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

On March 31, 2020, the Centers for Medicare and Medicaid Services (CMS) released an Interim Final Rule intended to provide flexibility to providers during the COVID-19 pandemic, titled *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency* (Final Rule). During the course of the COVID-19 Public Health Emergency (PHE), CMS is adding many services to the list of eligible Medicare telehealth services, eliminating certain frequency limitations for services, and clarifying several payment rules that apply to other services that are furnished using telecommunications. The Interim Final Rule also allows for supervision by a physician to be furnished remotely. CMS backdated the Final Rule's applicability to March 1, 2020, meaning that services provided since then are governed by the new policies. Although in effect now, the Final Rule is open to public comment until June 1, 2020.

Site of Service Changes

On an interim basis, starting on March 6, 2020, Medicare will pay for telehealth services to patients located anywhere in the country, including in a patient's place of residence. CMS states that payment to the furnishing provider should reflect costs as if the services were furnished in person. Therefore, CMS instructs physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code as if the service were furnished in person. Additionally, CMS requests that CPT telehealth modifier 95 be applied to claims to describe services furnished via telehealth. CMS also will maintain the facility payment rate for services billed using the general telehealth POS code 02 should practitioners choose to maintain their current billing practices for Medicare telehealth during the emergency period.

Addition of Services to Medicare Telehealth

The Rule adds numerous codes to Medicare telehealth services (see chart below). CMS notes that CPT codes describing Evaluation and Management (E/M) services reflect an assumption that the work involved varies, in part, based on the setting of care and the patient's status. CMS expects physicians and other practitioners to use the E/M code that best describes the nature of the care they are providing, regardless of the physical location or status of the patient.

Service Descriptor	CPT Codes
Outpatient/Office E/M Codes	99201, 99202, 99203, 99204, 99205, 99206, 99207, 99208, 99209, 99210, 99211, 99212, 99213, 99214, 99215
Emergency Department Visits	99281, 99282, 99283, 99284, 99285
Initial and Subsequent Observation, and Observation Discharge Day Management	99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236

Initial Hospital Care and Hospital Discharge Day Management	99221, 99222, 99223, 99238, 99239
Critical Care Services	99291, 99292
Home Visits	99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
⇒ *Home visit codes include E/M codes for new and established patients and the level of billing should vary by components of E/M visit*	
Care Planning for Patients With Cognitive Impairment	99483
Psychological and Neuropsychological Testing	96130, 96131, 96132, 96133, 96136, 96137, 96138
Therapy Services	97161, 97162, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521, 92522, 92523, 92524, 92507
⇒ *Section 1834(m) of the SSA does not provide for payment for therapy services as Medicare telehealth services when furnished by physical therapists, occupational therapists, or speech-language pathologists.*	

Code Level Selection for Office/Outpatient E/ M Visits
On an interim basis, CMS will allow level selection for office/outpatient E/M services furnished via telehealth to be based on medical decision making or time and remove any requirements regarding documentation of history and/or physical exam in the medical record.

Frequency Limitation Exceptions
Certain Medicare telehealth services include restrictions on how frequently a service may be furnished. During the emergency period, CMS removes the frequency restrictions for each of the following listed codes for subsequent inpatient visits and nursing facility visits. Additionally, CMS removes the restriction that critical care consultation codes may only be furnished to a Medicare beneficiary once per day.

Service Descriptor	**CPT Codes**
Subsequent Inpatient Visits	99231, 99232, 99233
Subsequent Nursing Facility Visits	99307, 99308, 99309, 99310
	HCPCS Codes
Critical Care Consultation Services	G0508, G0509

Telehealth Modalities and HIPAA Enforcement
Under Medicare, telephones, facsimile machines, and e-mail systems do not meet the definition of an interactive telecommunications systems for purposes of Medicare telehealth services. In addition, the HHS Office for Civil Rights is waiving penalties for HIPAA violations against

health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the PHE.

Beneficiary Cost-Sharing
On March 17, 2020, the Office of Inspector General issued a policy statement, notifying providers that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations that federal health care program beneficiaries may owe for telehealth services. This policy applies to both providers and facilities, and to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

Telephone Evaluation and Management (E/M) Services
On an interim basis for the duration of the PHE, Medicare will provide separate payment for CPT codes 98966–98968 and CPT codes 99441–99443. CMS will not conduct review of whether these services were furnished to new or established patients. CPT codes 98966–98968 describe assessment and management services performed by practitioners who cannot separately bill for E/M, such as Licensed Clinical Social Workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists.

