Summary of Second CMS Interim Final Rule on COVID-19 Public Health Emergency

On April 30, 2020, the Centers for Medicare and Medicaid Services (CMS) released a second Interim Final Rule intended to provide flexibility to providers during the COVID-19 pandemic, titled *Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Report* (April 30th IFC). This rule implements statutory changes required in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and further clarifies policy changes included the previously published *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency* (March 30th IFC). Most provisions of both rules are considered in effect for services provided as of March 1, 2020, through December 31, 2020, or when the public health emergency (PHE) declaration is no longer in effect.

Evaluation and Management (E/M) Services: Payment for Audio-Only Services

In the March 30th IFC, CMS established coverage for audio-only E/M services. However, because many beneficiaries struggle with video-enabled communication technology, audio-only services are more prevalent than expected. To ensure adequate reimbursement, in the April 30th IFC, CMS increased national average payment rates for audio-only services to mirror the face-to-face level 2, 3, and 4 office/outpatient E/M for established patients as follows:

- CPT code 99441 - $46. (5-10 minutes of medical discussion)
- CPT code 99442 - $76 (11-20 minutes of medical discussion)
- CPT code 99443 - $110 (21-30 minutes of medical discussion)

Use of Time for E/M Code Selection for Telehealth and Future Updates to the Telehealth List

In the March 30th IFC, CMS specified that E/M office/outpatient CPT Codes 99201-99215 could be billed for telehealth services as long as a video component was provided and that medical decision making criteria (MDM) or time could be used to determine code selection. In this April 30th IFC, CMS clarified that the times included in the CPT Code descriptors should be used to choose which level of CPT code to bill.

CMS stated in the April 30th IFC that for future additions of services to the Medicare telehealth list, for the duration of the PHE, CMS may use a sub-regulatory process to modify the services included on the Medicare telehealth list.

Expansion of the Primary Care Exception for Residents and Supervision Clarification

Currently, Medicare makes Physician Fee Schedule (PFS) payments in primary care settings only for certain services of lower and mid-level complexity furnished by a resident without the physical presence of a teaching physician, which is referred to as the “primary care exception.” The E/M codes that can be furnished under the primary care exception are the following:

CPT Codes	99201, 99202, 99203, 99211, 99212, 99213
HCPCS Codes	G0402, G0438, G0439

To increase capacity during the pandemic, in the April 30th IFC, CMS added services which will be paid under the PFS when furnished by a resident under the primary care exception, including:

CPT Codes	99441, 99442, 99443, 99495, 99496, 99421, 99422, 99432, 99452
HCPCS Code	G2012, G2010

In the March 30th IFC, CMS stated the presence of a teaching physician can be met, at a minimum, through direct supervision by audio/video real-time communications technology. In the April 30th IFC, CMS added, on an interim basis, that the teaching physician may not only direct the care furnished by residents, but also review the services provided with the resident, during or immediately after the visit, remotely through virtual, real time communications technology. CMS noted that the remainder of the teaching physician policies continue to apply.

Relocating Provider-Based Departments (PBD)

CMS varies payment to hospitals' provider-based departments (PBDs) depending on if a PBD is located on-campus versus off-campus or considered "excepted" under Medicare policy. Generally, under Medicare, off-campus outpatient departments are paid under the applicable payment system under Medicare Part B rather than by the outpatient prospective payment system (OPPS). However, certain off-campus PBDs also may be considered excepted from this policy and paid under OPPS using a "PO" modifier.

Under the April 30th IFC, for the duration of the PHE, Medicare will allow both excepted off-campus and on-campus PBDs to relocate to off-campus locations and begin furnishing and billing for services under the OPPS. Hospitals also may register a patient's home as a PBD. Hospitals may begin furnishing and billing for services under the OPPS prior to submitting documentation to the CMS Regional Office to support the extraordinary circumstances relocation request. Additionally, hospitals do not have to submit a unique request each time it registers a patient's home as a PBD; a single submission per location is sufficient.

CMS considered hospital outpatient services in three categories under this temporary rule: (1) hospital outpatient therapy, education, and training services, including partial hospitalization program services, that can be furnished other than in-person; (2) hospital outpatient clinical staff services furnished in-person to the beneficiary; and (3) hospital services associated with a professional service delivered by telehealth.

Hospital Outpatient Therapy, Education, and Training Services
Examples of these services include psychoanalysis, psychotherapy, diabetes self-management training, and medical nutrition therapy. Under the April 30th IFC, if a hospital's clinical staff is

furnishing hospital outpatient therapy, education, and training services to a registered patient of the hospital at a temporary expansion location (including the patient's home), Medicare requirements are met. The physician supervision requirements remain in place, meaning that for most services a service must be furnished under the physician's overall direction and control, but the physician's presence is not required during the service.

Hospital In-Person Clinical Services in a Temporary Expansion Location
Hospitals also provide services that are furnished by clinical staff under a physician's or qualified nonphysician practitioner's (NPP) order that do not require professional work by the physician or qualified NPP. These services are only billed under the OPPS when furnished by the hospital and are not separately billable by the practitioner under the PFS. Examples of these services include wound care, chemotherapy administration, and other drug administration. Because these services must be provided in person by clinical staff, these services cannot be furnished by telecommunication technology by the hospital. In these instances, hospital clinical staff must be physically present in the patient's home or other temporary expansion location. Hospitals should bill for these services as they ordinarily bill for services along with any specific billing requirements for relocating PBDs (that is, appending the PO modifier for excepted items and services and the PN modifier for nonexcepted services).

