On May 8, 2020, the Centers for Medicare & Medicaid Services (CMS) published an interim final rule with comment period (the “Interim Rule”) in the Federal Register, setting forth additional regulatory waivers and other changes to healthcare regulations and policies in response to the COVID-19 public health emergency (PHE). At a high level, the Interim Rule encompasses topics including expansion of telehealth, support for and expansion of COVID-19 testing, allowing certain licensed professionals to practice at the top of their licenses, Medicare payments for teaching hospitals, changes to the Medicare Shared Savings Program regarding financial methodologies, and application and risk assumption deadlines for accountable care organizations, among other changes. CMS has also updated provider-specific fact sheets on recent waivers and flexibilities, available here. Below are highlights from the Interim Rule. Providers are encouraged to read all applicable sections of the Interim Rule in their entirety here. Comments may be submitted to CMS within 60 days of the date of publication in the Federal Register.

Section A. Reporting Under the Home Health Value-Based...
Purchasing Model for CY 2020 During the COVID-19 PHE

The Interim Rule grants an exception to all home health agencies (HHAs) participating in the Home Health Value-Based Purchasing (HHVBP) Model for the April and July 2020 New Measure reporting requirements. The April 2020 New Measures submission period exception covers the data collection period of October 1, 2019 – March 31, 2020. The July 2020 New Measures submission period exception covers the data collection period of April 1, 2020 – June 30, 2020. According to CMS, this exception was granted to align HHVBP Model participating HHAs submission requirements with those exceptions or extensions granted for purposes of the Home Health Quality Reporting Program (HH QRP). HH QRP data submission requirements from October 1, 2019 – June 30, 2020 had already been excepted by CMS in earlier guidance.

Section B. Scope of Practice

In the Interim Rule, CMS implements certain recommendations from nonphysician practitioners (NPPs) to remove federal barriers to expanded scopes of practice for such NPPs to enable expanded access to care during the COVID-19 PHE, subject to applicable state laws. Changes include:

- Revisions to 42 C.F.R. § 410.32(b) to enable Nurse Practitioners, Clinical Nurse Specialists, Physician Assistants and Certified Nurse-Midwives to order, furnish and supervise the performance of diagnostic tests – to the extent permitted by applicable state law – during the PHE;

- Allowing physical or occupational therapists who establish maintenance therapy programs for patients to delegate the performance of such maintenance therapy services to an appropriately supervised physical therapist assistant or occupational therapist assistant, respectively, when clinically appropriate;

- Permitting any clinician authorized by Medicare to furnish and bill for professional services to review and verify (sign and date) – rather than having to re-document – notes in patient records made by “physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team;” and

- Clarifying that pharmacists are eligible “auxiliary personnel” who can provide services to beneficiaries that are “incident to” the professional services of a billing physician or NPP as long as the service is not separately reimbursable under Medicare Part D.

Section C. Modified Requirements for Ordering COVID-19 Diagnostic Laboratory Tests.

Previously, under 42 CFR § 410.32(a) certain diagnostic tests – including a COVID-19 test – were reimbursable under the Clinical Laboratory Fee Schedule only when ordered by a physician or NPP treating the patient for a specific medical problem when they use the results of the tests to manage that medical problem. 42 CFR 410.32(b) required a specified minimum level of physician supervision for a
diagnostic test. The Interim Rule modifies these regulations for the duration of the PHE to allow COVID-19 tests to be covered when ordered by any healthcare professional authorized to do so under state law (e.g., NPs, CNSs, PAs, and CNMs). Moreover, because COVID-19 symptoms are similar to those of certain other respiratory illnesses, CMS is also removing the same ordering requirements for influenza and respiratory syncytial virus testing – as well as for other illnesses that will be published in a list by CMS – as long as the testing is done “in conjunction with a COVID-19 diagnostic laboratory test as medically necessary in the course of establishing or ruling out a COVID-19 diagnosis or of identifying patients with an adaptive immune response to SARS-CoV-2 indicating recent or prior infection.” The modification will also remove certain corresponding documentation and recordkeeping requirements at § 410.32(d)(2) and (3) associated with orders for COVID-19 tests during the PHE. The Interim Rule also contains a requirement for clinical laboratories to report test results directly to patients when tests are furnished without a physician’s or NPP’s order. The Interim Rule stresses the importance of prompt reporting to patients and public health agencies to aid in containment and notes CMS expects such, preferably within 24 hours.

Section D. Opioid Treatment Programs (OTPs) - Furnishing Periodic Assessments Via Communication Technology.

For patients receiving services for opioid use disorders during the PHE, who do not have access to two-way audio-video communications technology, CMS had previously allowed the therapy and counseling portions of the weekly bundle of services, as well as the add-on code for additional counseling or therapy services, to be provided by audio-only communications during the PHE. The Interim Rule permits periodic assessments to be furnished by OTPs during the PHE using two-way interactive audio-video communication technology (or using audio-only telephone calls if there is no access to such two-way audio-video technology), provided all other applicable requirements are met. CMS cautioned OTPs to use clinical judgment to determine whether they can adequately perform the periodic assessment over audio-only phone calls — if not, then the assessment should be performed using two-way interactive audio-video communication technology, or in person as clinically appropriate. CMS notes that SAMHSA offers flexibilities to states to ensure that individuals being treated with medication for opioid use disorders can continue to receive their medication during the PHE for the COVID-19 pandemic, and provides specific guidance online.

