current guidance states that after July 21st that only G2025 is needed to

bill for teleservices. Is this based on submission date or date of service? All it says is date – services furnished.

Ryan: You said all it says is services furnished?

Annie: Yes. Services furnished between January and June 30th to submit with your regular CPT, your FQHC G code, and the G2025. It says, after July 1st, we only need to submit G2025. But it doesn't clarify if that is anything submitted after July 1st regardless of date of service or is it all bases on date of service?

Diane Kovach: Hi. This is Diane Kovach and that's for dates of service for plans that were submitted after 7/1.

Annie: So, it's based on date of service and not on when we submit it? So, if we're holding something from March, if we submit it, we still have to submit with CPT, FQHC, G code, and the G2025?

Diane Kovach: That's correct, but we can make sure that our FAQs are very clear on that point.

Annie: Yes, please. Thank you. There's been some miscommunication and certain MACs are giving different information.

Diane Kovach: OK. Thanks for that as well. Because we'll make sure that the – we reach out to the MACs and make sure that they're clear as well. Thank you very much.

Annie: OK. Yes. Thank you.

Operator: Your next question comes from the line of a participant with the last four digits of 5417. Please state your first and last name and your organization name. Your line is now open.

Kristy Maye: Hello. This is Kristy Maye and I am with Tennessee Orthopedic Clinic. And I'm calling regarding a couple of questions. Just to follow up, last time I asked regarding 2021 E&M and AUC for 2021. I was advised CMS was still considering. Has there been any word on those two programs at this time?

Demetrios Kouzoukas: No. Often we speak to that program – to those programs in the physician fee schedule. That's not always the exclusive place, but that would be one place where we might – you might expect us to talk about it.

Kristy Maye: OK.

Demetrios Kouzoukas: No promise that it will be there. It could be somewhere else instead or in addition, but that's the most likely place where we would speak to it.

Kristy Maye: OK. So, within the physician fee schedule, would you expect it to be in the 2021 calendar year of proposal maybe or will that be coming out as normal?

Demetrios Kouzoukas: That's often where we would be speaking to it.

Kristy Maye: OK.

Demetrios Kouzoukas: I can't guarantee that will – that that particular car will make that particular train, but that's a place where you might look and – or timing around then. After the timing of the physician fee schedule rule, we always – we work to try to get the rules out in a normal regular course. Obviously, with the pandemic, that can complicate things. But we're still within the window of what the usual issue as they would be. So, I don't think I can say more than stay tuned.

Kristy Maye: OK. Thank you so much.

Demetrios Kouzoukas: Thank you.

Operator: Your next question comes from the line of a participant with the last four digits of 0413. Please state your first and last name and your organization name. Your line is now open.

Ina Bender: Hi. This is Ina Bender from Mount Saini Hospital. Thank you for taking my call. I'm trying to follow up on one of the request we made about the new code, 0224U, for new antibody testing, and I was wondering if CMS has an idea when we can start using this code because we are providing these services today? Hello?

Demetrios Kouzoukas: This is the new code for …

Ina Bender: The antibody with the titer test that AMA just recently approved.

Demetrios Kouzoukas: I don't know. Ing Jye is there anything we have on this one yet? Our CCSQ colleagues? I don't know that we have an answer for that for you on the line right now. We'll (inaudible) back.

Ina Bender: OK. And another follow up, a number of participants have been asking about medical necessity policy where the use of booth COVID testing when you join the pre-admitting testing for a lot of patients or the patients who are getting M-search places today are all required to have a COVID testing done for identifying any potential risks. Do you know if CMS has come up with any decision on the policy about the medical necessity of this tests as well as testing donors who are donating their blood for the plasma projects?

Demetrios Kouzoukas: So, the plasma project I know is sort of in its own bucket if you will, around the clinical research rules and the like. And I know that you were looking for something that might shed some light and – different light and/or different way than the usual clinical trial rules.