Importantly, during the time period that the patient is receiving services from the hospital clinical staff as a registered outpatient, the patient's place of residence cannot be considered a home for purposes of home health services. This is because home health agencies (HHA) cannot bill for services furnished in PBDs of hospitals. When the patient is not receiving outpatient services by the hospital, the patient's home can be considered a home for purposes of the home health benefit and the HHA can furnish and bill for home health services. However, the hospital should be aware if the patient is under a home health plan of care and must not furnish services to the patient that could be furnished by the HHA while the plan of care is active.

Hospital Services Accompanying a Professional Service Furnished Via Telehealth
In the March 30th IFC, CMS instructed physicians furnishing telehealth services to beneficiaries in their homes to bill for those services in the same way they would if they were furnishing the services in person. In the April 30th IFC, CMS further clarified that, when telehealth services are furnished by a practitioner who ordinarily practices in the hospital outpatient department to a patient registered to the hospital in a location that is considered a hospital PBD (including the patient's home), the hospital in which the patient is registered may bill the originating site facility fee for the service.

Scope of Practice

For the duration of the PHE, CMS altered certain Medicare regulations for nonphysician practitioners (NPPs) which contain more restrictive supervision requirements than existing state scope of practice laws or which limit health professionals from practicing at the top of their license. Specifically, on an interim basis, CMS amended regulations to specify that diagnostic tests covered by Medicare and payable under the physician fee schedule (PFS) may be furnished by a nurse practitioner (NP), clinical nurse specialist (CNS), and physician's assistant (PA), and Certified Nurse Midwife (CNM). Additionally, CMS will allow NP, CNS, PA and CNM to

supervise COVID-19-related diagnostic psychological and neuropsychological testing services, in addition to physicians and clinical psychologists (CPs) who are currently authorized to supervise these tests. PAs may also perform these tests without physician supervision when authorized to do so under state law. CMS also changed rules to permit physical therapy assistants and occupational therapy assistants to perform maintenance therapy services if the program already is established by a physical therapist or occupational therapist.

Finally, CMS highlighted that pharmacists are auxiliary personnel under Medicare regulations. Therefore, pharmacists may provide services incident-to the services, and under the appropriate level of supervision, of the billing physician or NPP, if payment for the services is not made under the Medicare Part D benefit. This is not new policy, but CMS emphasized it to encourage innovative uses of pharmacists during the PHE.

Certification and Care Planning for Medicare Home Health Services

In the March 30th IFC, CMS expanded which beneficiaries may be considered "homebound", either because a practitioner has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19, or because a practitioner has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

The CARES Act, passed on March 27, 2020, amended Medicare to allow NPs, CNSs, and PAs to: (1) order and certify patients for eligibility under the Medicare home health benefit; and (2) establish and periodically review the home health plan of care. Additionally, the CARES Act amended Medicare to allow CNMs, NPs, CNSs, or PAs to establish policies that govern the services (and supervision of such services) provided to patients under the Medicare home health benefit. CNMs, NPs, CNSs, or PAs also may certify that an individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual is unable to learn the skills needed to self-administer the osteoporosis drug or is otherwise mentally or physically incapable of self-administering such drug. Finally, the CARES Act amended Medicare to allow payment for the furnishing of items and services under the home health prospective payment system when these items and services are prescribed by an NP, CNS, or PA. CMS applied these changes retroactively to March 1, 2020.

To facilitate these changes, CMS amended regulations to add NP, a CNS, and PAs as "allowed practitioners" for purposes of the Medicare home health benefit. Additionally, CMS amended the regulations so that all allowed practitioners may perform the face-to-face encounter for the patient for whom they are certifying eligibility. NPPs do not need communicate the clinical finding of the face-to-face encounter to the ordering physician. CMS noted that these changes are being implemented via the April 30th IFC rather than through notice-and-comment rulemaking. However, these changes are permanent and not time limited to the period of the PHE.

Modification of Previous Guidance on the "3-Hour Rule" for IRFs

The CARES Act requires waiver of the so-called "3-hour rule" for Inpatient Rehabilitation Facilities (IRF). CMS previously waived this rule under its own authority; however, the March 30th IFC was written prior to passage of the CARES Act. As such, CMS rescinded the clarifications provided in the March 31st IFC related to the 3-hour rule. In accordance with the CARES Act, in the April 30th IFC, CMS revised guidance for IRFs to state that IRF coverage criteria continue to be required except solely for care furnished in a freestanding IRF hospital to patients moved to the IRF to relieve acute care hospital capacity in an area that is experiencing a surge of patients during the PHE. For all other patients, IRF criteria continue to be in place, including the 3-hour rule, appropriate documentation in the medical record, and the use of interdisciplinary care teams.

Medical Education Payments to Teaching Hospitals

In the April 30th IFC, CMS changed policies during the PHE so that hospitals, IRFs, and Inpatient Psychiatric Facilities (IPFs) do not experience reductions in medical education or teaching status adjustment payment amounts.
To prevent reductions in payment during the PHE, for purposes of IME and DGME payments, CMS will allow teaching hospitals to claim the time spent by residents training at other hospitals, if the following conditions are met:

(1) The sending hospital sends the resident to another hospital in response to the COVID- 19 pandemic. (This criterion would be met if either the sending hospital or the other hospital are treating COVID-19 patients. CMS will not require that the resident be involved in the care of patients with COVID-19 for the sending hospital to demonstrate that it sent the resident to the other hospital in response to the pandemic.)

(2) The time spent by the resident at the other hospital would be considered to be time spent in approved training if the activities performed by the resident at the other hospital are consistent with any guidance in effect during the COVID-19 PHE for the approved medical residency program at the sending hospital.

(3) The time that the resident spent training immediately prior to and/or subsequent to the timeframe that the PHE associated with COVID-19 was in effect was included in the sending hospital's FTE resident count.