Section E. Treatment of Certain Relocating Provider-Based Departments During the COVID-19 PHE

Currently, there are two separate payment systems for hospital provider-based departments (PBDs) as a result of the Bipartisan Budget Act of 2015 and subsequent CMS policies: (1) on-campus and “excepted” off-campus PBDs that are reimbursed under the Medicare Outpatient Prospective Payment System (OPPS), and (2) non-excepted off-campus PBDs that are reimbursed (at generally lower amounts) under the Medicare Physician Fee Schedule (PFS). An excepted off-campus PBD that relocates after January 1, 2017, will lose its “excepted” status (ability to bill OPPS) unless it meets certain extraordinary circumstances.
In the Interim Rule, CMS adopts an “expanded version of the extraordinary circumstances relocation policy during the COVID-19 PHE” to give hospitals flexibility to expand sites for patient care. Excepted off-campus PBDs and on-campus PBDs that relocate on or after March 1, 2020, through the remainder of the PHE may seek an extraordinary circumstances relocation exception, and bill OPPS if the relocation is for purposes of addressing the COVID-19 pandemic. CMS notes that the policy is time-limited, and CMS expects that PBDs which relocate due to the PHE will return back to their original locations when the PHE concludes; accordingly, PBDs that are permanently relocated off-campus would therefore lose any “excepted” billing status. Following the PHE, a hospital may seek an extraordinary circumstances relocation approval from CMS for a relocated off-campus PBD by following the current process and filing an updated Medicare enrollment form. CMS cautions that the extraordinary circumstances relocation policy does not apply to relocated on-campus PBDs, and “hospitals should not rely on having relocated the off-campus PBD during the COVID-19 PHE as the reason the off-campus PBD should be permanently excepted following the end of the COVID-19 PHE.”

CMS then explains that in order to utilize the extraordinary circumstances exception, excepted off-campus and on-campus PBDs should email the Regional Office certain information pertaining to the relocation, including a “brief justification for the relocation and the role of the relocation in the hospital’s response to COVID-19; and an attestation that the relocation is not inconsistent with their state’s emergency preparedness or pandemic plan.” Per CMS, “[t]o the extent that a hospital may relocate to an off-campus PBD that otherwise is the patient’s home, only one relocation request during the COVID-19 PHE is necessary. In other words, the hospital would not have to submit a unique request each time it registers a hospital outpatient for a PBD that is otherwise the patient’s home; a single submission per location is sufficient.” CMS also notes that “during the COVID-19 PHE, a patient’s home would be considered a PBD of the hospital when the patient is registered as a hospital outpatient and is receiving covered OPD services from the hospital.”

CMS notes that it would be possible for a PBD to be relocated to a patient’s home, if all non-waived requirements for PBDs are otherwise met. PBDs that relocate due to the PHE in accordance with the Interim Rule are directed by CMS to append the modifier “PO” to OPPS claims for services in the relocated PBDs, but are warned that if a relocation is rejected by the Regional Office, the claims would need to be re-processed for payment at the PFS-equivalent rate. CMS further states that hospitals are permitted to partition (all or part of) PBDs into multiple locations and for all locations of a divided “excepted” off-campus PBD to continue billing OPPS if the relocation meets CMS policy requirements. CMS also directs that no additional enrollment activities are necessary for hospitals rendering services in relocated PBDs during the PHE that are billed by the main hospital.

Section F. Furnishing Hospital Outpatient Services in Temporary Expansion Locations of a Hospital or a Community Mental Health Center (including the Patient’s Home)

In the Interim Rule, CMS emphasizes that the steps it has taken are intended to enable beneficiaries to obtain critical outpatient services at temporary expansion
locations during the PHE, while limiting the need for beneficiaries to receive care on hospital campuses to reduce transmission risks. Among the steps taken include the blanket waivers of certain conditions of participation and enrollment requirements but, according to CMS, questions have arisen as to how hospitals should be billing for telehealth services and other hospital outpatient services that do not include separately billable professional services.

CMS provides additional clarity to providers in the Interim Rule, breaking the outpatient services into three categories:

1. **Hospital Outpatient and CMHC Therapy, Education and Training Services:** CMS notes that to the extent these services require communication, they can be furnished utilizing telecommunications technology without clinical staff being co-located with the patient. CMS states that as long as hospital staff are providing services to a registered hospital patient properly located in a hospital PBD (which may include the patient’s home), the hospital can bill for such outpatient therapy, education, and training services (provided applicable physician order and supervision requirements are also met). CMS has published a list of such services that can be provided via telecommunications technology on its website. CMS also provides guidance on the provision of partial hospitalization program (PHP) services by hospitals and CMHCs in temporary expansion locations. CMS expects PHP services to be furnished using technology involving both audio and video, but acknowledged in the April 30 Interim Rule that some patients may not have access to video communications. For these patients, during the PHE, CMS is permitting certain individual psychotherapy, education, and group psychotherapy services that hospitals or CMHC staff can furnish to patients in their home or other temporary expansion location that functions as a provider-based department of the hospital or expanded CMHC when the beneficiary is registered as an outpatient. CMS is maintaining a list online of the individual psychotherapy, patient education, and group psychotherapy services that hospitals or CMHCs can provide in such circumstances, and plans to update it periodically. CMS also reminds providers that “services that require drug administration cannot be furnished using telecommunications technology.”

2. **Hospital In-Person Clinical Staff Services in a Temporary Expansion Location:** Hospitals are also able to provide certain services commonly furnished by clinical staff (e.g., wound care, chemotherapy administration, and other drug administration) that do not require professional services of a physician or NPP and are only billable via the OPPS in temporary expansion locations of the hospital (including a patient’s home). These services cannot be provided by telecommunications technology and must be provided in-person (under general supervision of a physician) pursuant to an appropriate order, and for infection control purposes CMS does not expect that they would include surgical care. CMS also notes that for patients whose homes become hospital PBDs, during the period in which the patient is a registered hospital outpatient receiving services, the patient’s residence cannot be considered a home for purposes of home health agency services.

3. **Hospital Services Accompanying a Professional Service Furnished via...**
Telehealth: CMS directs that from March 1, 2020 until the end of the PHE, when a practitioner who normally practices in an HOPD provides telehealth to a patient at the patient’s home (or otherwise not in a telehealth originating site), the practitioner should bill as if the service were furnished in an HOPD. The service would be reimbursed at the facility rate, but the hospital also may bill an originating site facility fee for the service. On the other hand, a physician who normally sees patients in an office setting (not hospital-based) would use the office POS code and would be paid at the non-facility, office rate for telehealth services. Modifier 95 (telehealth) would be applied to the claims, although CMS noted that payments would still be made where the POS was designated as 02, for practitioners who chose to maintain their prior billing practices during the PHE.

