QUICK REFERENCE GUIDE

CMS INTERIM FINAL RULE WITH COMMENT PERIOD CONCERNING POLICY AND REGULATORY REVISIONS IN RESPONSE TO COVID PHE[1]

Comments due: June 1, 2020

IFC TOC	TOPIC/CATEGORY	IFC PAGE REFERENCE	SUBSTANCE
I	Purpose of Rule	Pg. 19232	"CDC has urged health care professionals to make every effort to interview persons under investigation for infection by telephone, text messaging system, or video conference instead of in person." "To facilitate the use of telecommunications technology as a safe substitute for in-person services, we are, on an interim basis, 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."
II(A)	Site of Service Differential for Medicare Telehealth Services	Pg. 19233	**Current Rule** POS 02 is required on claims for distant site telehealth services. All distant site telehealth services are paid at the facility rate. **IFC Change** Medicare will pay non-facility rates for telehealth services furnished by distant site practitioners. Under the IFC, CMS will permit telehealth services to be billed with the POS that would have been reported had the service been furnished in person (e.g., POS 11). This will allow for payment of telehealth services at the non-facility rate. If distant site telehealth services are furnished from an on- or off-campus HOPD, practitioner must report POS 19/22 on the claim and payment will be at the facility rate. CMS will require addition of Modifier 95 to claim lines that describe telehealth services. Distant site practitioners may continue to submit claims with POS 02 and receive payment at the facility rate if they choose to maintain current billing practices.

[1] CMS, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 PHE, 85 Fed. Reg. 19230 (Apr. 6, 2020) [CMS-1744-IFC].

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			Take-Away This temporary change means that telehealth services will be paid at the same rate as they would be paid if furnished in-person.
II(A)	Adding Services to List of Medicare Approved Telehealth Services	Pg. 19233	**Current Rule** CMS provides payment for a limited set of telehealth services and updates the list of approved telehealth services, by CPT code, on an annual basis. **IFC Change** CMS is adding 80 new CPT codes as Category 2 services (i.e., services that are not similar to the current list of telehealth services). These are intended to be temporary additions to the list of approved telehealth services for dates of service March 1, 2020 through the end of the declared Public Health Emergency (PHE), including subsequent renewals. CMS expects practitioners to E/M codes that best describes the nature of the care provided, regardless of the physical location or status of the patient. **Temporary Telehealth Services** • Emergency Department Visits [CPT Codes 99281-99285] • Initial and Subsequent Observation and Observation Discharge Day Management [CPT Codes 99217-99236] • Initial hospital care and hospital discharge day management [CPT Codes 99221-99239] • Initial nursing facility visits and nursing facility discharge day management [CPT Codes 99304-99316] • Critical Care Services [CPT Codes 99291-99292] • Domiciliary, Rest Home or Custodial Care Services [CPT Codes 99327-99337] • Home Visits [CPT Codes 99341 – 99350] • Inpatient Neonatal and Pediatric Critical Care [CPT Codes 99468-99476] • Initial and Continuing Intensive Care Services [CPT Codes 99477-99480] • Care Planning for Patients with Cognitive Impairment [CPT Code 99483] • Group Psychotherapy [CPT Code 90853] • End-Stage Renal Disease Services [CPT Codes 90952-90962] • Psychological and Neuropsychological Testing [CPT Codes 93130-96139]

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			• Therapy Services [*but not when provided by PT, OT, ST* as they are not an approved telehealth provider] [CPT Codes 97161-92507] • Radiation Treatment Management Services [CPT Code 77427] [weekly F2F component] **Take-Away** Consistent with the 1135 waiver of the originating site, the addition of these 80 new codes supports coverage of telehealth services by distant practitioners furnished to patients in all settings of care. **Comments Solicited** What other services could use telecommunications technology with clear clinical benefit during PHE? What are potential negative effects of adding these codes to telehealth?
II(B)	Frequency Limitations on Inpatient and Nursing Facility Settings; Critical Care Consults Visits	Pg. 19241	**Current Rule** Billing for subsequent inpatient visits [99231-99233] is limited to once every three days; subsequent nursing facility visits [99307-99310] is limited to once every 30 days; and critical care consultations [G0508-G0509] is limited to once per day. **IFC Change** For the duration of the PHE, the rule temporarily removes the frequency restrictions for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations furnished via Medicare telehealth. **Take-Away** By removing the frequency restrictions on these telehealth codes, CMS is seeking to allow increased access to care for patient populations that may not otherwise have access to clinically appropriate in-person treatment.
II(B)	Hands-On Visits for ESRD Capitation Payments	Pg. 19424	**Current Rule** CMS added ESRD-related services to the list of telehealth services effective for CY 2005 but required the clinical examination of a patient's vascular access site to be furnished face-to-face hands-on (without the use of interactive telecommunications system by physician, clinical nurse specialists, nurse practitioner, or physician assistant). As of January 1, 2019, Sections 1881(b)(3) and 1834(m) of the Social Security Act permit a patient determined to have ESRD receiving home dialysis to choose