I think the team is still working on that particular question on whether there's a sort of an additional answer beyond the research situation. And so, I don't think we have an answer for you around that, but it's different from what we had last time, which was general clinical trial rule around routine care or what would prevail.

And then with respect to medical necessity more generally, which is perhaps the more broadly applicable question, those are determinations we're leaving at the MAC level right now and I think the MACs are – have been processing claims consistent with their usual authorities. And so, we would leave that to the MACs in terms of the particular question about any particular situation.

Ina Bender: All right. Thank you. Just one other quick follow-up question. Can you just – sorry – can you just confirm if the C9803 code is it billed by itself with just

the COVID testing. So, we still need to have CS modifier and that's the only service we're providing?

Tiffany Swygert: So, for the CS modifier, there are several criteria that needs to be met. So, I'm not sure that there's a separate answer with respect to billing for C9803. But we would encourage you to look at the requirements of billing for the CS modifier to determine when it's appropriate to include.

Ina Bender: OK.

Tiffany Swygert: I'm not sure if there's a separate part to the question though.

Ina Bender: No. I'm saying in one of the session there was a mention that it was the only service that we're billing to Medicare, just COVID test and nothing else, that we should be adding CS modifier to the C9803 because it's kind of acting like an E&M type of a code or include E&M component on your billing for that.

Tiffany Swygert: Oh, I see what you're saying.

Ina Bender: Yes.

Tiffany Swygert: I see what you're saying. If it's included as one of the eligible evaluation and management visits?

Ina Bender: Correct.

Tiffany Swygert: We will – OK. I believe we will have some guidance coming out on – related to specific codes for which the CS modifier could be appropriately used. So, I would just stay tuned for that. But I don't believe that to date that we have offered any specific coding guidance on which codes to append the CS modifier on.

Ina Bender: OK. Thank you very much.

Tiffany Swygert: Thank you.

Operator: Your next question comes from the line of a participant with the last four digits of 0275. Please state your first and last name and your organization name. Your line is now open.

Juliana Belelieu: Hi. This is Juliana Belelieu with Memorial Sloan Kettering. Thank you for this call. I have another question that relates to that provider based and hospital without walls waivers, specifically about same day services.

So, we are wondering in a scenario where a cancer patient whose home has been made provider based to the hospital, has the telehealth visit with his or her medical oncologist and that's billed as telehealth and using the originating site, the facility side.

And then later, the same day, they have a significantly and separately identifiable remote visit with a nurse from our ostomy team who is assessing the patient's ostomy and providing additional teaching via audio-visual technology but as a remote service.

Can that ostomy team nurse bill G0463 for that ostomy assessment and teaching?

David: So, to the extent that the service is an OPPS service provided by a relocated provider based department of the hospital, it would be appropriate to bill that service as an OPPS service and with the appropriate either PO or PN modifier, depending on is it temporary extraordinary circumstances relocation request has been submitted for that patient's home.

As of the telehealth piece, I'll let Ryan or someone from DPS speak to that.

Ryan: So, I think that's right. And so, I think it's fair to say in that case that when a separately identifiable service is there, the separately identifiable OPPS service wouldn't necessarily be precluded because on that same day there was a professional telehealth service furnished but rather the Q code would be the appropriate facility to report in association with the telehealth service.

Operator: Your next question comes from the line of a participant with the last four digits of 0410. Please state your first and last name and your organization name. Your line is now open.

Catherine Cistoro: Hi. Good afternoon. My name is Catherine Cistoro and I am a regional director with CHE Behavioral Health Services. We provide services for nursing home residents for behavioral health for emotional and stresses.

So, my question is, is it possible to request the CMS waiver to include a waiver for LCSWs to get reimbursed to provide services for residents on Med A stay? And the reason behind this request is that COVID is exacerbating an already existing dearth of psychologists, particularly in areas that are not urban, where it's difficult to recruit. And of course, we have an increase in demand due to the emotional impact that COVID is having on many of our nursing home residents.

