Centers for Medicare & Medicaid Services
COVID-19 Office Hours
November 17, 2020
5:00 p.m. ET

OPERATOR: This is Conference # 2491556

Alina Czekai: Good afternoon and thank you for joining our November 17th CMS COVID-19 Office Hours. We appreciate you taking the 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 of agency officials regarding CMS' temporary actions that empowered 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 keep in mind the questions discussed on this call are general representative question and your specific circumstances may be different. Therefore, the information provided may not always be applicable to your unique situation. You are welcome to reach out to the COVID-19 mailbox for further assistance.

And since our last Office Hours Call on Tuesday, November 3rd, general updates had been made to the frequently asked questions to assist Medicare providers, the toolkit for states to mitigate COVID-19 in nursing homes and the CLIA guidance FAQ. On November 10th, CMS announced that Medicare

beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost sharing during the public health emergency.

The coverage applies to bamlanivimab which received emergency use authorization or EUA from the FDA on November 9th. This means that Medicare beneficiaries can receive coverage of the antibodies to treat COVID-19 with no cost sharing during the public health emergency.

CMS is finalizing additional provider FAQs on the antibody product but additional information on Medicare coverage and payment concurrently be found in the program instruction and monoclonal antibody toolkit issued on November 10th.

And we will open things up for questions. Please keep your questions to one question or one question and a follow up. Operator, (Ren), I'll turn it over to you.

Operator: As a reminder to ask a question, you will need to press "star" "1" on your telephone keypad. Again, that's "star" "1" on your telephone keypad.

Your first question comes from an anonymous line. Please state your first and last name. Your line is open.

For the participant who pressed "star" "1," please state your first and last name. Your line is open.

CMS - Alina Czekai: And the last four digits are 9176.

Operator, we'll take our next question.

Operator: Next line on the queue, please state your first and last name. Your line is open.

CMS - Alina Czekai: And the last four digits of that phone number are 5203.

Angela Simmons: Hi. My name is Angela Simmons from Vanderbilt University Medical Center. I wanted to ask about the reporting of the code for the new lab that’s available. Do we need to include any of the clinical trial?

Modifiers such as Q1 for payment for this since it's an emergency use drug and following up with that, to ensure that we have no copay, do we use the normal modifiers that were put out in March for that with CMS to make sure that no copay? Thank you.

CMS - (Diane Kovach): Hi, this is (Diane Kovach). So, you do not need to use any modifier with those – with that code or those codes. They're being paid under the vaccine benefit and there are no – there's no cost sharing for our vaccines. And you also don't need to put any type of indicator for our clinical trial, so just fill the codes on the claim and you'd be good to go.

Angela Simmons: Great. Thank you so much.

CMS - (Diane Kovach): You're welcome.

Operator: Your next question comes from the line from number ending 4802. Please state your first and last name. Your line is open.

(Jennie Stuart): Hello, my name is (Jennie Stuart). I'm calling from Legacy Health in Portland, Oregon. My question is regarding the new CPT codes released by the AMA for COVID, flu multiplex testing, CPTs 87636 and 87637. Can you advise if CMS is recognizing and covering these CPT codes yet? What are the reimbursement rates and if there are patient cost share?

CMS - (Sara Chairee): Hi, this is (Sara Chairee) in the Centers for Medicare. I can start. We are aware of those codes and I understand that the codes had been sent to the CMS Medicare Administrative contractors. So, I don't have an exact date but I imagine that they will be in the system shortly. As far as reimbursement, they will be contractor price at the local MAC.

And CS modifier, because they're a lab test would not be required as co-insurance has already not applied.

(Jennie Stuart): So, there is no co-insurance. So for other payers who might apply a co-insurance because COVID is part of this test, would we still have to ensure that no cost share is billed to the patients on that?

CMS - (Sara Chairee): Unfortunately, I can't speak for other payers. We would probably need to check in with the other payers that we work with.

(Jennie Stuart): OK. Thank you.

Operator: Your next question comes from the line of number ending 5694. Please state your first and last name. Your line is open.

Joanna Bennett: Hi, this is Joanna Bennett. I'm calling from Baylor Scott & White Health in Texas. Thank you for taking my question. My question relates to the billing for hospital outpatient department, auxiliary personnel phone calls to patients. So for this particular scenario, the HOPD was relocated to patient's home and a nurse or a pharmacist are also located in the HOPD.

