Issue Brief

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Medicare Issues Interim Final Rule On Changes Resulting From COVID-19

The Centers for Medicare & Medicaid Services has issued an interim final rule modifying a number of current regulations in response to the COVID-19 pandemic. A copy of the 229-page rule is currently available at https://www.federalregister.gov/d/2020-06990. The rule provides a 60-day comment period. Publication in the *Federal Register* is scheduled for April 6. These changes are effective March 31, 2020, with an applicable date beginning on March 1, 2020.

Many, if not all, of the items have been discussed in previously issued CMS fact sheets and updates.

CMS' latest updates and changes about its changes resulting from COVID-19 can be found at https://www.cms.gov/About-CMS/Agency-information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

PROVISIONS OF THE INTERIM FINAL RULE

A. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Starting on March 6, 2020, Medicare will pay for telehealth services, including office, hospital and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's place of residence. To facilitate the use of telecommunications technology as a safe substitute for in-person services, CMS, on an interim basis, also is adding many services to the list of eligible Medicare telehealth services, eliminating frequency limitations and other requirements associated with particular services furnished via telehealth, and clarifying several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks.

For Medicare telehealth services, CMS currently makes payment to the billing physician or practitioner at the Physician Fee Schedule facility rate since the facility costs (clinical staff, supplies, and equipment) associated with furnishing the service would generally be incurred by the originating site, where the patient is located, and not by the practitioner at the distant site.

CMS now is instructing physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person. CMS is finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95,

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which should be applied to claim lines that describe services furnished via telehealth.

The list of telehealth services, including the additions can be located on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html. This is an extensive list. Reported below, are the CPT codes without descriptions.

Emergency Department Visits: CPT codes:

99281	99284
99282	99285
99283	

Initial and Subsequent Observation, and Observation Discharge Day Management: CPT codes:

99217	99225
99218	99226
99219	99234
99220	99235
99224	99236

Initial Hospital Care and Hospital Discharge Day Management: CPT codes:

99221	99238
99222	99239
99223	

Initial Nursing Facility Visits and Nursing Facility Discharge Day Management: CPT codes:

99304	99315
99305	99316
99306	

Critical Care Services: CPT codes:

99291	99292

Domiciliary, Rest Home, or Custodial Care Services: CPT codes:

99327	99335
99328	99336
99334	99337

Home Visits: CPT codes:

99341	99347
99342	99348
99343	99349
99344	99350
99345	

Inpatient Neonatal and Pediatric Critical Care: CPT codes:

99468	99473
99469	99475
99471	99476

Initial and Continuing Intensive Care Services: CPT codes:

99477	99479

Care Planning for Patients With Cognitive Impairment: CPT codes:

99483	

Group Psychotherapy: CPT codes:

90853	

End-Stage Renal Disease (ESRD) Services: CPT codes:

90952	90959
90953	90962

Psychological and Neuropsychological Testing: CPT codes:

96130	96136
96131	96137
96132	96138
96133	96139

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Therapy Services
CMS says it believe there is sufficient clinical evidence to support the addition of therapy services to the Medicare telehealth list on a category 2 basis.

97161	97535
97162	97750
97163	97755
97164	99760
97165	99761
97166	92521
97167	92522
97168	92523
97110	92525
97112	92507
97116	

Radiation Treatment Management Services:
CMS is adding CPT code 77427 (Radiation treatment management, five treatments) to the telehealth list so that the required face-to-face visit can be furnished via telehealth.

B. Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations and Required "Hands-on" Visits for ESRD Monthly Capitation Payments

On an interim basis, CMS is removing the frequency restrictions for each of the following listed codes for subsequent inpatient visits and subsequent NF visits furnished via Medicare telehealth for the duration of the Public Health Emergency (PHE) for the COVID-19 pandemic. CMS also is removing the restriction that critical care consultation codes may only be furnished to a Medicare beneficiary once per day.

Subsequent Inpatient Visits: CPT codes:

99231	99233
99232	

Subsequent Nursing Facility Visits: CPT codes:

99307	99309

Critical Care Consultation Services: HCPCS codes:

G0508	G0509

Required "Hands-on" Visits for ESRD Monthly Capitation Payments:
In CY 205 CMS added ESRD related services to the Medicare telehealth list; however, CMS specified that the required clinical examination of the vascular access site must be furnished face-to-face "hands on" (without the use of an interactive telecommunications system) by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant.

CMS is exercising enforcement discretion on an interim basis to relax enforcement in connection with the requirements under Section 1881(b)(3)(B) of the Act that certain visits be furnished without the use of telehealth for services furnished during the PHE.