Communication Technology-Based Services (CTBS)
Medicare routinely pays for services that are furnished via telecommunications technology but are not considered Medicare telehealth services. During the PHE, CMS will allow these services to be billed for both new and established patients.

Service Descriptor	**CPT Codes**
Online digital E/M service	99421, 99422, 99423
	HCPCS Codes
Remote evaluation of recorded video and/or images	G2010
Brief communication technology-based service, e.g. virtual check-in	G2012
Qualified nonphysician healthcare professional online assessment and management	G2061, G2062, G2063

On an interim basis, CMS broadens the availability of HCPCS codes G2010 and G2012 to include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists. CMS seeks input on other kinds of practitioners who might be furnishing these kinds of services during the PHE.

Direct Supervision by Interactive Telecommunications Technology
The Medicare Physician Fee Schedule (PFS) pays for a number of services when provided under the supervision of physician or nonphysician practitioner (NPP). In many cases, the supervision requirements in physician office settings necessitate the presence of the physician or NPP in a particular location, usually in the same location as the beneficiary when the service is provided. During the PHE, CMS revises the definition of direct supervision to include real-time, interactive

audio and video technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. This change is limited to only the manner in which the supervision requirement can be met and does not change the underlying payment or coverage policies related to the scope of Medicare benefits.

CMS explicitly specifies that these direct supervision changes apply to diagnostic services furnished directly or under arrangement in the hospital or outpatient department of the hospital, and to pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services.

CMS also states that direct supervision can include virtual presence through audio/video real-time communications technology where the physician enters into a contractual arrangement for auxiliary personnel. For example, physicians may enter into contractual arrangements with a home health agency or a qualified infusion therapy supplier in order to utilize their clinical staff as auxiliary personnel under leased employment. In such instances, the provider/supplier would seek payment for any services they provided from the billing practitioner and would not submit claims to Medicare for such services.

CMS notes that to be covered under Part B drugs furnished ''incident to'' a service are typically injectable drugs that are bought by the physician, administered in the physician's office, and then billed by the physician to the Medicare Administrative Contractor (MAC). By definition, ''incident to a physician's professional service'' requires the item or service to be billed by the physician. CMS notes that, even in the context of the PHE, furnishing certain services without the physical presence of the physician in the same location could be inappropriate. However, CMS indicates that individual practitioners are in the best position to make decisions based on their clinical judgement in particular circumstances. As such, the supervision changes apply to "incident to" Part B drugs during the PHE as the clinician finds appropriate. CMS seeks information whether there should be guardrails to this policy and what kind of risk this policy might introduce for beneficiaries.

Clarification of Homebound Status Under the Medicare Home Health Benefit

Under Medicare, an individual is considered to be ''confined to his home'' if the individual has a condition that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device, or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden, the condition of the individual should be such that there exists a normal inability to leave the home. During the PHE, CMS expands the homebound definition to include an individual if: (1) a physician 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 (2) a physician 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. In cases where it is medically contraindicated for the patient to leave the home, the medical record documentation for the patient must include information as to why the condition of the patient is such that leaving the home is medically contraindicated.

Use of Telecommunications Technology Under the Medicare Home Health Benefit
Under Medicare, home health benefits are paid as a ‘‘bundled’’ 30-day unit of payment that is adjusted for case-mix and area wage differences. Home health agencies (HHAs) may furnish services via a telecommunications system, as long as such services do not: (1) substitute for in-person home health services; and (2) are not considered a home health visit for purposes of eligibility or payment. Although CMS cannot waive these statutory requirements, CMS provided guidance on how HHAs can use telecommunications under the home health benefit. Specifically, HHAs may use technology to optimize services as long as the plan of care describes how the technology will help to achieve goals without substituting for an in-person visit.

Use of Technology Under the Medicare Hospice Benefit
For the duration of the PHE, CMS will allow hospices to provide routine home care via telecommunications if it is feasible and appropriate to do so. The use of such technology must be included on the plan of care and must be tied to patient specific needs.

Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement
Medicare requires a face-to-face encounter to recertify hospice benefits. During the PHE, CMS will allow the use of telecommunications technology for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services.