So, is it possible to bill G0463 for such phone calls and a scenario for such a phone call would be, for example, physician order, a follow up on a patient blood pressure, so generally it will be like an in-person nurse's visit or pharmacist call related to patient, anticoagulation management when there's some dosage changes and patient has some potential – I don't know, symptoms that needs to be reviewed or complications or things like that.

CMS - Male: Sure, so I think the kind of – the general overview again on the provision of the remote services is, the question of whether or not there's a distant site practitioner i.e. a physician who is not at the hospital location providing the service. If that's the case, then you should be billing under the telehealth codes.

If that's not the case, then there's hospital service being provided as if they were in the hospital, then you can bill that service as if it was in the hospital using the off-campus provider-based codes for either PN or PO, depending on whether or not the patients home has become – has received a temporary extraordinary circumstances, a relocation request.

Joanna Bennett: OK, so if we, patient's home is HOPD, the RN or pharmacist are in the HOPD, we would be OK billing the G0463, correct, for those phone calls as – if the patient was – for interacting with the patient in HOPD, correct?

CMS - Male: If you're providing the service as – as if you would provide a service in the – in the physical location, yes.

Joanna Bennett: OK, OK, thank you so much.

Operator: Your next question comes from the line from the phone number ending 5762. Please state your first and last name. Your line is open.

(Janelle Gleeson): Hi, this is (Janelle Gleeson). In the second interim final rule, CMS offered physicians the flexibility to bill audio only E&M services using the telephone visit code, saying that clinicians that they are furnishing evaluation and management service using the audio only technology and the service would otherwise had been provided in person at the office.

They should bill using codes 99441, 99443 and the payment for those codes was increased to meet the levels of resources that would be needed if it were an in-person visit. So, we are finding that there might need to be an accommodation for an NCCI edit that rejects the telephone codes when a chronic care management service is built on the same calendar month.

The telephone E&M codes are viewed as a component code of the chronic care management services bundle but during the PHE, these codes are largely being built to describe E&M services that would usually take place in person and those are not traditionally more comprehensive than the chronic care management.

So, just wondering if there's a way to accommodate this billing procedure during the pandemic, given the temporary use of the phone codes to describe that more complex care? Is there any sort of NCCI modifier that we can put in place to differentiate when those codes are truly telephone codes or if they're meant to describe that in person visit?

CMS - (Emily): Yes, hi, this is (Emily). I think that – so this is an issue that is known to us. It certainly is not the intention of our policy to prohibit the billing of those services, those audio only phone visit that as you pointed out are actually taking the place of sort of in-person office visit alongside PCM.

We think that – because those phone visits are functioning as an in-person visit which are billable on site PCM, that they should be – that the same rule essentially should apply to them. So, we're working to resolve that issue currently.

(Janelle Gleeson): OK. Fantastic, thank you.

Operator: Your next question comes from the line of Joann Baker from University of Iowa. Your line is open.

Joanne Becker: Hello. This is Joanne Becker from the University of Iowa and I have a question regarding MLN Matters SE20015 where it talks about the positive COVID test within 14 days of admission. So, we understand that we need to have a positive test in the record within 14 days of the admission.

But our question is what happens when a patient gets a positive test and it's greater than 14 days after the admission but the patient is still in-house, still an acute patient but the patient has a positive test say on day 15 or later for protracted acute admission, would that still be eligible for the 20 percent increase in the DRG?

CMS - Male: I think we're going to have to take that one back.

Joanne Becker: OK. Is there someone I should send that e-mail to or is it ...

CMS - Male: Alina, do you want to give out your – for the right – for the e-mail.

CMS - Alina Czekai: You bet. The COVID e-mail box is covid-19@cms.hhs.gov.

Joanne Becker: Thank you.

CMS - Alina Czekai: Thank you and we'll take our next question please.

Operator: Your next question comes from the line of (Aileen Sachiko) from Owner Health. Your line is open.

(Aileen Sachiko): Hi, thank you so much for taking my call. I wanted to know if you're recognizing CPT code 0241U and if you are, if you have any reimbursement information on that yet?