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			to receive certain monthly ESRD-related clinical assessments via telehealth. However, Social Security Act § 1881(b)(3)(B) still requires such patients to receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial three months of home dialysis and at least once every three months after the initial three months. **IFC Change** During the declared PHE, CMS is permitting the clinical examination of the vascular site to be furnished via a telehealth visit. CMS is also exercising discretion to relax enforcement of the requirements of 1881(b)(3)(B) that certain visits be furnished without the use of telehealth. CMS will not conduct reviews to consider whether these visits were conducted face-to-face, without the use of telehealth. Affected CPT Codes: 90951-90970. **Take-Away** Removal of the face-to-face hands-on requirement for these services will help ensure that the clinical examination of patients will continue to occur albeit through virtual means.
II(C)	Telehealth Modalities	Pg. 19243	**Current Rule** Under 42 CFR 410.78(a)(3), telephones, facsimile machines and electronic mail systems do not meet the definition of interactive telecommunications systems for Medicare telehealth services. **IFC change** Adds exception to 410.78(a)(3) on interim basis: 410.78(a)(3)(i) – Exception: For duration of PHE as defined in 400.200..., *interactive telecommunication 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. **Take-Away** Telehealth still requires audio-video and two-way, real-time interactive communication, even though it is removing from the definition of "interactive telecommunication system" the references to telephones, facsimile machines and electronic mail systems for the duration of the PHE.

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II(C)	Beneficiary Cost-Sharing	Pg. 19243	CMS restates in the IFC the OIG's Policy Statement notifying physicians and practitioners that they will not be subject to administrative sanctions during the PHE for reducing or waiving cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services furnished consistent with applicable coverage and payment rules. CMS notes that the OIG's policy in this regard applies to telehealth visits, virtual check-in services, e-visits, monthly remote care management and monthly remote patient monitoring.
II(D)	Communication Technology-Based Services (CTBS)	Pg. 19243	**Current Rule** *Virtual check-in services* [G2010; G2012] may not be furnished to new patients, nor may they be reported when the communication originates from a related E/M services (including one furnished via telehealth) within the prior 7 days by the same physician or practitioner or result in an E/M visit or procedure within the next 24 hours or soonest available appointment. These codes require the practitioner to have an established relationship the patient. These services may be billed by practitioners who bill E/M codes. *E-Visits* [99421-99423; G2061-G2063] must be initiated by an established patient. **IFC Change** *Virtual Check-in*: For the period of the PHE, CMS is removing the requirement for an established patient relationship. This means virtual check-in services may be used with new patients, so long as the virtual check-in does not result in a visit, including a telehealth visit. CMS is also allowing patient consent to be obtained and documented by auxiliary personnel under general supervision and that consent can be obtained at the same time as the service is rendered. *E-Visits*: For the period of the PHE, CMS is removing the requirement for an established relationship. CMS is also allowing patient consent to be obtained and documented by auxiliary personnel under general supervision and that consent can be obtained at the same time as the service is rendered. *Types of non-physician practitioners who may bill Virtual Check-In and E-Visit services*: CMS is permitting practitioners who do not bill E/M codes, such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech-language pathologists to provide virtual check-in and e-visit services. CTBS "G codes" will be designated "sometimes therapy" services that would require Private Practice physical therapists, occupational therapists and speech-

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			language pathologists to include the corresponding GO, GP or GN therapy modifier on claims for these services. **Comments Solicited** What other kinds of practitioners might furnish virtual check-in services and e-visit services during the PHE? **Take-Aways** Note that while CTBS are not telehealth services, they still enable practitioners to engage with patients through virtual means. Practitioners who are not able to provide telehealth services (e.g., PT, ST, OT) are now permitted to furnish CTBS.
II(E)	Direct Supervision by Interactive Telecommunications Technology	Pg. 19245	**Current Rule** As defined in 42 CFR § 410.32(b)(3)(ii), direct supervision means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not require the physician to be present in the room when the procedure is performed. **IFC Change** The rule amends the current definition of direct supervision for the duration of the PHE to allow the use of real-time interactive audio and video technology (i.e., virtual presence) by the supervising physician to satisfy the direct supervision requirement. CMS is also permitting physicians to leverage additional staff and technology necessary to provide care that would normally be furnished incident to a physician's services (including services that can be performed via telehealth). **Comments Solicited** Should there be any guardrails and what kind of risk might this policy introduce for beneficiaries while reducing risk of COVID-19 spread? **Take-Away** The IFC policy changes the way in which direct supervision can be met; it does not change the underlying payment policy. Moreover, it allows physicians to contract with another provider/supplier type to provide virtual visits for patients in their homes and to bill for incident to services furnished by

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			the auxiliary personnel so long as supervision is provided through audio-video real-time communication technology.
II(E)	Supervision Changes for Certain Hospital and CAH Diagnostic and Therapeutic Services	Pg. 19246	**Current Rule** As defined in 42 CFR § 410.28(e)(1), direct supervision means that the physician must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not require the physician to be present in the room when the procedure is performed. Most therapeutic services in the hospital require general supervision and the supervision requirements for diagnostic services generally conform to the service-level supervision levels required for payment under the physician fee schedule. Pulmonary rehabilitation (42 CFR § 410.47), cardiac rehabilitation and intensive cardiac rehabilitation (42 CFR § 410.49) require direct supervision. **IFC Change** For the period of the PHE, the rule amends the definition of direct supervision for hospital diagnostic and therapeutic services, pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation services to allow the use of real-time interactive audio and video technology (i.e., virtual presence) by the supervising physician to satisfy the direct supervision requirement. **Take-Away** The ability to satisfy supervision requirements through the use of virtual presence will help to reduce the risk of exposure and improve the availability of medical professionals.
II(F)	Clarification of Home Bound for Medicare Home Health Benefit	Pg. 19246	**Current Rule** Social Security Act §§ 1814(a) and 1835(a) provide that an individual will be considered "confined to his home" if the individual has a condition, due to an illness or injury, 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. An individual does not have to be bedridden to be considered "confined to his home;" however, the condition must be such that there exists a normal inability to leave home and leaving home requires considerable and taxing effort by the individual.