And so, we're very concerned if the crisis continues that there is an increasing demand with an unmet need for those on the Med A stay. And as I'm sure you realize those who are residents – permanent residents in a long-term care facility who once going to the hospital and then returning they may have the benefit of their psychotherapist prior to their hospitalization. But then when they need them most, when returning on Med A stay, if there's not a psychologist, they can't get any services to help them through that part of their recovery.

And so, the request for the waiver would be for LCSW who are already CMS approved to provide such services when residents are not on Med A, if during this crisis they can be reimbursed when a resident is on a Med A stay.

Jason: Thank you for your question. What you are referencing is a Medicare Part A stay that is subject to consolidated billing.

Catherine Cistoro: Yes.

Jason: Congress has been very prescriptive in statute with regard to what is part of consolidated billing. And CMS has very little discretion including through waivers to expand on that list. And as a result, we have not found them we

have the authority to do an expansion of the nature that you're describing today.

Catherine Cistoro: OK. Thank you for your feedback. Do you have any suggestions on where we can try to have this request heard from an authority that might be able to take some action on it?

Jason: The only advice that I would just note is that it's a statutory issue. And so, with our interpretation being that it's statutory, that would need to be changed by an act of Congress.

Catherine Cistoro: Oh, OK. I understand now. OK. Thank you.

Operator: Your next question comes from the line of a participant with the last four digits of 0289. Please state your first and last name and your organization name. Your line is now open.

Cynthia Morton: Hi. This is Cynthia Morton and I'm with National Association for the Support of Long Term Care, NASL. More of a clarification really than a question. We were reviewing the recent update to the provider burden relief FAQ and it mentions that CMS is going to pick back up or actually the MACs are going to pick back up on some of the medical review programs, targeted probe, and educate – and a couple of other programs that had been suspended because of the pandemic.

And I – that is increasing quite a bit of burden for nursing facility providers, rehab therapy providers. In fact, we were actually undergoing more reviews. We got more COVID patients now than we really did a couple of months ago when the reviews were suspended because of the burden of COVID.

So, I guess it was – my point is really, as I said, more of a clarification than a question. This is couched in terms of burden reduction, but it's actually a burden increase with the medical review beginning again. So, I guess I just want to make sure I'm seeing what I'm reading. Am I really understanding this? And thank you so much for these calls. They are really helpful and I know they take a lot of your time and resource and I just want to express my appreciation for them.

Demetrios Kouzoukas: I do think that the mention that you saw is one that has some context to it. I know – I think we do have a couple of colleagues from our program integrity group on the line. I don't know if they have more to share.

But I'll just say generally that the signal we made to indicate that some of these efforts would be restarted. It wasn't necessarily a suggestion that it will be done without a sensitivity or some consideration for what circumstances of any particular provider are and the like, particularly given what's going on with the public health emergency in different parts of the country. So, that's a dialogue I imagine that could still be entertained and I don't know if that context provides some additional help.

I'll also say that in terms of burden reduction, the purpose of target probe and educate is to avoid and identify the – avoid the use of sort of more heavy handed techniques and circumstances where they're not necessary and to educate. And so, that's the spirit in which some of these things that we consider them to be burden reduction in that regard.

I don't know if any CPI colleagues have more to add. OK. And then we do have an answer on, I think, the previous question around the antibody code. Jason, I don't know if you want to …

Jason: That's correct, Demetrios. I just wanted to confirm that CPT code 0224U, the antibody testing, that is actually billable right now.

Cynthia Morton: That's good news. I think – as a follow up, I think you're maybe suggesting that providers could maybe expressed to their MACs if their – if they have a very heavy COVID population that's demanding almost all of their staff time and resources that maybe that could be taken into account by the MAC when – as these medical reviews are starting back up and MACs are asking for documentation and the kind of thing that goes along with the review.

Is that kind of which you're saying or am I interpreting it a little too broadly?

Demetrios Kouzoukas: No. I think our MACs want to know if they're in a situation where it would impact patient care. I don't want to sort of necessarily invite all these things accepted without question or circumstance you could imagine.