CMS - (Sara Chairee): Hi, this is (Sara Chairee) in CM, the U-code 0241U as with other – of their codes developed for laboratory testing are contractor price and I do not have that rate available. If you would like to check in with your Medicare Administrator Contractor, they should be able to assist you.

(Aileen Sachiko): Thank you. And this code is accepted by CMS, correct?

CMS - (Sara Chairee): I think we are up-to-date on all of the recent codes except the ones that were released by CPT on the 10th of November. So, it's acceptable in the system as far as I know.

(Aileen Sachiko): OK, perfect. Thank you so much. I appreciate your time.

CMS - (Sara Chairee): You're welcome.

Operator: Your next question comes from the line of Steve Gillis from Massachusetts Gen. Your line is open.

Steve Gillis: Hi, how are you? Thank you. Steve Gillis, Mass General Hospital, Mass General, Brigham. My question pertains to the COVID testing for an asymptomatic patient with no known COVID exposure and it's not related to elective hospital admission or procedure. Some payers have confirmed coverage during the public health emergency, some have stated they will not cover. Medicare, I still haven't really seen explicit guidance on that. Could you opine on that please?

CMS - (Demetrios Kouzoukas): Did you say it was for COVID testing without known exposure?

Steve Gillis: Yes.

CMS - (Demetrios Kouzoukas): So, I think we got some guidance that we put out – it must have been mid-summer that explained that we're not – for Medicare we're not paying for screening or for COVID testing in the context of screening, that our longstanding policies continue to apply with regards to screening.

And so now, obviously, there's some judgment call about what an individual circumstance or facts are and whether it's a screening situation or not but we have put out indication that we don't – we haven't change our policy of not paying for screening.

It is one circumstance related to initial testing in certain skilled nursing facilities which we're considering not to be screening and that's been a subject of some earlier issuances as well. But that's – I think that's what we – that's about the high-level of what we said so far. Does that answer your question?

Steve Gillis: So with – yes, so with – thank you. So, we have the right to charge a Medicare beneficiary upfront prior to delivering that service?

CMS - (Demetrios Kouzoukas): Sounds like an ABN question.

Steve Gillis: Is it statutorily excluded? (Method).

CMS - (Demetrios Kouzoukas): That's a – I don't know if we have any of our billing folks there or folks who – familiar with the ABN process about the circumstances under which that can be done and how, if you want to speak to that. Anyone from our team?

CMS - Female: I think that would be the Medicare Enrollment and Appeals Group, so I don't think we have the right people on the call.

CMS - (Demetrios Kouzoukas): OK. Well, I'll give you – this is answer and we can – if you need more, we can work that work group to get you that. But essentially if you're following the applicable procedures for an ABN which you might well be familiar with already. I just don't have the details at hand, then refer non-covered services and you'd be able to proceed to treat – to bill for a non-covered service. You just have to follow the requirements about when an ABN applies and how.

Steve Gillis: OK. So then asymptomatic or no known COVID exposure, non-coverage for Medicare beneficiaries?

CMS - (Demetrios Kouzoukas): (Tim), do you have anything to add to, sort of the way of being

characterized here? I think we've spoken in terms of screening and preventive that we don't have a statutory authority to go there but at the ...

CMS - (Tim): Right, yes – no (Demetrios). I thought you – yes, I thought you characterized it correctly and accurately and that's the guidance we gave. I don't have an answer on the ABN issue though.

CMS - (Demetrios Kouzoukas): OK.

Steve Gillis: OK. It just seems as though now there's a lot more communication from state leaderships and other prominent leaders suggesting to get tested just for the sake of getting tested. So, it will be great if you could provide additional guidance to the MACs, so that we could get guidance from the MACs because these questions had been asked and we haven't been able to get a direct answer on that, so thank you.

CMS - (Demetrios Kouzoukas): (Tim), do you have any thoughts on that or maybe tell us which MAC in particular?

Steve Gillis: NGS, National Government Services.

CMS - (Female): OK. We can reach out to NGS to see what's going on but they do have, as Demetrios has outlined, they do have – they do have instruction along those lines.

Steve Gillis: OK, thank you.

Operator: Your next question comes from the line of Diane Collins. Your line is open.