Modification of the Inpatient Rehabilitation Facility (IRF) Requirements
For inpatient rehabilitation facility (IRF) admission, Medicare expects that patients require extensive physician supervision. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least three days per week. During the PHE, CMS will allow the face-to-face visits to be conducted via telehealth. Additionally, CMS will not require post-admission evaluation by physicians during the PHE. Further, under current industry standards, an intensive rehabilitation therapy program generally consists of at least three hours of therapy per day at least five days per week. While these requirements remain in place, CMS clarified that in cases where an IRF’s intensive rehabilitation therapy program is impacted by the PHE (for example, due to staffing disruptions) the IRF does not need to meet the industry standard but should instead make a note to this effect in the medical record.

Application of Teaching Physician and Moonlighting Regulations During the PHE
To increase the capacity of teaching settings to respond to the PHE, on an interim basis, CMS will permit the presence of a teaching physician to be met through direct supervision by interactive telecommunications technology during the key portion of the service. Specifically, this change applies to: all levels of an office, outpatient E/M services provided in primary care centers; interpretation of diagnostic radiology and other diagnostic tests (although the teaching physician must still review the resident’s interpretation); psychiatric services; and telehealth services by residents. This exception will not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, or anesthesia services.

To expand teaching hospitals capacity, on an interim basis, CMS will allow residents to separately bill for services under the PFS that are not related to their approved GME programs. For example, a resident in a hospital's approved GME program for anesthesia, who typically furnishes only anesthesia-related services in an operating room, can separately bill physicians' services when treating inpatients in the intensive care unit for COVID–19 infection. Services must still be identifiable physicians' services and meet the conditions of payment for physicians' services to beneficiaries. The resident must also be fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed.

Application of Certain National and Local Coverage Determination Requirements
National Coverage Determinations (NCDs) are determinations by CMS of whether a particular item or service is covered nationally under Medicare. Local Coverage Determinations (LCDs) are determinations by a Medicare Administrative Contractor (MAC) with respect to whether or not a particular item or service is covered in the MAC's geographical areas. On an interim basis, CMS is lifting NCDs and LCDs that would otherwise require a face-to-face or in-person visit. However, statutorily required face-to-face encounter requirements, such as for DMEPOS Power Mobility Devices, continue to apply. Additionally, CMS will not enforce the clinical indications for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs.

To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish a service, procedure or any portion thereof, CMS will allow the chief medical officer or equivalent of a facility to authorize another physician specialty or other practitioner type to meet those requirements during the PHE. Additionally, to the extent NCDs and LCDs require a physician or physician specialty to supervise other practitioners, professionals or qualified personnel, the chief medical officer of a facility can authorize that such supervision requirements do not apply during the PHE.

Counting of Resident Time
For the duration of the PHE, CMS will permit hospitals to claim residents for IME and DGME purposes when paying residents' salary and fringe benefits for the time that the resident is at home or in the home of a patient if the resident is performing patient care duties.

Expansion of Practitioners Who Can Order Medicaid Home Health Benefits
Current Medicaid regulations require an individual's physician to order home health services as part of a written plan of care. To expand workforce capacity, CMS will allow licensed practitioners practicing within their scope of practice, such as, but not limited to, Nurse Practitioners and Physician Assistants, to order Medicaid home health services during the PHE. This change applies to who can order Medicaid home health nursing and aide services, medical supplies, equipment and appliances and physical therapy, occupational therapy or speech pathology and audiology services covered, but does not expand the benefit categories.

Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital
Medicare typically does not allow for routine, inpatient hospital services to be provided under arrangement outside the hospital. However, if routine services are provided under arrangements outside the hospital to its inpatients during the PHE, CMS will consider these services as being

provided by the hospital. Hospitals need to continue to exercise sufficient control and responsibility over the use of hospital resources in treating patients regardless of whether that treatment occurs in the hospital or outside the hospital under arrangements.

Advance Payments to Suppliers Furnishing Items and Services Under Part B
CMS is expanding its authority to make advanced payment to Part B suppliers during the PHE to include situations where the contractor is unable to process the claim timely, or is at risk of being untimely in processing the claim; or when the supplier has experienced a temporary delay in preparing and submitting bills to the contractor beyond its normal billing cycle.