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			IFC Change CMS clarifies that, for purposes of the home health benefit, the "confined to home" requirements can be met if (1) a physician has determined that it is medically contraindicated for the individual to leave home because he or she has a confirmed or suspected diagnosis of COVID-19; or (2) where the physician has determined that it is medically contraindicated for the individual to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19. CMS makes clear that an individual who is exercising "self-quarantine" for one's own safety would not be considered "confined to the home" [or home bound] unless a physician certifies that it is medically contraindicated for the patient to leave the home. Medical record documentation must include information as to why the individual condition of the patient is such that leaving the home is medically contraindicated. The individual must still meet all other eligibility requirements for receiving home health care services. This change will not only apply to the COVID-19 PHE but will also apply to any other outbreak of infectious disease and instances where the individual's condition is such that it is medically contraindicated for the patient to leave home. **Comments Solicited** CMS is soliciting comments on this clarification. **Take-Away** This clarification represents a far broader interpretation of what it means to be confined to home not only during a time of an infectious disease outbreak, but also in general.

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II(G)	Use of Technology for Home Health Benefit during PHE	Pg. 19247	**Current Rule** CMS prohibits use of telecommunications systems when the services substitute for in-person home health services ordered as part of a plan of care certified by a physician. **IFC Change** The rule amends the plan of care requirements at 42 CFR § 409.43(a), on an interim basis for the duration of the PHE, to allow for the provision of remote patient monitoring or other services furnished through telecommunication systems. Any such services must be tied to patient-specific needs as identified in the comprehensive assessment, cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purpose of patient eligibility or payment. The plan of care also must describe how the use of technology will help to achieve the goals outlined in the plan of care. CMS is providing home health agencies flexibility to obtain physician signatures for changes to the plan of care to incorporate the use of technology. Home health agencies can report costs of telecommunications equipment as allowable A&G costs. **Take-Away** Use of technology to augment home health services may result in changes to the frequency or types of in-person visits outlined in the plan of care.
II(H)	Use of Telecommunications Technology under Medicare Hospice Benefit	Pg. 19250	**Current Rule** Current rules do not contemplate use of telecommunications technology under the Medicare hospice benefit. **IFC Change** The rule amends 42 CFR § 418.204 to allow hospices, for the duration of the PHE, to provide services via telecommunications system if it is feasible and appropriate to ensure that Medicare patients can continue to receive services that are reasonable and necessary for the palliation and management of a patient's terminal illness and related conditions without jeopardizing the patient's health or the health of those providing such services. The role of technology must be documented in the plan of care and must be tied to specific patient needs as identified in comprehensive assessment and measurable outcomes that the hospice anticipates will occur with the plan of care.

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			This change will not result in additional payment beyond the per diem amount under the hospice benefit and only in-person visits should be reported on the claim form. Hospices will, however, be allowed to report the costs of telecommunications technology under routine home care level of care during the PHE as "other patient care services" using Worksheet A. **Take-Away** CMS is seeking to improve access to and use of technologies, such as telemedicine and remote patient monitoring, that will enable flexibility for patients to receive necessary services without endangering their health or the health of those individuals providing the services.
II(I)	Telehealth and Medicare Hospice Face-to-Face Encounter	Pg. 19251	**Current Rule** Under 42 CFR § 418.22(a)(4), a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each Medicare hospice patient whose total stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the third benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care. **IFC Change** The rule amends 42 CFR § 418.22(a)(4) in order to permit, on an interim basis, the use of telecommunications technology by the hospice physician or hospice nurse practitioner for the face-to-face visit when such visit is solely for the purpose of recertifying a patent for hospice during the PHE. The telecommunications technology equipment must include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient (from home, or any other site permissible for receiving services under the hospice benefit) and distant site hospice physician or hospice nurse practitioner. Use of telecommunication equipment is not separately billable but considered an administrative expense. **Take-Away** Allowing the non-billable administrative requirement of obtaining a recertification to be done through the use of real-time audio-video technologies helps to reduce the risk of exposure for patients and practitioners.

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II(J)	Modification to Inpatient Rehab Facility Face-to-Face Requirement during COVID-19	Pg. 19252	**Current Rule** Under 42 CFR § 412.622(a)(3)(iv), there must be a reasonable expectation at the time of patient admission to an inpatient rehabilitation facility that the patient requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. Under 42 CFR § 412.29(e), the rehabilitation physician must provide at least three face-to-face visits per week to assess the patient both medically and functionally, and to modify the course of treatment as needed to maximize the patient's capacity to benefit from rehabilitation services. **IFC Change** The rule amends 42 CFR § 412.622(a)(3)(iv) and § 412.29(e) to allow the face-to-face visits required by those rules to be provided by the rehabilitation physician during the PHE through the use of telehealth services. **Take-Away** Allowing the use of telehealth for the physician supervision requirements will enable the provision of medically necessary services without jeopardizing the patient's health or the health of those who are providing those services, while minimizing overall risk to public health.
II(K)	Removal of IRF Post-Admission Physician Evaluation Requirement for the PHE and Clarification of the 3-hour Rule	Pg. 19252	**Current Rule** Under 42 CFR § 412.622(a)(4)(ii), CMS requires that a patient's medical record at the inpatient rehabilitation facility must contain a post-admission physician evaluation that: • Is completed by rehab physician within 24 hours of patient's admission to IRF; • Documents the patient's status on admission to IRF, including a comparison with information noted in pre-admission screening documentation, and serves as basis for development of overall individualized plan of care; and • Is retained in the patient's medical record at the IRF. Coverage rules also require that a beneficiary must be able to participate actively in and benefit from intensive rehab therapy program on admission to IRF. The industry standard is that an intensive rehab therapy program generally consists of at least three hours of therapy (PT, ST, OT, or prosthetics/orthotics therapy) per day at least five days per week.