Diane Collins: Hi, this is Diane Collins with Baylor Scott & White Health. My colleague was previously on the call and she did address the question, so I don't need any time to ask again. Thank you very much.

CMS - Alina Czekai: And we'll take our next question please.

Operator: Your next question comes from the line of (Christy Taylor) from (Afta Government Affairs). Your line is open.

(Christie Seiler): Thank you. This is (Christie Seiler) with (inaudible). Our question is CMS willing to eliminate the plan of care signature requirement during the COVID-19 pandemic?

This is necessary because during normal circumstances compliance with the physician signature requirement imposes a significant with difficult and administrative burden for both therapy providers and the physicians, taking valuable time and resources away for (delivering) patient, waiting for a plan of care certification (of course) delays of clinically significant.

CMS - (Demetrios Kouzoukas): I feel like we got Connie on from CPI. I don't know if you're in a position to answer that.

CMS - Connie Leonard: Hi, (Demetrios), this is Connie. So far, we have only waived signatures when it's been from a beneficiary signature perspective. We have not waived any signatures from a physician's perspective. My suggestion, if you want us to take another look at that would be to send it into the mailbox with a little bit more detail. As to the (burden) it's causing and why it's causing it, so that we can reexamine it with the appropriate staff.

(Christie Seiler): OK and that is the same – the covid-19@cms.hhs.gov?

CMS - Connie Leonard: Correct, that's the e-mail and then they'll get it to – they'll get it over to me.

(Christie Seiler): Do I need to address it to you?

CMS - Connie Leonard: That will be fine. If you want to put, please forward to Connie Leonard, that would be perfectly fine.

CMS - Alina Czekai: We'll (move) to our next question, please.

Operator: Your next question comes from the line of Debra Walsh from Eastern Health. Your line is open.

Debra Walsh: Hello, thank you for taking my call. My question is in how to bill for the administration fee of the COVID vaccine. I realized that the vaccine itself is going to be supplied for free but when we submit our claim for the

administration charge, will we get a denial if we don't have a vaccine charge to go along with the administration charge? Should we be putting a penny for the vaccine itself?

CMS - (Diane Kovach): No, this is (Diane Kovach), and you will not get a denial if you go just for the administration during the time when you get the vaccine itself for free, so you should just go for the administration.

Debra Walsh: OK, so we don't need any other modifiers or anything else on our claim, will – it should get paid with just the administration charge?

CMS - (Diane Kovach): That's correct.

Debra Walsh: All right, thank you.

CMS - (Diane Kovach): Thank you.

Operator: Your next question comes from the line of Maria Tiberend from BJC Healthcare. Your line is open.

Maria Tiberend: Hi, thank you for taking my question. I'm following up from the last call regarding whether or not hospital outpatient therapy departments are eligible providers to bill the e-visit codes, the G2061 or G2063. I can see in the FAQs and other information that independent physical therapists are able to bill that on a 1500, but our question is about hospital employed therapist billing on a UB.

CMS - Male: So, I think this would have the same sort of response as the prior question and if there's a hospital service being provided as if it were in person and there is not a distant site practitioner, then it can be billed as it was a hospital service, assuming the patient's home has received a temporary extraordinary circumstances relocation request.

Maria Tiberend: OK, so when you say assuming the professionals – I mean we're speaking the physical therapists, this is (not) a physician service. Does that make sense?

CMS - Male: It does.

Maria Tiberend: OK, OK. Thank you.

Operator: Your next question comes from the line of (Dave Gothill) from Legacy health System. Your line is open.

(Dave Gothill): Hi, thank you for taking my call. Similar questions that had been asked previously, it's regarding telephone visits. But, we got a situation where an employed physician is working in a provider base location, the physician is billing the 99442 code for example and wondering if we could get some guidance on whether it's appropriate to bill a facility fee for that and whether that will qualify for the G-codes in certain circumstances or would they always be the Q3014?

CMS - Female: Hey, so I can start. So in instances where the practitioner did billing for the – for the 99442, there's a separate sort of professional claim for that sort of – for that telehealth service and the hospital is an originating site and they would bill for the originating site facility fee which would be the Q-code.

(Dave), I don't know if you want to speak to other scenarios?