With the patient’s home now being allowed as an originating site during the PHE, a hospital would be able to bill the originating site facility fee for a beneficiary who is a registered outpatient — including when the patient is at home — but only when the services are provided after the home is made a provider-based department (PBD) of the hospital – meaning the applicable conditions of participation are met, to the extent they are not waived during the PHE. CMS notes that when a telehealth service is provided to a patient located in an HOPD, “the hospital is presumed to provide administrative and clinical support services.” Finally, CMS reminds hospitals that services furnished to a beneficiary in the home – where the home is designated a PBD – would be reimbursed under the PFS (as a non-excepted PBD) unless the hospital follows the temporary extraordinary circumstances exception policy for relocation of an excepted PBD and bills OPPS using the appropriate modifier.

Section G. Medical Education

CMS is revising regulations at 42 CFR § 412.105(d)(1) to ensure that teaching hospitals do not experience a reduction in indirect medical education (IME) payments resulting from a temporary surge in the number of hospital beds in response to the COVID-19 PHE. Hospitals receive IME payments based on the resident-to-bed ratio, and such payments would generally decrease with an increase in number of beds. CMS is therefore revising 42 CFR § 412.105(d)(1) to state that beds temporarily added during the COVID-19 PHE are excluded from the calculations to determine IME payment amounts. For purposes of determining a hospital’s IME payment amount, for the duration of the COVID PHE, the bed count for a teaching hospital will remain the same as it was on the day before the COVID-19 PHE was declared.

CMS responds to similar concerns raised by inpatient rehabilitation facilities (IRFs) and inpatient psychiatric facilities (IPFs), which receive teaching status adjustment payments based on an average daily patient census. To encourage such facilities to continue admitting patients resulting in an increased daily census, CMS is freezing teaching status adjustment payments for IRFs and IPFs for the duration of the COVID-19 PHE. The payments will remain the same as they were on the day before the COVID-19 PHE was declared.

Further, CMS is revising regulations at 42 CFR §§ 412.105(f)(1)(iii)(A) for IME and
413.78 for direct graduate medical education (DGME) to allow teaching hospitals during the COVID-19 PHE to claim the time spent by residents training at other hospitals. Under current regulations, a hospital cannot claim the time spent by residents training at another hospital. However, to encourage hospitals to send residents on an emergency basis to other hospitals where they are most needed without regard for GME financial considerations, CMS will allow teaching hospitals to claim for purposes of IME and DGME payments the time spent by residents training at other hospitals during the COVID-19 PHE, if the following conditions and all other applicable requirements 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. The resident need not be involved in patient care activities for patients with COVID-19 for the sending hospital to demonstrate that it sent the resident to the other hospital in response to the COVID-19 pandemic.

2. 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.

CMS notes that if a resident is claimed by the sending hospital, no other hospital, teaching or non-teaching, would be able to claim that time. CMS further notes that during the COVID-19 PHE, the presence of residents in non-teaching hospitals will not trigger establishment of per-resident amounts or FTE resident caps at those non-teaching hospitals.

Section H. Rural Health Clinics (RHCs)

For the duration of the PHE, CMS is modifying its policy for determining whether a rural health clinic (RHC) is excepted from a per-visit payment limit, so that an RHC can retain its exception during any temporary surge in capacity due to COVID-19. Currently, RHCs are paid an all-inclusive rate for medically-necessary, face-to-face visits with an RHC practitioner, but this rate is subject to a statutory payment limit. A provider-based RHC that is an integral and subordinate part of a hospital (including a critical access hospital) is excepted from the per-visit payment limit if the hospital has fewer than 50 beds. CMS recognizes that such payment-limit exceptions may be jeopardized if a hospital adds temporary surge capacity. Therefore, for the duration of the PHE, CMS will use the number of beds from the cost reporting period prior to the start of the PHE as the official hospital bed count in applying this policy, allowing RHCs that were not subject to the limit prior to the PHE to maintain that status.

Section I. Durable Medical Equipment (DME) Interim Pricing in the CARES Act
CMS is revising regulations at 42 CFR § 414.210(g)(9) to implement the CARES Act directive to increase fee schedule amounts for certain DME items and services. CMS is increasing the fee schedule amounts for DMEPOS items and services furnished in non-competitive bidding areas (CBAs) other than rural and noncontiguous non-CBAs through the duration of the PHE. The fee schedule amounts in these non-CBA areas are currently based on 100 percent of an adjusted fee schedule amount, but section 3712(b) of the CARES Act requires CMS to pay for these DMEPOS items and services based on 75 percent of the adjusted fee schedule amount and 25 percent of the historic, unadjusted fee schedule amount until the end of the emergency period. This increases payments so that they are approximately 33 percent higher than the payments at the fully adjusted fee schedule amounts. There is no change to the current adjusted fee schedule amounts in former CBAs, which will continue to be based on the single payment amounts from 2018 increased by update factors for subsequent calendar years until new competitive bidding contracts are in place. The above changes are effective starting March 6, 2020, and for the duration of the PHE.

Section J. Care Planning for Medicare Home Health Services

The Interim Rule relaxes certain historical requirements related to Medicare reimbursement of home health services. Historically, a physician was required to certify that a beneficiary needed home health services before Medicare would reimburse for home health services. The physician was required to establish and review a plan of care for providing services to the individual. Additionally, the physician was required to document that (1) the physician, (2) a nurse practitioner (NP) or a certified nurse specialist (CNS) collaborating with the physician, or (3) a certified nurse midwife (CNM) or physician assistant (PA) working under the supervision of the physician, had a face-to-face encounter with the patient related to the reason for the home health visit. The Interim Rule permits NPs, CNSs and PAs, subject to applicable state law, to order and certify Medicare beneficiaries for home health services, as well as establish and review the home health plan of care. The practitioner certifying the beneficiary for home health services must perform a face-to-face encounter with the beneficiary. Where the face-to-face encounter is performed by an NP, CNS or PA in an acute care or post-acute care facility from which the patient is transferred, the certifying practitioner may be different from the practitioner performing the face-to-face encounter. The above home health changes are retroactively effective to March 1, 2020.