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			IFC Change The rule amends 42 CFR § 412.622(a)(4)(ii) by providing that the post-admission physician evaluation is not required during the PHE. CMS is *not* removing the three-hour standard but advises that where an IRF's intensive rehab therapy program is impacted by the PHE (e.g., due to staffing disruptions, infection, etc.) the IRF should not feel obligated to meet the industry standard but instead should document the reason for not meeting the standard in the medical records. **Take-Away** The strict documentation and coverage requirements applicable to IRFs would be a disincentive to have IRFs accept patients who might not qualify for coverage. The relaxation of these coverage rules is intended to facilitate the transfer of patients to IRFs.
II(L)	Expansion of Virtual Communication Services Furnished by RHCs and FQHCs	Pg. 19253	**Current Rule** Current rules permit RHCs/FQHCs to be paid separately (on the RHC/FQHC claim) for virtual communication services under code G0071 and waives the face-to-face requirement for those services. Virtual communication services are covered for established patients who have had a billable RHC/FQHC visit within the prior year so long as the medical discussion or remote evaluation is for a condition not related to the RHC/FQHC visit provided in prior seven days and does not lead to an RHC/FQHC visit within next 24 hours or soonest available appointment. **IFC Change** The rule expands the types of services that can be billed as virtual communication services under G0071 and will update the payment rate to reflect addition of those services. The additional services that can be billed under G0071 include e-visit services (traditionally billed under 99421 – 99423). Payment will be the average of the Medicare Physician Fee Schedule national non-facility payment for G2012, G2010, 99421, 99422, and 99423. The face-to-face requirement is waived. The rule allows RHCs/FQHCs to provide virtual communication services to new patients and established patients and consent can be obtained at the time of the service and must be obtained prior to billing by staff under general supervision of RHC/FQHC practitioner. **Take-Away** This change will permit RHCs/FQHCs to provide a greater array of virtual services under code G0071, but it does not mean that RHCs/FQHCs may furnish telehealth services.

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II(L)	RHC/FQHC: HHA Shortage Area Requirements for Furnishing Visiting Nursing Services	Pg. 19254	**Current Law** Visiting nurse services are covered if the RHC/FQHC is located in an area in which the Secretary has determined that there is a shortage of home health agencies. 42 CFR § 405.2417 provides additional requirements for an area to be determined to have a shortage of home health agencies. **IFC Changes** The rule amends 42 CFR § 405.2416 to provide that during the PHE, any area typically served by the RHC and any area that is included in an FQHC service area plan is determined to have a shortage of HHS. No request for determination will be required.
II(M)	Medicare Clinical Laboratory Fee Schedule; Payment for Specimen Collection for COVID-19 Testing New "Homebound" Definition for Labs	Pg. 19256	**Current Rule** The Social Security Act provides for payment of a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the lab sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). **IFC Change** CMS will now provide additional payment during the PHE in the form of a specimen collection fee for an individual in an SNF or by a laboratory on behalf of an HHA for COVID-19 testing and will provide a travel allowance for a laboratory technician to collect a specimen for COVID-19 testing from a non-hospital inpatients or homebound patients. Travel expenses can be tracked electronically. Specimen collection fee will be $23.46 for homebound and non-hospital inpatients [G2023]. Specimen collection fee will be $25.46 for individuals in an SNF or individuals whose samples will be collected by lab on behalf of HHA [G2024]. Homebound status for purposes of the PHE would apply for those patients: (1) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home due to a confirmed or suspected diagnosis of COVID-19; or (2) where 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.

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			A patient who is exercising "self-quarantine" for his or her own safety, would not be considered "homebound" unless it is also medically contraindicated for the patient to leave the home. Determinations of whether the patient is homebound must be based on an assessment of each beneficiary's individual condition. **Take-Away** By providing a specimen collection fee for COVID-19 testing during the PHE, CMS will provide independent laboratories with additional resources to provide this testing and at the same time help with efforts to limit patients' exposure to the general population.
II(N)	Requirements for Opioid Treatment Programs	Pg. 19258	**Current Rule** 42 CFR § 410.67(b)(3) and (4) require the use of two-way interactive audio/video communication technology for substance use counseling and for individual and group therapy sessions. **IFC Change** The rule amends 42 CFR § 410.67(b)(3) and (4) to allow therapy and counseling portions of weekly bundles, as well as add-on codes for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology during PHE if beneficiary does not have access to two-way audio-video communication technology, provided all other requirements are met. **Take-Away** The change will help to support the ongoing provision of these therapy services during the PHE.
II(O)	Teaching Physicians and Moonlighting Regulations during PHE	Pg. 19258	**Current Rule** With some exceptions, under 42 CFR § 415.172, if a resident participates in a service furnished in a teaching setting, PFS payment is made only if the teaching physician is present during the key portion of any service or procedure for which payment is sought. For office/outpatient E/M services provided in the outpatient department of a hospital or another ambulatory care entity (that is, primary care centers) the physical presence requirements are met: • For the interpretation of diagnostic tests, PFS payment is made if the interpretation is performed or reviewed by a physician other than a resident.