CMS - (Dave): Sure and so – and again that is in the case if there's a distant site practitioner providing the service. If the – if the practitioner is at the hospital location, in that case the service provided remotely to the patient's home can be billed as if it were a face-to-face visit at the hospital location using the G0463, assuming again that the patient's home has received a temporary extraordinary circumstances relocation request and is now part of the hospital.

(Dave Gothill): OK, thank you very much.

Operator: Your next question comes from the line of Natalie Chadwell from University of Illinois. Your line is open.

Natalie Chadwell: Hi. I have a question about the alternative care site. I wanted to know where I can find information on what services can be provided, particularly can infusion services be provided in these COVID tents?

CMS - (Demetrios Kouzoukas): So, I'll invite my – any of our CCSQ colleagues or others to add

on to my response but the – there are a list of specific waivers of conditions of participation that facilitate the alternative care sites. And so, it is really ultimately a function of what the patient needs are and then in an individual case and whether that implicates any of the conditions of participation.

Natalie Chadwell: OK.

CMS - (Demetrios Kouzoukas): I (think) that's generally infusion just at a high level is the kind of thing that we've seen hospitals used in alternative care sites. So, that is not likely going to be an issue under the – as long as you're following the conditions of the waiver but obviously every case might involve some particular service or patient need.

And so that's part of I think the assessment that a hospital or others would be making in determining which waivers to rely on, what they might need in terms of putting together the suite of services they might provide in alternative care sites.

Natalie Chadwell: OK.

CMS - (Demetrios Kouzoukas): But we are – we did envision infusion as being within the scope of the kinds of things we're hoping that can be done in alternative care sites and I think some hospitals are doing things like that.

Natalie Chadwell: OK, thank you.

Operator: Once again to ask a question, you will need to press "star" "1" on your telephone keypad. Your next question comes from the line of Ronald Hirsch from R1. Your line is open.

Ronald Hirsch: Hi guys, first I want to say it's wonderful to hear Connie Leonard on these calls. She's an asset to CMS. So, first thing is a follow up to the phone call question. The gentleman who answered it with the 9942 kept referring to if the patient's home is designated as a temporary location or relocation. Wouldn't the same thing apply, you could use a G0463 if it's just set as a temporary location but without a relocation, official notification? So, we would just use the PN modifier (inaudible) through.

CMS - Male: That's correct.

Ronald Hirsch: OK, I just wanted to ask ...

CMS - Male: That's correct, you could use the PN modifier in that circumstance, the other ...

Ronald Hirsch: Right.

CMS - Male: ... circumstance, you use the PN modifier.

Ronald Hirsch: Right, well it's payment equity, so really it's not worth the hassle of reporting the address. So, my real question is with the 20 percent DRG thing, we're now seeing a lot of patients being referred from places like group homes or long-term care facilities that have a rapid point of care test, where there's no written result that comes out of those machines. They get a positive, they send the patient to the hospital.

Can a – like a note from a nurse or somebody at that facility same patient tested point of care positive, will that suffice as proof of a positive test and be reportable as such, and, therefore eligible or must the hospital retest the patient to get their own result?

CMS - Connie Leonard: So, this is Connie Leonard and I can talk about it from a (inaudible) perspective. I think the hospital should put as much information in the medical record as possible regarding the rapid test and that there is a positive diagnosis or positive results from the test. And I believe that would be enough.

I will take that back and see if we – if others disagree, if we need to update our FAQ or not. But I feel like as long as the detail is in there from a clinician, it would probably be enough. I don't know if anyone else on the phone from the (inaudible) area has anything else to add.

Ronald Hirsch: And I'll just add in a previous call, they said if a patient went through a drive-thru clinic or somewhere else and they were told that it was positive that would not suffice. So, I don't hear it as you mentioned the clinician documenting it would be more evidence.

CMS - Connie Leonard: Exactly. I think that that would be the difference. We would be looking in the medical record for a clinician stating that there was a positive result versus the beneficiary from the drive-thru. But we'll also take that back and talk to some others and make sure that that is the correct answer. And if we need to update in FAQs, we'll either do it on the next Office Hours or through the FAQs that are posted.

Ronald Hirsch: Thank you, Connie.