CMS will not conduct reviews to consider whether those visits were conducted face-to-face, without the use of telehealth. The following CPT codes, when furnished via Medicare telehealth, are impacted by these policies:

90951	90962
90952	90963
90953	90964
90954	90965
90955	90966
90957	90967
90958	90969
90959	90970
90960	

continued

C. Telehealth Modalities and Cost-sharing

Clarifying Telehealth Technology Requirements

CMS is revising §410.78(a)(3) to add an exception for the duration of the PHE for the COVID-19 pandemic providing that for the duration of the public health emergency as defined in §400.200, "interactive telecommunications system" means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

Beneficiary Cost-sharing

The Office of Inspector General issued a Policy Statement to notify physicians and other practitioners 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 furnished consistent with the then applicable coverage and payment rules.

D. Communication Technology-Based Services (CTBS)

In the context of the PHE for the COVID-19 pandemic, when brief communications with practitioners and other non-face-to-face services might mitigate the need for an in-person visit that could represent an exposure risk for vulnerable patients, CMS says it believes that services should be available to as large a population of Medicare beneficiaries as possible.

Therefore, on an interim basis, CMS is finalizing that services, which may only be reported if they do not result in a visit, including a telehealth visit, can be furnished to both new and established patients.

CMS also is clarifying that there are several types of practitioners who could bill for these services. For example, the services could be furnished as licensed clinical social worker services, clinical psychologist services, physical therapist services, occupational therapist services, or speech language pathologist services, so practitioners that report services in those benefit categories also could report these online assessment and management services.

E. Direct Supervision by Interactive Telecommunications Technology

CMS is revising the definition of direct supervision to allow, for the duration of the PHE for the COVID-19 pandemic, direct supervision to be provided using real-time interactive audio and video technology.

CMS is adopting similar changes in the regulations at §410.28(e)(1) with respect to the supervision of diagnostic services furnished directly or under arrangement in the hospital or in an on-campus or off-campus outpatient department of the hospital, as defined in §413.65.

F. Clarification of Homebound Status under the Medicare Home Health Benefit

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act state that payment for home health services is made when a physician certifies that such services are or were required because the individual is or was confined to his home and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who

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no longer has such a need for such care or therapy, continues or continued to need occupational therapy.

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 individual condition of the patient is such that leaving the home is medically contraindicated. With regards to a pandemic outbreak of an infectious disease, this can include reviewing and applying any guidance on risk assessment and public health management issued by the CDC.

G. The Use of Technology Under the Medicare Home Health Benefit During the PHE for the COVID-19 Pandemic

CMS says that it is statutorily-prohibited from paying for home health services furnished via a telecommunications system. For the duration of the PHE for the COVID-19 pandemic, CMS is amending the regulations at §409.43(a) on an interim basis to provide HHAs with the flexibility, in addition to remote patient monitoring, to use various types of telecommunications systems (that is, technology) in conjunction with the provision of in-person visits.

To appropriately recognize the role of technology in furnishing services under the Medicare home health benefit, the use of such technology must be included on the plan of care.

H. The Use of Telecommunications Technology Under the Medicare Hospice Benefit

For the duration of the PHE for the COVID-19 pandemic, CMS is amending the hospice regulations at 42 CFR 418.204 on an interim basis to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions without jeopardizing the patients' health or the health of those who are providing such services during the PHE for the COVID-19 pandemic. To appropriately recognize the role of technology in furnishing services under the hospice benefit, the use of such technology must be included on the plan of care.

I. Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement

A hospice physician or hospice NP must have a face-to-face encounter with each Medicare hospice patient whose total stay across all hospices is anticipated to reach the 3rd benefit period.

CMS is amending the regulations at §418.22(a)(4) on an interim basis to allow the use of telecommunications technology by the hospice physician or NP for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services during the PHE for the COVID-19 pandemic.

J. Modification of the Inpatient Rehabilitation Facility (IRF) Face-to-Face Requirement for the PHE During the COVID-19 Pandemic

A rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

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In §412.622(a)(3)(iv), CMS is revising this paragraph to state that physician supervision by a rehabilitation physician is required, except that during the PHE, as defined in §400.200, such visits may be conducted using telehealth services.

K. Removal of the IRF Post-Admission Physician Evaluation Requirement for the PHE for the COVID-19 Pandemic and Clarification Regarding the "3-Hour" Rule

CMS says that in cases where an IRF's intensive rehabilitation therapy program is impacted by the PHE for the COVID-19 pandemic (for example, due to staffing disruptions resulting from self-isolation, infection, or other circumstances related to the PHE), the IRF should not feel obligated to meet the industry standards referenced in §412.622(a)(3)(ii), but should instead make a note to this effect in the medical record.

L. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient. Coinsurance and deductibles apply to RHC claims for HCPCS code G0071 and coinsurance applies to FQHC claims for HCPCS code G0071.

To facilitate the ability of RHCs and FQHCs to take measures when appropriate, on an interim basis, CMS is expanding the services that can be included in the payment for HCPCS code G0071, and update the payment rate to reflect the addition of these services. Specifically, CMS is adding the following three CPT codes: 99421, 99422, and 99423.

M. Medicare Clinical Laboratory Fee Schedule: Payment for Specimen Collection for Purposes of COVID-19 Testing

CMS is changing Medicare payment policies during the PHE for the COVID-19 pandemic to provide payment to independent laboratories for specimen collection for COVID-19 testing under certain circumstances.

The nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally will be $23.46 and for individuals in a SNF or individuals whose samples will be collected by laboratory on behalf of an HHA will be $25.46.

To identify specimen collection for COVID-19 testing, CMS is establishing two new level II HCPCS codes. Independent laboratories must use one of these HCPCS codes when billing Medicare for the nominal specimen collection fee for COVID-19 testing for the duration of the PHE for the COVID-19 pandemic. These new HCPCS codes are G2023 and G2024.

N. Requirements for Opioid Treatment Programs

CMS is revising §410.67(b)(3) and (4) to allow the therapy and counseling portions of the weekly bundles, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology during the PHE for the COVID-19 pandemic.

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O. Application of Teaching Physician and Moonlighting Regulations During the PHE for theCOVID-19 Pandemic

To increase the capacity of teaching settings to respond to the PHE for the COVID-19 pandemic as more practitioners are increasingly being asked to assist with the COVID-19 response, on an interim basis, for the duration of the PHE for the COVID-19 pandemic, CMS is amending the teaching physician regulations to allow that as a general rule under §415.172, the requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology.

Starting on March 1, 2020, Medicare will pay for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere across the country including in a patient's place of residence.

For telehealth services involving residents, the requirement that a teaching physician be present for key portions of the service can be met through virtual means.

P. Special Requirements for Psychiatric Hospitals (§482.61(d))

CMS says that NPPs practicing in the psychiatric hospital setting should be able to record progress notes of psychiatric patients for whom they are responsible. Therefore, CMS will allow the use of NPPs, or APPs, to document progress notes of patients receiving services in psychiatric hospitals, in addition to MDs/DOs as is currently allowed.

Q. Innovation Center Models

CMS is amending the Medicare Diabetes Prevention Program expanded model to modify certain MDPP policies during the PHE.

CMS is implementing two changes to the Comprehensive Care for Joint Replacement (CJR) model to support the continuity of model operations and to ensure that CJR participants do not unfairly suffer financial consequences from the impact of COVID-19 due to their participation in CJR.

Specifically, CMS is implementing a 3-month extension to CJR performance year 5 such that the model will now end on March 31, 2021, rather than ending on Dec. 31, 2020.

R. Remote Physiologic Monitoring

CMS is finalizing on an interim basis, that RPM services can be furnished to new patients, as well as to established patients.

S. Telephone Evaluation and Management (E/M) Services

CMS is finalizing, for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443.

T. Physician Supervision Flexibility for Outpatient Hospitals - Outpatient Hospital Therapeutic Services Assigned to the Non-Surgical Extended Duration Therapeutic Services (NSEDTS) Level of Supervision

CMS is assigning all outpatient hospital therapeutic services that fall under §410.27(a)(1)(iv)(E), a minimum level of general supervision to be consistent with the minimum default level of general supervision that applies for most

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outpatient hospital therapeutic services, and is revising §410.27(a)(1)(iv)(E) to reflect this change in the minimum level of supervision.

U. Application of Certain National Coverage Determination and Local Coverage Determination Requirements During the PHE for the COVID-19 Pandemic

CMS is finalizing that to the extent an NCD or LCD (including articles) would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements would not apply during the PHE for the COVID-19 pandemic.

V. Change to Medicare Shared Savings Program Extreme and Uncontrollable Circumstances Policy

In response to the PHE for the COVID-19 pandemic, CMS has determined that the 2019 MIPS data submission deadline will be extended by 30 days until April 30, 2020, to give eligible clinicians more time to report quality and other data for purposes of MIPS.

W. Level Selection for Office/ Outpatient E/M Visits When Furnished Via Medicare Telehealth

Under the waiver issued by the Secretary pursuant to Section 1135(b)(8) of the Act, telehealth office/outpatient E/M codes can be furnished to any patient in their home regardless of their diagnosis or medical condition.