Cynthia Morton: Sure.

Demetrios Kouzoukas: Sometimes these kinds of situations are used as a pre-text by others who are – would rather not be asked questions about their billing and so on. I know that's not the vast majority of providers by any means. And so, the MACs I think would want to know if they're bringing – if they're having that kind of impact.

Cynthia Morton: Thank you very much.

Operator: Your next question comes from the line of a participant with the last four digits of 5000. Please state your first and last name and your organization name. Your line is now open.

Eileen Sullivan: Yes. Hi. My name is Eileen Sullivan from Moorestown Medical Center in New Jersey. My question is related to the PHE CFR 482.30 waiver. Can you clarify if this waiver suspends code 44 requirements or only if you are committee concurrent with the outpatient status? And specifically, for these inpatient and outpatient conversion is written notice still required to be given to the patient and code 44 reporting on the outpatient claim required or waived during this time?

Demetrios Kouzoukas: You have to give me – to give us a little bit more context for the code 44.

Eileen Sullivan: Sure. So, the CFR 482.30, which is utilization review – the condition of our participation for utilization review is – falls under that CFR. Then the code 44 requirement, which is a very cumbersome process to take an inpatient claim, a hospital inpatient claim or admission. The patient was admitted as an inpatient and has not been discharged normally with all other payers.

We realize they don't meet inpatient criteria, the physician and – as soon as the patient was brought to the hospital they're admitted as an inpatient and the

case manage under review will say, this is not meeting criteria. It goes to our physician advisor and – or your physician advisor and they determine this really is only meeting outpatient. We get an outpatient order from the physician and we're good to go. That's how it's done with all the other payers.

Medicare requires whenever you have an inpatient and you want to take it the entire state back to outpatient as though the inpatient admission did not exist and we're just going to submit for an outpatient claim. They require a process of getting the utilization review committee involved, notifying the patient in writing that the patient can't be discharged.

So, anyway, our understanding and my communication with my colleagues at other hospitals, we're very confused. Is code 44 – I mean if CFR 482.30 is waived for this PHE time, does that include the code 44 requirements of notifying the patient in writing? So, we're wondering, can we just put in the – get the outpatient order from the physician and submit the claim as an outpatient or do we have to continue with the code 44 process of reporting it on the claim, giving written notice to the patient, involving our UR committee, the – there's just a whole – a lot of difference of opinions by the MACs.

So, I'm very active in the American Case Management Association and we're hearing a lot of different responses and confusion by case management directors. Do we follow the code 44 process? We thought it was waived. Others say, oh, it's not waived. The MACs are saying – case management directors are saying, well, my MAC is saying we still have to follow code 44. Mine is saying, well, you don't need UR committee concurrence, but you still have to give written notice and note it on the claim.

So, either the code 44 requirements are suspended or they're not. We're very – we're just very confused. So, I volunteered to bring this question to this call today. And I don't know if – I also submitted it in writing when your – when it was first – the call was first opened up and they gave the e-mail. I also submitted the question to the COVID-19 e-mail.

Alina Czekai: That's great. Thank you submitting that question in writing and for taking the time to explain it. I certainly understand why it could be confusing. So, I think with respect to the utilization review requirements and the waiver there, that was sort of done independently as a waiver for the public health emergency. There is no corresponding waiver or pause on condition code 44 when there is a change in patient status prior to discharge.

However, I think you raised some good point and we should look – take another look to see if there's any interaction there at a minimum to see if we can issue some clarifying guidance just because, as you mentioned, the requirement – the UR committee review is part of the condition code 44 requirement. So, we'll certainly take that back and follow up on a later – at a later time.

Eileen Sullivan: Thank you.

Operator: Your next question comes from the line of a participant with the last four digits of 4534. Please state your first and last name and your organization name. Your line is now open. For our participant with the last four digits of 4534, your line is now open.

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

Operator: Your next question comes from the line of a participant with the last four digits of 3571. Please state your first and last name. Your line is now open.