Operator: Once again, to ask a question, you will need to press "star" "1" on your telephone keypad. You have another question from Joanne Becker from University of Iowa. Your line is open.

Joanne Becker: Hi. This is Joanne again from the University of Iowa. Thank you. We have another question. This is in regards to the provisional provider enrollment relief for residents and fellows to re-enroll from the ordering, referring, prescribing privileges to billing privileges. And then, once the PHE is over, then re-enrolling in the ordering, referring, and prescribing privileges.

We understand that the process to do this can be quite onerous. And it can be quite time consuming. So, we've heard some conflicting responses about whether or not that re-enrollment for after the PHE from a billing provider to the ordering, referring, prescribing provider is automatic or is that going to have to be kind of manually done through the re-enrollment process?

I'm sorry. I was just going to add – and the other concern is that residents and fellows have is that it could be disruptive of them completing all of their residency program requirements if they can't get back, re-enroll timely. So, that was the concern.

CMS - (Alicia): Hi. This is (Alicia). And if they want to – after the PHE is over, if they want to remain as the billing provider, that enrollment would still allow them to order and refer. So, there's not necessarily a change that needs to be made unless they want to move back to strictly being able to order and refer only.

We do have an option online if you enroll through (payco) to convert your enrollment from the ordering, referring to a billing providers and vice versa. That's a really simple process. So, if you need to do that then that probably would be the best option for you, so easily convert and not go through the entire paper process.

Joanne Becker: OK. That's really helpful. I think that the issue remains if they remain a billing provider then the issue might remain with the residency completion requirements. But we'll take that back. Thank you.

CMS - (Alicia): You're welcome.

Operator: Your next question comes from the phone number ending 2320. Please state your first and last name and your organization name. Your line is open.

Female: (Inaudible) and we're calling with regards to a facility question. If a therapist, for example, registered dietitian, SLP, PT, OT, who is doing an audio-only phone call using 98966 through 98968 with the PN modifier, can that clinician call the patient at home from their own home or do they have to be in the outpatient clinic? In other words, does a location of the clinician for hospital billing matter?

CMS - Male: So, again, as I mentioned with this provision of the remote services, the differentiators that there's a distant site practitioner which would then necessitate the use of the telehealth codes. If that's not the case, then you would have availability of the hospital services codes rather than telehealth if there's not a distant site practitioner ...

Female: OK. So ...

CMS - Male: ... or as a service.

Female: So, the hospital service – so, in other words, same thing with either an registered nurse or pharmacist. If they were to call the patient from their own home while the patient is at home and they’re using the PN modifier because the patient's home becomes provider-based department, that would be allowed.

It's more of the location of the person making the phone call. There's no distant site. It's only hospital billing. So, there's no professional bill.

CMS - Male: Yes. So, again, if the – if there's not a physician at the distant site, it is a service that could – that it is a hospital service and the patient's remote location is now being billed as part of the hospital then the hospital can bill for those services as if they were provided in the facility.

Female: OK. Thank you so much.

Operator: Your next question comes from the line of (Rosy Fossle) from AdventHealth (inaudible). Your line is open.

(Rosy Fossle): Hello. I have a question about the CMS ruling, the most recent one, about U0005, and proving our turnaround time, our – within two days. So, in January, are we going to be looking at December 2020's overall turnaround time? And then the individual test done in January?

CMS - (Sara Chairee): Hi, there. Yes. This is (Sara). And that's correct. For January claims, you can go use the U0005 based on information from the month of December 2020.

(Rosy Fossle): OK. And I have one additional question about how we report U0005. Do we bill this on the claim like any other charge, like we assign a charge amount to it or is there a specific spot in the UB that it's supposed to go?

CMS - (Sara Chairee): There's no specific spot, I believe, and if anyone in the claims area can help me. But it would – it's like any other HCPCS code.

(Rosy Fossle): OK. So, we would just assign it the right revenue code and report it with the HCPCS with the charge and you would pay it $25.

CMS - (Sara Chairee): Correct.

(Rosy Fossle): OK. Thank you very much.

CMS - (Sara Chairee): You're welcome.

Operator: Once again, to ask a question, you will need to press "star" "1" on your telephone keypad. Your next question comes from the line of Joanny Diaz from C&OPD. Your line is open.