Section K. CARES Act Waiver of the “3-Hour Rule” and Modification of IRF Coverage and Classification Requirements for Freestanding IRF Hospitals for the PHE During the COVID-19 Pandemic

The CARES Act waived, during the PHE, the requirement that at the time of a Medicare beneficiary’s admission to an inpatient rehabilitation facility (IRF), the beneficiary is expected to need at least three hours of therapy five days per week (known as the “3-Hour Rule”). The Interim Rule clarifies that the 3-Hour Rule waiver applies to any IRF admission, including those admissions that are required to relieve capacity issues at an acute care hospital. The Interim Rule further modifies
certain requirements related to admissions to freestanding IRF hospitals (facilities with Medicare provider numbers ending in 3025 through 3099) during the PHE. Specifically, the following requirements are waived to permit Medicare payments to be made for patients admitted to a freestanding IRF hospital solely to relieve acute care hospital capacity during the PHE:

- Pre-admission screening procedures;
- At least three face-to-face visits per week by a physician;
- The creation, review and revision of a patient’s plan of care;
- Use of a coordinated care delivery team;
- IRF coverage criteria (including the 3-Hour Rule);
- Documentation requirements for each patient; and
- Interdisciplinary team approach to care of the patient.

The flexibilities are available only to Medicare beneficiaries admitted to freestanding IRF hospitals located in states that are in phase 1 or before entering into phase 1 of the Guidelines for Opening Up America Again, and where the admission is solely to relieve capacity issues at an acute care hospital. Freestanding IRF hospitals taking advantage of the above waivers must use modifier “DS” when billing for an applicable patient’s stay. Payment will be made at the IRF prospective payment system rates. The above changes are retroactively effective to March 1, 2020.

Section L. Medicare Shared Savings Program

In response to significant input from accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP), CMS has made significant changes to the MSSP to address concerns arising out of the PHE. Highlights of the changes affecting MSSP ACOs are summarized below.

1. Optional Extension of Agreement Periods Ending December 31, 2020. CMS is cancelling the January 1, 2021 MSSP application cycle and is offering MSSP ACOs whose current agreement with CMS ends on December 31, 2020, a one-time option to extend their agreement period for one additional year (January 1, 2021 to December 31, 2021). Each ACO that chooses to extend its agreement for an additional year would remain under its current historical expenditure benchmark for the additional year, meaning that 2020 would not be used in benchmarking the ACO’s expenditures. ACOs that choose to extend their agreements will likely need to review their existing agreements with participants, providers and suppliers to determine whether those agreements will need to be extended as well. CMS will issue forthcoming guidance on the timing and manner in which an ACO may make an election to extend its agreement.

2. BASIC Track ACO Extension Option. The BASIC track of the MSSP allows ACOs to
gradually assume an increasing level of risk along a glide path, and ACOs are automatically advanced to the subsequent level each performance year. Under the Interim Rule, each BASIC track ACO will have the one-time option to maintain its current risk-level in 2021. Following 2021, the ACO will be automatically advanced to the level it would have otherwise advanced to if it had not repeated its current level. For example, if an ACO is currently in risk level B and elects to remain in level B for 2021, beginning in 2022, the ACO will be advanced to level D. The Interim Rule does not prevent an ACO from advancing along the glide path more quickly. CMS intends to issue guidance specifying the timing and manner in which an ACO may make its election; however, CMS expects that ACOs will be required to make their election between June 18, 2020 and September 22, 2020.

3. **MSSP Extreme and Uncontrollable Circumstances Policy Clarifications.** CMS’s existing policies and regulations address how certain extreme and uncontrollable circumstances may affect an ACO’s financial performance, and in particular, how shared losses are mitigated as a result of such circumstances. Existing policy states that an ACO’s shared losses are reduced according to the following formula: ACO’s shared losses multiplied by percentage of months in the year affected by the extreme and uncontrollable circumstances multiplied by the percentage of assigned beneficiaries that reside in an area affected by the circumstance. In the Interim Rule, CMS clarifies that the PHE is an extreme and uncontrollable circumstance affecting the entire country, and thus all beneficiaries assigned to an MSSP ACO, and that it began in January 2020 and will extend until the end of the PHE. Because the PHE has lasted four months plus, to date, all MSSP ACOs with downside risk will have their shared losses reduced by at least one-third (four months out of 12).

4. **MSSP Calculation Adjustments Due to the PHE.** MSSP ACO expenditure benchmarks, which are used to determine whether an ACO receives shared savings (or is required to repay any shared losses), is determined based on the three most-recent years of Medicare Parts A and B expenditures for beneficiaries assigned to the ACO. Due to the PHE, CMS expects an increase in Medicare Parts A and B expenditures, and CMS further believes that these higher expenditures may not be properly captured using the current benchmarking calculations. As a result, CMS is excluding from its expenditure calculations all Part A and B payment amounts for an “episode of care” for treatment of COVID-19 that are triggered by an inpatient service. The episode of care includes the month in which the patient is admitted as an inpatient as well as the month after the patient is discharged. CMS notes that outpatient care received during this period would be excluded from the calculation. CMS will also treat the episode of care as if the assigned beneficiary was not enrolled in Medicare for purposes of calculating the per-beneficiary expenditures.

Additionally, CMS will remove Parts A and B expenditures relating to an episode of care for the following calculations:

- County-level and national fee-for-service expenditures;
- BASIC track loss-recoupment limits;
• Determination of whether an ACO is high-revenue or low-revenue for purposes of the ACO’s participation options; and

• The ACO’s repayment mechanism.

5. **Inclusion of Certain Telemedicine Services to Assign Beneficiaries.** Beneficiaries are assigned to MSSP ACOs based on utilization of primary care services from physicians participating in the ACO. CMS has specified the HCPCS/CPT codes that qualify as primary care services. In an earlier interim final rule, CMS established separate payment during the PHE for certain remotely performed services that do not qualify as telehealth services, such as e-visits, virtual check-ins and telephone evaluation and management services. CMS believes that these remotely performed services should be included in the definition of primary care services for purposes of beneficiary assignment so that the use of technologies is appropriately captured. Consequently, the following HCPCS/CPT codes will be included in the definition of primary care services for this current ACO performance year and any other performance year that begins during the PHE:

- HCPCS G2010 (remote evaluation of patient images/video);
- HCPCS G2012 (virtual check-in);
- CPT 99421, 99422 and 91423 (e-visits); and
- CPT 99441, 99442 and 99443 (telephone evaluation and management services).