Slavika: Hi. This is Slavika again and thank you again for taking my question today. I have question regarding the skilled nursing facility and the renewed benefit period under the waiver. There has been a publication, probably like three weeks ago, S.E. 20011, if I'm not mistaken, that outlines for us exactly how we supposed to proceed with the billing for a claim that has 100 days for the first benefit period followed up with the additional benefits period for day 101 and forward.

There has been detailed information on that how to end claims for the first benefit period and specifically the suggestion is that we supposed to bill this

as a discharge bill with the patient status code 01, which under normal circumstances represent that we're discharging patient home.

In many of these cases, when the resident actually do have a need for the renewed benefit period, they are not really physically discharging the resident. The resident stays in the facility. And my concern really here was that with the billing instructions that we have been provided, we kind of now reflecting what is the actual census installation for that particular resident. Is that something we should be concerned? Should we just follow what was suggested just because this is everything going under the Condition Code DR and the public emergency waiver?

And also we were not really clear whether the discharge code should be on day 100 or day 101 because then you bill with the discharge code normally you don't get paid for a discharge day.

Jason: Thank you for your question. We have been working to try to facilitate the best approach that we can recognizing that it does take some time and effort for us and our contractors to make adjustments to the billing systems and that sometimes these waivers require some creativity or some complexity on our part to implementing what is our routine day-to-day processes. This particular portion of the waiver has had fairly limited exercise in prior emergencies. And so, this is the best approach that we have at this point.

I believe that that article speaks to the question about day 100 versus day 101. I'll pause at the end to see if another colleague has additional information on it that they would like to share. But I think with regard to any specific questions like that, the article also references contacting your MAC as we know that there can be some unique circumstances with some of these particular cases and some of these particular scenarios that your administrative contractor may need to walk through with you for billing.

Slavika: OK.

Diane Kovach: This is Diane Kovach. In that article, just to be clear with folks, it's a Special Edition article 20011, SE 20011, and it does specifically say in there re-admit

the beneficiary day 101 to start the benefit period waiver and there are very specific kind of step-by-step instructions on submission of the claims.

As Jason said, if you have any questions at all, you can contact your MAC.

Slavika: OK. Yes. The instruction is specific for day 101, but the actual discharge day, it's just suggests that we're supposed to bill with the discharge code for a day 100 but it does not necessarily specify that the discharge code is on a true date, which would be your day 100 or whether you extended one day, and if you're ever going to run into a situation where you're going to have a problem with the overlapping claim when you start re-billing on day 101.

So, that was really my concern, but I guess we just take it claim by claim and reach out to the MAC if that's what you're suggesting is the best approach.

Diane Kovach: Well – and with that specific question, we'll certainly go back and look at the instructions to see if we can clarify in terms of day 100 versus 101 for the actual discharge code.

Slavika: Yes. That would be really, really helpful and we certainly would appreciate that.

Alina Czekai: Thank you. And we'll take our final question please.

Operator: Your final question comes from the line of a participant with the last four digits of 3564. Please state your first and last name and your organization name. Your line is now open.

Tina Azanero: Hello. My name is Tina Azanero with Texas Health Physicians Group. And I'm calling to see if you could give me some clarification. I've looked through all of the FAQs and I can only find directions for hospitals or ASCs for billing for an expansion for testing.

So, what I wanted to know is if us, as a large physicians group, wants to do testing at an offsite location, is that covered or is that permissible?

Ryan: So, I'm not sure if there are folks on the provider enrollment area on the phone to answer that. But physician offices in general have – could contact their

MACs regarding the rules and the flexibilities surrounding identifying with your MAC outside of an expansion site for testing.

Tina Azanero: OK. That's what I needed. Thank you so much. I appreciate your help.

Ryan: Sure.

Alina Czekai: Great. And thank you everyone for joining our call today. You can continue to submit questions through our COVID mailbox and again that e-mail address is COVID-19@cms.hhs.gov. We look forward to speaking with you next week. Have a great rest of your week.

End