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			• For psychiatric services, supervision may be met by observation of the service by use of a one-way mirror, video equipment, or similar device. **IFC Change** For the PHE, real-time, audio and video telecommunications technology will enable supervising physicians to furnish assistance and direction without requiring the teaching physician's physical presence for the key portion of the service. Included in this rule are: • All levels of an office/outpatient E/M service provided under direct supervision of the teaching physician by interactive telecommunications technology. For 42 CFR § 415.180, for the duration of the PHE for the COVID-19 pandemic. • The interpretation of diagnostic radiology and other diagnostic tests when the interpretation is performed by a resident under direct supervision of the teaching physician by interactive telecommunications technology. The teaching physician must still review the resident's interpretation. The requirement for the presence of the teaching physician during the psychiatric service in which a resident is involved may be met by the teaching physician's direct supervision by interactive telecommunications technology. For the PHE, pandemic exceptions previously described will not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope and anesthesia services. **Take-Away** CMS is seeking to increase the availability of medical personnel. **Comments Solicited** CMS seeks comment on whether other procedures should also be exempt from this policy given the complex nature or potential danger to the patient.

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II(O)	Application of Expansion of Telehealth Services to Teaching Physician Services	Pg. 19260	**Current Rule** The general rule under 42 CFR § 415.172 is that if a resident participates in a service furnished in a teaching setting, the PFS payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought. **IFC Change** The rule amends 42 CFR § 415.172(a) to provide that during a PHE, Medicare may make payment under PFS if a resident participates in a service furnished in a teaching setting, provided a teaching physician is present during the key portion of the service using interactive telecommunications technology for any service or procedure for which payment is sought. CMS is also permitting payment under the PFS for teaching physicians' services when the resident is furnishing such services while in quarantine under direct supervision of the teaching physician by interactive telecommunications technology. **Take-Away** CMS is seeking to increase the capacity of teaching settings to respond to the pandemic by permitting the supervision of a teaching physician to be provided through virtual means.
II(O)	Moonlighting Regulation	Pg. 19260	**Current Rule** A licensed resident physician is considered to be "moonlighting" when furnishing physicians' services to outpatients outside the scope of an approved graduate medical education (GME) program but, the services of residents in hospitals in which the residents have their approved GME program are not considered separately billable as physicians' services. When a resident furnishes services that are not related to their approved GME programs in an outpatient department or emergency department of a hospital in which they have their training program, those services can be billed separately as physicians' services and payable under the PFS. **IFC Change** 42 CFR § 415.208 will now state that the services of residents that are not related to their approved GME programs and are performed in the inpatient setting of a hospital in which they have their training program are separately billable physicians' services for which payment can be made under the PFS. The service must be identifiable physicians' services and the resident must be fully licensed

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			to practice medicine, osteopathy, dentistry or podiatry by the state in which the services are performed. **Take-Away** The current regulation limited the qualified practitioners available to render services that are billable. This will make more physicians available to provide billable services.
II(P)	Requirements for Psychiatric Hospitals	Pg. 19261	**Current Rule** Except for a few provisions in the CoPs, such as those directly related to 42 CFR § 482.12(c) described here, the remainder of the CoPs apply to all patients, regardless of payment source, and not just Medicare beneficiaries. **IFC Change** This change permits a greater scope of practice for these professionals in the psychiatric hospital context. Advanced Practice Practitioners (APPs), including PAs, NPs, psychologists, and CNSs (as well as other qualified, licensed practitioners) when acting in accordance with state law, their scope of practice and hospital policy, should have the authority to practice more broadly and to the highest level of their education, training and qualifications as allowed under their respective state requirements and laws in this area. 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. **Take-Away** Prior law may have inadvertently exacerbated workforce shortage concerns by restricting a hospital's ability to allow APPs and other NPPs to operate within the scope of practice allowed by state law.
II(Q)	Innovation Center Models: MDPP; CJR; Alternative Payment Models	Pg. 19262	**Current Rule** *Medicare Diabetes Prevention Program (MDPP)* Under the MDPP program, MDPP would be delivered in-person, in a classroom-based setting, within an established timeline. At the time, the priority was placed on establishing a structured service that, when delivered within the confines of the rule, would create the least risk of fraud and abuse,