**Section M. Additional Flexibility under the Teaching Physician Regulations.**

As explained by CMS, under 42 CFR § 415.172, for teaching physicians to obtain reimbursement under Medicare, sufficient personal and identifiable physicians’ services must be provided to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought — the key portion of any service or procedure for which payment is sought. There is an exception for primary care under 42 CFR § 415.174, which provides that Medicare reimburses for certain professional services of lower and mid-level complexity furnished by a resident in the primary care setting without a teaching physician being present. Among other requirements, for the primary care exception to apply, teaching physicians can only direct the care of four residents at a time, must have no other responsibilities at the time, be immediately available (i.e., provide direct supervision), assume management responsibility for the patients seen by residents, ensure that the services furnished are appropriate, and review with each resident during or immediately after each visit the medical history, physical examination, diagnosis, and record of tests and therapies.

CMS had previously allowed a teaching physician to meet the physical presence requirement through direct supervision by audio/video real-time communications technology. This was not limited to the primary care exception. CMS also revised the scope of E/M codes that can be furnished under the primary care exception and amended regulations to allow all levels of office/outpatient E/M services furnished
in primary care centers under the primary care exception to be furnished under direct supervision of the teaching physician by interactive telecommunications technology.

In the Interim Rule, where the primary care exception applies, CMS is allowing teaching physicians to direct care furnished by residents, and also review services provided with the resident, during or immediately after the visit, remotely via audio/video real time communications technology. CMS explains that “this means that Medicare may make payment under the PFS for teaching physician services when a resident furnishes services permitted under the primary care exception, including via telehealth, and the teaching physician can provide the necessary direction, management and review of the resident’s services using interactive audio/video real-time communications technology.” The remainder of the requirements continue to apply in that the teaching physician must have no other responsibilities at the time, assume management responsibility for the beneficiaries seen by the residents, ensure that the services furnished are appropriate, and review with each resident during or immediately after each visit the beneficiary’s medical history, physical examination, diagnosis, and record of tests and therapies. For the duration of the PHE, Medicare will reimburse the teaching physician for the following additional services when furnished by a resident under the primary care exception: CPT code 99421-99423, 99441-99443, 99452, 99495–99496, and HCPCS codes G2010 and G2012.

CMS also clarifies that the office/outpatient E/M level selection for services under the primary care exception when furnished via telehealth can be based on MDM or time, and the requirements regarding documentation of history and/or physical exam in the medical record do not apply. According to CMS, this means that on an interim basis for the duration of the PHE, Medicare will reimburse for teaching physician services when a resident furnishes a service included in the expanded list of services in primary care centers, including via telehealth, and the teaching physician can provide the necessary direction, management and review for the resident’s services using audio/video real-time communications technology.

Section N. Payment for Audio-Only Telephone Evaluation and Management Services.

Prior to the PHE, a number of services that did not qualify as Medicare “telehealth” services were available for reimbursement to physicians and other practitioners able to furnish evaluation and management (E/M) services to Medicare beneficiaries, including:

- brief audio-only telephone communications called “virtual check-ins” (HCPCS code G2012),

- online digital assessment services called “E-Visits” (CPT codes 99421-99423), and

- the remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward, HCPCS code G2010).
These services could only be provided to established patients. Previously, CMS indicated it would allow these services to be provided to both new and established patients on an interim basis during the PHE.

CMS emphasized that the audio-only virtual check-ins are to be used only where patient needs are not significant enough to require the increased time and attention that is specified in codes for in-person or telehealth visits. However, in the PHE context, CMS previously had recognized there were circumstances where prolonged, audio-only communications could be clinically appropriate – but that this would not include more complex situations where a face-to-face or telehealth visit would be indicated. To accommodate this, for the duration of the PHE, where two-way audio/video capability “might not be available,” CMS decided to allow prolonged, audio-only communication to be reimbursed using existing telephone E/M codes 99441-99443, for practitioners who can bill for E/M services, and codes 98966-98968, for practitioners who cannot separately bill for E/Ms (including, among others, licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists). Prior to the PHE, while these codes existed, they were designated as “noncovered.”

CMS provided the following example of a circumstance where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate, yet not fully replace a face-to-face visit:

an established patient who was experiencing an exacerbation of their condition could have a 25- minute phone conversation with their physician during which the physician determines that an adjustment to the patient’s medication would alleviate their symptoms. The use of CPT code 99443 in this situation prevents a similar in-person service.

As CMS had stated previously, these codes can be used during the PHE for audio-only telephone E/M services comprised of medical discussions that do not originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours (or the soonest available appointment). According to CMS, the codes may be used for both new and established patients during the PHE and it will “not conduct review to consider whether those services were furnished to established patients.” The assigned RVU’s for reimbursement were .25 for codes 98966 and 99441, .50 for codes 98967 and 99442, and 0.75 for codes 98968 and 99443. CMS also finalized direct PE inputs consisting of 3 minutes of post-service RN/LPN/MTA clinical labor time for each code. However, these audio-only services were not considered “telehealth” services.

Prior to the PHE, the provision of telehealth services could not be made using a telephone, even if it had real-time interactive audio and video capabilities. This requirement was waived during the PHE, allowing telephones to be used to provide telehealth services for the duration of the PHE, as long as the telephones had both audio and video interactive, real-time communication capabilities. The Interim Rule provided an additional limited expansion of this waiver.

In the Interim Rule, CMS said that stakeholders had informed it that the use of audio-only services was more prevalent than previously considered, and in some situations audio-only E/M services were being furnished as substitutes for
office/outpatient E/M services. CMS recognized that in those cases the audio-only communications more closely approximated regular face-to-face encounters. Accordingly, CMS decided to recognize the services described by audio-only E/M service codes 99441-99443 as “telehealth” services, and added them to the published list of Medicare telehealth services for the duration of the PHE. CMS did not add codes 98966-98968 to the telehealth services list or increase the payment rates for these codes (audio-only telephone services furnished by non-physician practitioners who cannot independently bill for E/M services). In order to determine reimbursement during the PHE, CMS cross-walked these codes to the most analogous office/outpatient E/M codes. Specifically, codes 99441, 99442, and 99443 were cross-walked to codes 99212, 99213, and 99214, respectively. For the duration of the PHE, CMS increased the work RVUs from the lower values listed in the March 31 Interim Rule — from .25 to .48 for code 99441; from .50 to .97 for code 99442; and from .75 to 1.50 for code 99443.