Johnny Diaz: Hi. Good evening. Thank you so much for taking my call. My name is Johnny Diaz. I'm a respiratory practitioner. Prior to COVID, I've done a lot of research with hospital readmissions, which thankfully our agencies have been able to decrease by 100 percent on 30, 60, 90 days.

The challenges is now with COVID, we're getting a significant amount of patients that may be COVID positive still and coming home. I have not been able to obtain a clear answer to – can we bill for respiratory care in a home care setting. And if I'm in the wrong line, please direct me to the right line.

I've been really trying to communicate what we've accomplished for a long time and kind of been circling. So, I hope I can be redirected if so. If not, I'd love to know if there's a code, (G-Code, CPT Code) code that can be recognized by Medicare for home – respiratory at home.

CMS - Demetrios Kouzoukas: Is the question about an outpatient – hospital outpatient department providing respiratory care and how under the hospital without walls waivers or hospital at home current situation or is it something different?

Johnny Diaz: It seems like a combination of what I've been doing is working with our local hospitals and like we were discussing virtual. Sometimes, I will see a patient with pulmonary team – let's say, for her, she (med pen) medicine. And there are trach and vented patient post COVID that we're managing. And they're doing a virtual visit.

But I personally can't bill for that visit. The doctor may (ask) is what I'm hearing from our conversation. The doctors are able to bill for that virtual call. But as a respiratory practitioner, nursing, PT, OT, speech, everyone else is OK to bill Medicare.

I have a G code but I don't think it's recognized by Medicare. Our agency has been really suffering with that concept. And I have not been able to find someone to assist us with that.

CMS - Demetrios Kouzoukas: I think what we – I'm trying to figure out the best way to help you because I think what you're asking about probably involves – fairly involves sort of individual situation. It seems to me that the best approach for what you're engaged in might be to – for the outpatient department to bill. But I think what you're asking for is you want to bill directly as a professional, right – if I have that right.

Johnny Diaz: That's correct. Yes. I mean, we're taking high (inaudible) patients with greater than 75 percent FiO2. Essentially, our home care model simulates an intermediate unit. They're from the ICU and they're (stock) or they're at an (out tack). And they're saying we can't get the station in a nursing facility and/or home especially with COVID.

Are we able to – is my agency able to handle it? Well, I've done research for 10 years and I have accomplished that to bring patients home on greater than 75 liters and even greater than 88 percent FiO2, which is very delicate. But thankfully, we have had success and we've also had decannulations and also vent weans.

Now, all that sounds great. But I've never been able to bill for a vent wean at home, decannulation at home, and obviously, I work under the supervision of a pulmonologist, and working together at that. So, a lot of great production and notes and reflection of patients progress especially with COVID.

And I'm just – my hands are tied. Everybody is all excited about our company providing these services, but I don't get any reimbursement or any support. So, I have to get down to the bottom of how we can do that so we can continue to serve more of this community which sometimes is stuck in a facility at home or increasing length of stay and out tack as well as hospitals.

CMS - Demetrios Kouzoukas: How do you bill for the service when it's in person?

Johnny Diaz: There's no code. I kind of just take what we are able to get in comprehensive amount that we get from Medicare. And we divvy out our 30 visits throughout the clinicians that we have. And I kind of eat the cost. I'm getting to the point as a person that wants to continue to service these patients that I have to get to the bottom of that. I've been eating the cost of that for the last two years.

CMS - Demetrios Kouzoukas: OK.

Johnny Diaz: And now with COVID, it's a more prevalent. We got a patient that on paper he's excessively sick and he was on 72 percent FiO2 with a 45-liter flow. We were able to bring him home and certain codes don't allow us to use the BiPAP for this patient. He's not OSA. But I utilize the BiPAP to provide some support in a high-flow device called AIRVO, which Medicare does not acknowledge as well.

It's very inexpensive but there's no reimbursement for it. So, I'm doing a lot of work to maintain these patients and thank God, good outcomes but not financial support. So, I've been trying to – I've been a clinician for a long time. And the last six months, nine months, because of COVID, I've rolled up my sleeves and become more of the administrator of my company to know the ins and outs and I've gotten to the point where I want to keep providing these services but my hands are tied.