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			increase the likelihood of success, and maintain the integrity of the data collected for evaluation purposes. **IFC Change** The rule will permit certain beneficiaries to obtain the set of MDPP services more than once per lifetime, increase the number of virtual make-up sessions, and allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis. Under these temporary flexibilities, the requirement for in-person attendance at the first core session will remain in effect. As a result, if beneficiaries are prohibited from attending the first core session in person, suppliers will be unable to start any new cohorts with MDPP. *Comprehensive Care for Joint Replacement (CJR):* To enable the CJR model to adjust for the effect of COVID-19, CMS is broadening the "extreme and uncontrollable circumstances" policy by applying certain financial safeguards to participant hospitals that have a CCN primary address that is located in an emergency area for episodes that overlap with the emergency period. This change for participant hospitals affected by the COVID-19 pandemic allows participant hospitals to concentrate on patient care and ensures that participant hospitals are not held financially liable for episode costs that escalate due to effects from the COVID-19 pandemic. Specifically, CMS is stating that for a fracture or non-fracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before the date that the emergency period (as defined in section 1135(g) of the Act) begins or that occurs through the termination of the emergency period (as described in section 1135(e) of the Act), actual episode payments are capped at the target price determined for that episode under 42 CFR § 510.300. *Alternative Payment Models under QPP:* We acknowledge that possible changes might be needed to address issues that may arise for APM participants in light of the current emergency. We will consider undertaking additional rulemaking, including possibly another interim final rule, to amend or suspend APM QPP policies as necessary to ensure accurate and appropriate application of Quality Payment Program policies in light of the PHE. **Take-Away** The scale of the unexpected circumstances here is causing CMS to make changes to some innovation program policies to cushion the blow to participants.

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II(R)	Remote Physiologic Monitoring	Pg. 19264	**Current Rule** RPM codes can be used for physiologic monitoring of patients with acute and/or chronic conditions. The typical patient needing RPM services may have a chronic condition (for example, high blood pressure, diabetes, COPD). Remote Physiologic Monitoring (RPM) codes that were approved recently, include: • CPT code 99091 (Collection and interpretation of physiologic data transmitted by the patient to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time), • CPT code 99453 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment), • CPT code 99454 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days), • CPT code 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes), and • CPT code 99458 Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes). **IFC Change** Under the rule, RPM services can now be furnished to new patients, as well as to established patients. To enhance beneficiary protection, for both new and established patients, CMS suggests that the physician review consent information with a beneficiary, obtain the beneficiary's verbal consent, and document in the medical record that consent was obtained. However, CMS also believes that acquiring patient consent should not interfere with the provision of RPM services during the PHE. Therefore, consent to receive RPM services can be obtained once annually, including at the time services are furnished, during the duration of the PHE.

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			Take-Away CMS is expanding the use of RPM services while seeking to protect patients from surprise bills for copayments on such monitoring.
II(S)	Telephone E&M Services	Pg. 19264	**Current Rule** Telephone E/M services described in CPT codes 98966 – 98968; 99441 – 99443 are considered categorically noncovered (Status Indicator "N"). **IFC Change** CMS is providing separate payment for these telephone E/M codes during PHE and permitting the services described by these codes to apply to both new and established patients. CMS is permitting CPT codes 98966-98968 to be billed by practitioners who do not bill E/M. This means that LCSWs, clinical psychologists, PT, OT, ST may bill for these services. CMS is considering these services to qualify as "sometimes therapy," and therefore, they should be billed by these practitioners with the GO, GP, GN therapy modifier, as appropriate. **Take-Away** The addition of these codes as payable means that practitioners, including now those that cannot provide telehealth services (e.g., PT, OT and ST) may provide E/M services via telephone (i.e., audio-only).
II(T)	Physician Supervision Flexibility for Outpatient Hospitals – Outpatient Hospital Therapeutic Services Assigned for Non-surgical Extended Duration Therapeutic Services	Pg. 19266	**Current Rule** Non-surgical extended duration therapeutic services (NSEDTS) describe services that have a significant monitoring component, that are not surgical, and that typically have a low risk of complications after the assessment at the beginning of the service. The minimum default supervision level of NSEDTS is direct supervision during the initiation of the service, which may be followed by general supervision at the discretion of the supervising physician or the appropriate NPP (42 CFR § 410.27(a)(1)(iv)(E)). CMS requires general supervision as the appropriate level of supervision after the initiation of the service because it is challenging for hospitals to ensure direct supervision for services with an extended duration and a significant monitoring component, particularly for CAHs and small rural hospitals.

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			IFC Change CMS is assigning, on an interim basis, all outpatient hospital therapeutic services that fall under 42 CFR § 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 outpatient hospital therapeutic services. General supervision, as defined in 42 CFR § 410.32(b)(3)(i) to mean that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. **Take-Away** Changing the minimum default level of supervision to general supervision for NSEDTS during the initiation of the service will give providers additional flexibility they will need to handle the burdens created by the PHE for the COVID-19 pandemic.
II(U)	Application of NCD and LCD during PHE Face-to-Face Respiratory Home Coagulation Infusion Pump Supervision	Pg. 19266	**Current Rule** National Coverage Determinations (NCDs) are determinations by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII. 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 under section 1862(a)(1)(A) of the Act in the particular MAC's geographical areas. NCDs and LCDs contain clinical conditions a patient must meet to qualify for coverage of the item or service. Some NCDs and LCDs may also contain requirements for face-to-face, timely evaluations or re-evaluations for a patient to initially qualify for coverage or to qualify for continuing coverage of the item or service. These requirements are more often present in NCDs and LCDs for durable medical equipment than for other items and services. It should be noted that this change does not confer changes to the clinical indications of coverage for any LCD or NCD unless specifically indicated below. Rather, most of these changes impact documentation of medical necessity. **IFC Changes** *FACE-TO-FACE* To the extent an NCD or LCD 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.