CMS cautioned that the E/M service codes should not be used for administrative or other non-medical discussion with the patient. CMS also encouraged practitioners to educate beneficiaries on cost-sharing policies, noting that although practitioners can waive cost-sharing during the PHE, patients are still liable for cost-sharing amounts where practitioners do not waive them. CMS is seeking comments on how to minimize unexpected cost-sharing, plans to monitor utilization of these services, and said that it will potentially consider refining billing rules, documentation requirements or claims edits in future rulemaking. CMS provided a link to the full list of Medicare telehealth services, including those added during the PHE. CMS indicated it will be issuing a separate 1135(b) waiver under the CARES Act for telehealth services to be able to be provided using audio-only technology in the circumstances described in the Interim Rule preamble.

Section O. Flexibility for Medicaid Laboratory Services.

The Interim Rule modifies Medicaid limitations on how and where diagnostic testing must occur for reimbursement allowing collection in non-office settings. CMS notes that “Section 6004(a) of the Families First Coronavirus Response Act added a new mandatory benefit in the Medicaid statute at section 1905(a)(3)(B)” that mandates coverage for in vitro diagnostic products that detect SARS-CoV-2 and administration of those tests. In order to provide this benefit in light of the growing utilization of non-office settings for testing – such as parking lots or other temporary outdoor locations – the Interim Rule makes changes to the current regulations that govern lab test payments. Previously, Medicaid-covered laboratory and X-ray services had to be ordered and provided by or under the direction of a physician or other licensed practitioner or ordered by a physician but provided by a referral laboratory. Moreover, Medicaid previously only covered laboratory and X-ray services provided in an office or similar facility other than a hospital outpatient department (HOPD) or clinic. Accordingly, there was some difficulty in providing the mandatory benefit for testing preformed in alternate locations. Now, under the Interim Rule, Medicaid will cover tests administered in non-office settings, and cover for laboratory processing of self-collected COVID-19 tests that are FDA-authorized for self-collection. Moreover, the Interim Rule permits states to cover laboratory processing of self-collected test systems that the FDA has authorized for home use, without the order of a treating physician or other licensed NPP. The changes will be effective for the
COVID-19 PHE and any period of surveillance after the PHE. Also, the Interim Rule makes an addition to the Medicaid testing regulations that will allow these changes to also be effective in to future PHEs resulting from outbreaks of communicable disease to quickly permit limited contact testing. The changes are effective retroactively to March 1, 2020.

Section P. Improving Care Planning for Medicaid Home Health Services

The Interim Rule changes which providers can order Medicaid home health services, including durable medical equipment. Importantly, because this section is designed to implement a portion of the CARES Act, and “the language in section 3708 of the CARES Act is not time limited to the period of the COVID-19 PHE; the revisions to the Medicaid home health program will be permanently in effect.” The Interim Rule amends the home health regulations at 42 CFR § 440.70(a)(3) to allow other licensed practitioners besides physicians to order medical equipment, supplies, and appliances when they are allowed to do so practicing in accordance with state laws. For other services covered by the Medicaid home health benefit, the Interim Rule amends 42 CFR § 440.70(a)(2) to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) to order home health services described in 42 CFR § 440.70(b)(1), (2) and (4). “Specifically, part-time or intermittent nursing services, home health aide services, and if included in the state’s home health benefit, therapy services.” This section also removes the requirement that NPPs described in 42 CFR § 440.70(a)(2) report the clinical finding of a face-to-face encounter to the ordering physician. Under the CARES Act, NPPs are allowed to perform these face-to-face encounters independently unless state law does not allow such flexibility. Only if not allowed by state law is the NPP required to work in collaboration with a physician. Lastly, CMS notes that the flexibility afforded to NPs, CNSs and PAs to order home health services must be done within their scope of practice under state law, which may require varying degrees of independence or supervision.

Section Q. Basic Health Program Blueprint Revisions

The Interim Rule revises the certification requirement for states that wish to make changes to their Basic Health Program (BHP) Blueprint. The BHP is a portion of the Affordable Care Act that allows states to create a coverage program for individuals who do not qualify for Medicaid but also do not exceed 200 percent of the federal poverty level. States with these programs must submit to Health and Human Services (HHS) a BHP Blueprint detailing the program for certification. When significant changes to the program are made, a state must submit a revised BHP Blueprint for certification and cannot implement the changes until the program is certified. The section changes this requirement to allow states to submit a revised BHP Blueprint with temporary significant changes to respond to the PHE for the COVID-19 pandemic with the option for the states to make such changes effective retroactive to the start of the PHE. These revisions would only be allowed for the duration of the PHE and any necessary following time.

Section R. Merit-based Incentive Payment System (MIPS)
Qualified Clinical Data Registry (QCDR) Measure Approval Criteria

The Interim Rule delays deadlines for QCDR measure testing and data collection for the 2021 MIPS performance period. CMS has made these delays in response to concern voiced by QCDRs that due to COVID-19 they will not be able to complete data measure testing and collection in time. Accordingly, CMS is delaying the requirement that “beginning with the 2021 performance period, all QCDR measures must be fully developed and tested, with complete testing results at the clinician level, prior to submitting the QCDR measure at the time of self-nomination.” This process is being delayed one year and the requirement will go into effect beginning with the 2022 performance period. Moreover, CMS is delaying the requirement that “beginning with the 2021 performance period, QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.” This process will also be delayed by one year and the requirement will go into effect beginning with the 2022 performance period.

Section S. Application of Certain National Coverage Determination (NCD) and Local Coverage Determination (LCD) Requirements during the COVID-19 PHE

Section S of the Interim Rule clarifies earlier rulemaking as it relates to the medical necessity of covered items and services and expands CMS’ relaxation of enforcement of certain clinical indications in LCDs during the COVID-19 PHE. Referencing external stakeholders who, according to CMS, appear to be misinterpreting statements in prior rulemaking, the Interim Rule confirms that there is nothing in prior guidance or rulemaking that could be interpreted to permanently or temporarily waive the reasonable and necessary statutory requirement expressed in Section 1862(a)(1)(A) of the Social Security Act. CMS states: “Physicians, practitioners, and suppliers are required to continue documenting the medical necessity for all services. Accordingly, the medical record must be sufficient to support payment for the services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary).” The Interim Rule further provides that to permit COVID-19 patients to more closely monitor their glucose levels, during the COVID-19 PHE CMS will not enforce the clinical indications for therapeutic continuous glucose monitors in LCDs. For example, CMS will not enforce current clinical indications restricting the type of diabetes a beneficiary must have or relating to the demonstrated need for frequent blood glucose testing to permit COVID-19 infected patients with diabetes to receive a Medicare covered therapeutic glucose monitor.