CMS is revising its policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record.

X. Counting of Resident Time During the PHE for the COVID-19 Pandemic

For the duration of this emergency situation, CMS is permitting the hospital that is paying the resident's salary and fringe benefits for the time that the resident is at home or in the home of a patient that is already a patient of the physician or hospital, but performing patient care duties within the scope of the approved residency program to claim that resident for IME and DGME purposes.

Y. Addressing the Impact of COVID-19 on Part C and Part D Quality Rating Systems

CMS is (1) replacing the 2021 Star Ratings measures calculated based on HEDIS and Medicare CAHPS data collections with earlier values from the 2020 Star Ratings (which are not affected by the public health threats posed by COVID-19); (2) establishing how CMS will calculate or assign Star Ratings for 2021 in the event that CMS' functions become focused on only continued performance of essential Agency functions and the Agency and/ or its contractors do not have the ability to calculate the 2021 Star Ratings; (3) modifying the current rules for the 2021 Star Ratings to replace any measure that has a data quality issue for all plans due to the COVID-19 outbreak with the measure-level Star Ratings and scores from the 2020 Star Ratings; (4) in the event that CMS is unable to complete Health Outcomes Survey (HOS) data collection in 2020 (for the 2022 Star Ratings), replaces the

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measures calculated based on HOS data collections with earlier values that are not affected by the public health threats posed by COVID-19 for the 2022 Star Ratings; (5) removing "guardrails" for the 2022 Star Ratings; and (6) expanding the existing hold harmless provision for the Part C and D Improvement measures to include all contracts for the 2022 Star Ratings.

Z. Changes to Expand Workforce Capacity for Ordering Medicaid Home Health Nursing and Aide Services, Medical Equipment, Supplies and Appliances and Physical Therapy, Occupational Therapy or Speech Pathology and Audiology

CMS says it recognizes that increased demand on the direct care services provided by physicians during the PHE for the COVID-19 pandemic could cause a delay in the availability of physicians to order home health services in the normal timeframe. In recognition of the critical need to expand workforce capacity, CMS is amending 42 CFR 440.70 to allow licensed practitioners practicing within their scope of practice, such as, but not limited to, NPs and PAs, to order Medicaid home health services during the existence of the PHE for the COVID-19 pandemic.

AA. Origin and Destination Requirements Under the Ambulance Fee Schedule

CMS is expanding the list of destinations at §410.40(f) for which Medicare covers ambulance transportation to include all destinations, from any point of origin, that are equipped to treat the condition of the patient consistent with Emergency Medical Services protocols established by state and/or local laws where the services will be furnished.

BB. Merit-based Incentive Payment System (MIPS) Updates

As a result of the PHE for the COVID-19 pandemic, CMS is applying the MIPS automatic extreme and uncontrollable circumstances policy at §414.1380(c)(2)(i)(A)(8) and (c)(2)(i)(C)(3) to MIPS eligible clinicians for the 2019 MIPS performance period/2021 MIPS payment year.

CMS is extending the deadline to submit an application for reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances (§414.1380(c)(2)(i)(A)(6)) and the Promoting Interoperability performance category based on extreme and uncontrollable circumstances (§414.1380(c)(2)(i)(C)(2)) from Dec. 31, 2019, to April 30, 2020, or a later date that CMS may specify. This extended deadline of April 30, 2020, mirrors the MIPS data submission deadline extension.

CC. Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital During the PHE for the COVID-19 Pandemic

CMS is changing its under arrangements policy during the PHE for the COVID-19 pandemic so that hospitals beginning March 1, 2020, are allowed broader flexibilities to furnish inpatient services, including routine services outside the hospital.

DD. Advance Payments to Suppliers Furnishing Items and Services under Part B

CMS is revising the definition of advance payment in §421.214(b). Currently, paragraph (b) defines advance payment as a conditional partial payment made by the carrier in response

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to a claim that it is unable to process within established time limits. CMS is revising this definition to state that the conditional partial payment will be made by the "contractor" (not the carrier).

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

FINAL COMMENT

CMS has been sending numerous communications regarding changes stemming from the COVID-19 pandemic. Much has been redundant making it more difficult to understand such changes.

This rule provides a good source to understand the many changes being made on a temporary basis.

A good part of CMS' changes center on the expansion of telehealth services. CMS has been cautious and reluctant to recognize the benefits of telehealth. Perhaps many of these conditional telehealth services will continue in the future.

There is much more detail in the rule itself than can be presented in this analysis. All the major sections have been identified above. Nonetheless, organizations impacted by specific sections/items need to review the rule's material in-depth.