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			Take-Away CMS notes that some face-to-face encounter requirements (e.g., for DMEPOS Power Mobility Devices (PMDs)) are mandated by statute for program integrity purposes. For example, PMD face-to-face encounter requirements are found in section 1834(a)(1)(E)(iv) of the Act, as codified in 42 CFR § 410.38, and CMS's regulation already permits the use of telehealth in accordance with Medicare guidelines *RESPIRATORY, HOME ANTICOAGULATION MANAGEMENT AND INFUSION PUMP* CMS will not enforce the clinical indications for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs (including articles) allowing for maximum flexibility for practitioners to care for their patients. These policies include, but are not limited to: • NCD 240.2 Home Oxygen. CMS-1744-IFC 129 • NCD 240.4 Continuous Positive Airway Pressure for Obstructive Sleep Apnea. • LCD L33800 Respiratory Assist Devices (ventilators for home use). • NCD 240.5 Intrapulmonary Percussive Ventilator. • LCD L33797 Oxygen and Oxygen Equipment (for home use). • NCD 190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management. • NCD 280.14 Infusion Pumps. • LCD L33794 External Infusion Pumps. At the conclusion of the PHE, we will return to enforcement of these clinical indications for coverage. *CONSULTATIONS OR SERVICES FURNISHED BY OR WITH THE SUPERVISION OF A PARTICULAR MEDICAL PRACTITIONER OR SPECIALIST STAFFING* To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish a service, procedure or any portion thereof, CMS has authorized the chief medical officer or equivalent of the facility can authorize another physician specialty or other practitioner type to meet those requirements during the PHE.

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			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 the facility can determine that such supervision requirements do not apply during the PHE. **Take-Away** This loosening of supervisory requirements will reduce shortages of physicians where their physical presence might otherwise be required, such as outpatient radiation therapy which must generally be supervised by a radiation oncologist.
II(V)	Changes to MSSP Extreme and Uncontrollable Circumstances Policy	Pg. 19267	**Current Rule** The current extreme and uncontrollable circumstances policy for the Medicare Shared Savings Program (MSSP) at 42 CFR § 425.502(f) provides relief for ACOs and their clinicians impacted by extreme and uncontrollable circumstances, such as hurricanes, wildfires, or other triggering events. This policy established an alternate approach to determine quality performance scores for MSSP Accountable Care Organizations (ACOs) impacted by extreme and uncontrollable circumstances during a certain performance year, including the applicable quality data reporting period for the performance year, if the quality reporting period was not extended. **IFC Change** The rule acknowledges that, due to the nationwide COVID-19 pandemic, simply extending the reporting period for quality data will likely be insufficient for ACOs and their clinicians who are focused on patient care at this time. This IFC revises the regulation at 42 CFR § 425.502(f) to remove the restriction that prevents application of the MSSP extreme and uncontrollable circumstances policy for disasters that occur during the quality reporting period if the reporting period is extended. This provides some relief for all ACOs who may be unable to submit complete and accurate quality date for the 2019 performance period due to the need to focus on COVID-19 efforts while the reporting period is open. The IFC also notes because the PHE for COVID-19 was declared during the reporting period for performance year 2019, the provisions that allow for an adjustment to shared losses for ACOs affected by extreme and uncontrollable circumstances cannot apply to the previous performance year. Rather, for the performance year 2020 financial reconciliation, this will be considered as addressed in 42 CFR § 400.200.

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			Take-Away This change acknowledges the challenge that many ACOs will face in submitting quality data reporting during the extended reporting period due to the efforts required by the COVID-19 PHE. Because the PHE is nationwide, this change applies to all ACOs and their clinicians for the 2019 performance year reporting period. If quality data is not submitted, the alternate approach will be applied in the scoring methodology.
II(W)	Level Selection for Office/Outpatient E/M Visits When Furnished Via Telehealth	Pg. 19268	**Current Rule** The primary factor used to select E/M service level is time spent counseling the patient. **IFC Change** Under the rule, CMS is revising its policy to allow the selection for office/outpatient E/M level when furnished via telehealth to be based on MDM (medical decision making) or time, with time defined as all the time associated with the E/M on the day of the encounter. CMS is maintaining its expectations that practitioners will document E/M visits as necessary to ensure quality and continuity of care. **Take-Away** The change will enable practitioners to select the level of E/M services based on both face-to-face and non-face-to-face time personally spent by the practitioner in furnishing the telehealth visit.
II(X)	Counting Resident Time During the PHE	Pg. 19269	**Current Rule** Pursuant to 42 CFR § 412.78(a), (g), for purposes of DGME and IME a resident must be either in a hospital or non-provider site, such as a doctor's office or clinic, to be included in the resident count. **IFC Change** During the PHE, a hospital that is paying the resident's salary and fringe benefits may count that resident for IME and DGME purposes 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, so long as the resident is performing patient care duties within the scope of the approved residency program (and meets appropriate physician supervision requirements as set forth in this rule above). **Take-Away** Providers may count resident time providing services remotely from their or patients' homes.