Section T. Delay in the Compliance Date of Certain Reporting Requirements Adopted for IRFs, LTCFs, HHAs and SNFs

The Interim Rule delays compliance dates for reporting of certain transfer of health information quality measures (TOH Information Measures) and certain standardized patient assessment data elements (SPADEs) adopted for Quality Reporting Programs for inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), home
health agencies (HHAs) and skilled nursing facilities (SNFs). The Interim Rule requires providers to begin collecting data for TOH Information Measures and SPADEs as follows:

1. IRFs and LTCHs:
   - For TOH Information Measures, beginning with discharges on October 1 of the year that is at least one full fiscal year after the end of the COVID-19 PHE (for example, if the COVID-19 PHE ends on September 20, 2020, beginning with patients discharged on October 1, 2021); and
   - For SPADEs, for admissions and discharges, or in some cases for admissions only, on the same date.

2. HHAs:
   - For TOH Information Measures, beginning with discharges and transfers on January 1 of the year that is at least one full calendar year after the end of the COVID-19 PHE (for example, if the COVID-19 PHE ends on September 20, 2020, beginning with patients discharged or transferred on January 1, 2022); and
   - For SPADEs, beginning with the start of care, resumption of care, and discharges, or in some cases at the start of care only, on the same date.

3. SNFs:
   - For TOH Information Measures, beginning with discharges on October 1 of the year that is at least two full fiscal years after the end of the COVID-19 PHE (for example, if the COVID-19 PHE ends on September 20, 2020, beginning with patients discharged on October 1, 2022); and
   - For SPADEs, beginning with admissions and discharges, or in some cases for admissions only, on the same date.

Section U. Update to the Hospital Value-Based Purchasing (VBP) Program Extraordinary Circumstance Exception (ECE) Policy

The Interim Rule expands the ECE policy for the Hospital VBP Program and grants an ECE with respect to the COVID-19 PHE to all hospitals participating in the Hospital VBP Program for specified reporting requirements.

1. Expansion of Hospital VBP Program ECE Policy. Under the current Hospital VBP ECE policy, CMS will consider providing an exception from the Hospital VBP Program requirements to hospitals affected by natural disasters or other extraordinary circumstances upon submission of a hospital request, including available evidence of the impact of the extraordinary circumstances on the hospital’s quality measure performance, within 90 calendar days of the date on which the natural disaster or other extraordinary circumstance occurred. The Interim Rule expands the Hospital VBP Program’s ECE policy to allow CMS to grant ECE exceptions to hospitals which have not requested them when CMS determines that an extraordinary circumstance that is out of the hospitals’ control, such as an act of nature (for example, a hurricane) or public health...
emergency (for example, the COVID-19 pandemic), affects an entire region or locale. The Interim Rule notes that if CMS grants an ECE to hospitals located in an entire region or locale and as a result one or more hospitals located in that region or locale do not report the minimum number of cases and measures required to enable CMS to calculate a Total Performance Score for that hospital for the applicable program year, the hospital will be excluded from the Hospital VBP Program for the applicable program year, and further that a hospital that does not report the minimum number of cases or measures for a program year will not receive a two percent reduction to its base operating diagnostic related grouping (DRG) payment amount for each discharge in the applicable program year, and will also not be eligible to receive any value-based incentive payments for the applicable program year.

2. Granting of ECE with Respect to the COVID-19 PHE. In accordance with the updated ECE policy, the Interim Rule grants an ECE with respect to the COVID-19 PHE to all hospitals participating in the Hospital VBP Program for the following reporting requirements:

- Hospitals will not be required to report National Healthcare Safety Network (NHSN) healthcare-associated infection (HAI) measures and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data for the following quarters:
  - October 1, 2019 – December 31, 2019 (Q4 2019),
  - January 1, 2020 – March 31, 2020 (Q1 2020), and
  - April 1, 2020 – June 30, 2020 (Q2 2020).

(However, hospitals can optionally submit part or all of these data by the posted submission deadlines.)

- CMS will exclude qualifying claims data from mortality, complications, and Medicare Spending per Beneficiary measures for the following quarters:
  - January 1, 2020 – March 31, 2020 (Q1 2020) and
  - April 1, 2020 – June 30, 2020 (Q2 2020).

Section V. COVID-19 Serology Testing

The Interim Rule provides that on an interim basis that during the COVID-19 PHE, Medicare will cover FDA-authorized COVID-19 serology tests, which can be used to detect whether a patient may have previously been infected with SARS-CoV-2, the virus that causes COVID-19, as per CMS they are reasonable and necessary for beneficiaries with known current or known prior COVID-19 infection or suspected current or suspected past COVID-19 infection. Specifically, the Interim Rule finalizes on an interim basis that FDA-authorized COVID-19 serology tests fall under the Medicare benefit category of diagnostic laboratory test and therefore, are coverable by the Medicare program because they fall under at least one Medicare benefit category. The Interim Rule notes that CMS would ordinarily use the National
Coverage Determination (NCD) process, which includes a 30-day public comment period on proposed decisions, to establish a benefit category and establish that an item or service is reasonable and necessary under Medicare. However, CMS has determined that coverage for FDA-authorized COVID-19 serology tests should be established in an interim final manner through the Interim Rule given the need to establish timely and uniform national coverage that is relevant during the COVID-19 PHE.

Section W. Modification to Medicare Provider Enrollment Provision Concerning Certification of Home Health Services

CMS is revising regulations at 42 CFR § 424.507(b)(1) to provide that NPs, CNSs, and PAs working in accordance with state law may certify the need for home health services. Medicare currently pays for home health services only when they are certified by a physician, however, the CARES Act mandated that PAs, NPs, and CNSs may also certify these services. CMS is therefore revising 42 CFR § 424.507(b)(1) to include ordering/certifying physicians and other licensed practitioners, PAs, NPs, and CNSs as individuals who can certify the need for home health services. Similar to other modifications to Medicare rules concerning the certification and provision of home health services, this revision to the Medicare regulations is permanent and is applicable to services provided on or after March 1, 2020.