And by the way, that patient is doing great. He just came home. I mean, we had a lot of patients but he was very delicate and he came home and he's doing well based on the supplies and equipment that I provide that. It's not under Medicare coding.

So, I just wish I got a little more support with that (inaudible) that Medicare can see that sometimes unconventional equipment; BiPAPs and AIRVOs, and high-flow devices can be provided at home with a good clinical team that has the knowledge of it as well as family education.

CMS - Male: I think we certainly appreciate all of the work that you're doing. I think the issue has to do with the benefits that are designed in the law in terms of who can bill for which services under Medicare. And it sounds like the services with the expertise that you're providing are billed as hospital services.

And so, the rules regarding hospital services would apply. But we're certainly happy to take any more information that you have in writing and we can take a look to make sure that there's nothing else. So, thank you again.

Johnny Diaz: Yes. Thank you so much. I really appreciate that. Obviously, you guys have my contact. I'd be happy to present to you what we've accomplished and however way I can help us nationally in any way possible. It's my intention. I have a kid with special needs and it's what got me into creating the first respiratory home care.

You couldn't ask for more on this person to say – here's how we could save some money. Here's how we can provide some service. Here's how we can expand the shortness of staffing buy providing respiratory and partnering nursing and respiratory together. And I'd be happy to do that if you guys will just give me the opportunity.

CMS - Demetrios Kouzoukas: Thank you. All right, our challenge is always that the statute and the laws that Congress passes in Medicare fee for service are by definition they're sort of category by category and there's a category for physician services and a category for hospital services. And you might be asking us about a – something that falls direct – in between those categories.

And so, I think that to the extent, you hoping for an answer right now, I don't think – believe that we have a category for what you're describing. But again, if you wanted to send more details and we had a different thought based on that, we would have to just let you know.

Johnny Diaz: Thank you so much.

CMS - Alina Czekai: And we'll take our final question tonight. Thank you.

Operator: Your final question comes from the line of [Tanya (Inaudible)]. Your line is open.

(Tanya): Hi. I've got a couple of questions. So, piggybacking on the admin question earlier, we are wondering how you're not going to deny it. That's the same CPT code as any of the other infusions that we bill.

CMS – Diane Kovach: I'm sorry. Could you repeat that question please?

(Tanya): Yes. So, earlier, someone did ask about that admin only charge and that it won't be denied. How are you going to identify those so that they won't be denied because it's the same CPT code that we use for our other infusions?

CMS – Diane Kovach: So, it will not be the same CPT code that you use for the other infusions and Jason Bennett can jump in here if I say anything incorrect. But the intention, I believe, is to have a separate infusion and vaccine code for each different vaccine that's available.

(Tanya): OK.

CMS - Jason Bennett: Yes. That's correct. And if you're asking specifically about the recently approved monoclonal antibody bamlanivimab, you would bill using administration code M0239 for Medicare.

(Tanya): OK. And then I have one other question. If the vaccine admin antibody and antibody admin are covered without a copayment, should we be (appending) the CS modifier to those codes? And is the waiving of the copayment only during the public health emergency?

CMS – Diane Kovach: So, you do not need to bill the CS modifier because the system is set up to automatically not apply any co-insurance.

(Tanya): OK. And is the waiving of the copayment only during the public health emergency time or will it be waived after that?

CMS – Diane Kovach: So, I will start rather – I'm sorry. If you want to address that, (Ryan), please go right ahead.

CMS - (Ryan): Sure. So, I would say under the current policy that's articulated, Medicare will pay for the monoclonal antibodies as we do for vaccines. And I think that that will remain in effect until the policy is addressed at a later date, which we

would anticipate as we've stated in the fourth interim final rule that we would address continuing payment rules surrounding products paid as vaccines through future notice and (common) rule making.

And so, it's a long winded way of saying that will be the case until a policy change is addressed in the future.

(Tanya): Thank you.

Alina Czekai: Thank you. And thanks everyone for joining our call today. We will not have Office Hours next week because it's Thanksgiving. Hope you all have a nice Thanksgiving with your family and friends. Many of you probably celebrating at a distance this year.

In the meantime, you can continue to submit any questions to our COVID mailbox, which again is covid-19@cms.hhs.gov. This concludes today's call. Have a nice rest of your day.

End