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II(Y)	Impact of COVID-19 on Part C and Part D Quality Rating System	Pg. 19269	**Current Rule** Pursuant to 42 CFR Parts 417, 422, 423, CMS obtains data from Medicare Advantage (MA) and Part D plans that CMS uses for various purposes, including providing data to beneficiaries regarding the plans and making quality bonus payments. **IFC Change** The rule amends the calculation for the 2021 and 2022 Part C and D Star Ratings due to impact of the PHE on data collection activities as follows: (1) replaces 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) establishes 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) modifies 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 HOS data collection in 2020 (for the 2022 Star Ratings), replaces the measures calculated based on Health Outcomes Survey data collections with earlier values that are not affected by the public health threats posed by COVID-19 for the 2022 Star Ratings; (5) removes guardrails for the 2022 Star Ratings; and (6) expands the existing hold harmless provision for the Part C and D Improvement measures to include all contracts for the 2022 Star Ratings. **Take-Away** CMS is making changes to data collection for quality rating purposes for the 2021 and 2022 rating to allow providers to focus on increased patient needs during the PHE and to avoid the need to retrieve data that may not be able to be retrieved working remotely.
II(Z)	Changes to Expand Workforce Capacity for Ordering Medicaid Home Health Nursing and Aide Services, Medical Equipment,	Pg. 19275	**Current Rule** Medicaid regulations at 42 CFR § 440.770(b) requires a physician to order home health services as part of a plan of care, and to review the plan of care every 60 days, except for medical supplies, equipment and appliances, which must be reviewed annually.

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	Supplies, and Appliances, PT, OT, ST and Audiology Services		**IFC Change** The rule allows 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 PHE. **Take-Away** NPs and PAs will be permitted to order Medicaid home health services.
II(AA)	Origin and Destination Requirements – Ambulance Fee Schedule	Pg. 19276	**Current Rule** 42 CFR § 410.44(f) restricts covered ambulance services to only particular origins and destinations. **IFC Change** During the PHE a covered destination includes a ground ambulance transport from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local EMS protocols where the services will be furnished. These destinations include, but are not limited to, any location that is an alternative site determined to be part of a hospital, CAH or SNF, community mental health centers, FQHCs, RHCs, physician offices, urgent care facilities, ASCs, any location furnishing dialysis services outside of an ESRD facility when an ESRD facility is not available, and the beneficiary's home. Home may be an appropriate destination for a COVID-19 patient who is discharged from the hospital to home to be under quarantine. The requirement that ground ambulance service is medically necessary for the patient is not changed. **Take-Away** During the PHE, ambulance services that are medically necessary include transport from any point of origin to a destination equipped to treat the patient consistent with state and local EMS protocols.
II(BB)	Merit-Based Incentive Payment System (MIPS) Updates	Pg. 19276	**Current Rule** Under MIPS, eligible clinicians are eligible for a payment adjustment based on data reported in four areas. One of those areas is identified improvement activities. CMS maintains a list of eligible improvement activities which are identified to improve clinical practice of care delivery and, when effectively executed, likely to result in improved outcomes.

IFC TOC	TOPIC/CATEGORY	IFC PAGE REFERENCE	SUBSTANCE
			IFC Change Under the rule, CMS added a new eligible improvement activity related to COVID-19 clinical trials to be included in the MIPS scoring for the CY 2020 performance period. To receive credit for this activity, a MIPS-eligible clinician must participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study. **Take-Away** MIPS clinicians may earn credits by participating in a certain COVID-19 clinical trials. **Current Rule** CMS provides exceptions to meeting the MIPS program requirements for certain circumstances out of a clinician's control. **IFC Change** CMS is: (1) 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; (2) extending the deadline to submit certain applications for reweighting based on extreme and uncontrollable circumstances from December 31, 2019 to April 30, 2020, or a later date that we may specify; and (3) modifying the policy at §§ 414.1380(c)(2)(i)(A)(*6*) and 414.1380(c)(2)(i)(C) to create an exception for the 2019 performance period/2021 MIPS payment year to allow a clinician who is adversely affected by the PHE and submits data to have the data reweighted, and the data submission would not effectively void the application for reweighting. **Take-Away** CMS has invoked the automatic extreme and uncontrollable circumstances policy to provide relief in scoring for qualified MIPS clinicians.
II(CC)	Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital During PHE	Pg. 19278	**Current Rule** Routine services cannot be provided under arrangement outside the hospital. Accordingly, if a hospital's patient received routine services from another hospital, that patient would have to be discharged and transferred to the other hospital.

IFC TOC	TOPIC/CATEGORY	IFC PAGE REFERENCE	SUBSTANCE
			IFC Change Effective for services provided for discharges for patients admitted to the hospital during the PHE beginning March 1, 2020, if routine services are provided under arrangements outside the hospital to its inpatients, these services are considered as being provided by the admitting hospital. This can only be done if the hospital can exercise sufficient control and responsibility over the use of hospital resources in treating the patient outside the hospital under arrangement. **Take-Away** The ability to move patients to another hospital for routine services and still be able to bill for the patient provides additional flexibility to hospitals during this PHE.
II(DD)	Advance Payments to Suppliers Furnishing Items and Services under Part B	Pg. 19280	**Current Rule** 42 CFR § 421.214 limits CMS' ability to make advance payments in situations where a CMS contractor is unable to process claims within established time limits and limits such payments to 80 percent of the anticipated claim. **IFC Change** The rule amends the regulation: • To allow CMS to approve, in writing to the contractor, the making of advance payment during a PHE or a Presidential Disaster Declaration if the contractor is unable to process the claim timely or is at risk for being untimely, or when the supplier has experienced a temporary delay in preparing and submitting bills to the contractor. • To increase the limit for payment of such a claim to 100 percent of the anticipated claim based historical claims payment data. • To include bankruptcy as a disqualifying event for advance payments. **Take-Away** Part B suppliers are eligible for advance payment of claims at 100 percent of the anticipated claims.