Section X. Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges: Separate Billing and Segregation of Funds for Abortion Services

The Interim Rule delays implementation of the Qualified Health Plan (QHP) separate billing policy for coverage of non-Hyde abortion services. The 2019 Program Integrity Rule included a requirement at 45 CFR § 156.280(e)(2)(ii) that “issuers of individual market QHPs offering coverage of non-Hyde abortion services ... separately bill policy holders for the portion of their premium attributable to coverage of non-Hyde abortion services.” CMS is granting a 60-day extension to comply with this policy to allow QHPs to devote resources to COVID-19 related matters. Now, QHPs must comply beginning on or before the QHP issuer’s first billing cycle following August 26, 2020.

Section Y. Requirement for Facilities to Report Nursing Home Residents and Staff Infections, Potential Infections, and Deaths Related to COVID-19

CMS is adding new regulations at 42 CFR § 483.80(g)(1) and (2) for infection control reporting to the Centers for Disease Control (CDC) related to COVID-19. Under the new regulations, nursing facilities must electronically report information about COVID-19 including, but not limited to, information on: suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; total deaths and COVID-19 deaths among residents and staff; personal protective equipment and hand hygiene supplies in the facility; ventilator capacity and supplies available in the facility; resident beds and census; access to
COVID-19 testing while the resident is in the facility; staffing shortages; and other information specified by the Secretary. Facilities are required to provide the above information no less than weekly to the Centers for Disease Control’s National Healthcare Safety Network.

Furthermore, CMS is adding a new section at 42 CFR § 483.80(g)(3) requiring facilities to inform residents, their representatives, and families of those residing in facilities of confirmed or suspected COVID-19 cases in the facility among residents and staff. Facilities must inform residents, their representatives, and families by 5 p.m. the next calendar day following the occurrence of either: a single confirmed infection of COVID-19; or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours of each other. Also, cumulative updates to residents, their representatives, and families must be provided at least weekly by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified; or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. The information must be reported in accordance with existing privacy rules, and must not include any personally identifiable information. Facilities must also include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered, such as restrictions or limitations to visitation or group activities. CMS states that for purposes of this reporting requirement, facilities are not expected to make individual telephone calls. Instead, facilities can utilize communication mechanisms that make this information easily available to all residents, their representatives, and families, such as paper notification, listservs, website postings, and/or recorded telephone messages.

The above reporting requirements at 42 CFR § 483.80(g)(1) through (3)(iii) are effective as of the date the Interim Rule is published in the Federal Register. Other current infection reporting requirements at 42 CFR § 483.80 remain unchanged.

Section Z. Time Used for Level Selection for Office/Outpatient Evaluation and Management CMS-5531-IFC 10 Services Furnished Via Medicare Telehealth.

CMS previously revised its policy to specify that the office/outpatient E/M level selection for office/outpatient E/M services when furnished via telehealth can be based on either medical decision-making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. CMS had provided a link to a public use file containing MDM times. According to CMS, members of the physician community subsequently pointed out that the MDM times in the public use file did not align with the typical times included in the office/outpatient E/M code descriptors. Acknowledging this confusion, in the Interim Rule, CMS has changed its policy to provide that, for the duration of the PHE for the COVID-19 pandemic, the times to be used for purposes of level selection for an office/outpatient E/M are those times listed in the CPT code descriptors.

AA. Updating the Medicare Telehealth List.

CMS has revised 42 CFR § 410.78(f) to specify that, during a PHE, CMS will use a
“subregulatory process” to modify the services included on the Medicare telehealth list without notice and comment rulemaking. CMS notes that this could involve posting new services to the web listing of telehealth services when the agency receives a request to add (or identifies through internal review) a service that can be furnished in full, as described by the relevant code, by a distant site practitioner to a beneficiary in a manner that is similar to the in-person service. CMS also stresses that any additional services added using the revised process would remain on the list only during the PHE for the COVID-19 pandemic.

BB. Payment for COVID-19 Specimen Collection to Physicians, Nonphysician Practitioners and Hospitals.

The Interim Rule creates a reimbursement option for physicians, NPPs and HOPDs for specimen collections. It also waives Medicare beneficiary cost sharing for this service. Previously, CMS had created codes G2023 and G2024 for specimen collection for COVID-19 laboratory tests. “Independent laboratories must use one of these HCPCS codes when billing Medicare for the nominal specimen collection fee for COVID-19 testing.” To further support testing the Interim Rule allows physicians and NPPs to use code 99211 to bill for services furnished incident to their professional services, for both new and established patients, when clinical staff assess symptoms and collect specimens for purposes of COVID-19 testing. CMS is also waiving all cost sharing on this code when all requirements under section 6002(a) of the Families First Coronavirus Response Act are met. Moreover, CMS has created a new OPPS code, code C9803, for HOPDs to bill for a clinic visit dedicated to specimen collection. CMS has adopted a policy to conditionally package payment for this code and make separate payment for HCPCS code C9803 under the OPPS when no other primary service is furnished in the same encounter. Cost sharing on the OPPS code is also waived when all requirements under section 6002(a) of the Families First Coronavirus Response Act are met.

CC. Payment for Remote Physiologic Monitoring (RPM) Services Furnished During the COVID-19 Public Health Emergency.

CMS had previously updated policies related to payment for Remote Physiologic Monitoring services under the Physician Fee Schedule during the PHE, in order “to eliminate as many unnecessary obstacles as possible to delivering these services as part of the response to the pandemic.” To that end, CMS is allowing RPM services to be furnished during the PHE to new patients in addition to established patients; with beneficiary consent to be obtained at the time services are furnished and by auxiliary personnel for physiologic monitoring of patients with acute and/or chronic conditions; and under general supervision. The Interim Rule establishes a policy for the duration of the PHE to allow RPM monitoring services to be reported to Medicare for periods of time that are fewer than 16 days of 30 days, but no less than 2 days, as long as the other requirements for billing for RPM monitoring are met, and the patient has a suspected or confirmed diagnosis of COVID-19.

This post was co-authored by Michael Lisitano, legal intern at Robinson+Cole. Michael is not yet admitted to practice law.

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