

Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge

The Centers for Medicare & Medicaid Services (CMS) issued an interim final rule on Monday, March 30, detailing new rules to equip the American healthcare system with flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration.

The rule includes details in the following areas:

- Further Promote Telehealth in Medicare
- Teaching Physician Regulations
- Increase Hospital Capacity – CMS Hospitals Without Walls
- Rapidly Expand the Healthcare Workforce
- Put Patients over Paperwork

Below are links to an Interim Final Rule, CMS fact sheet on the new policies and a CMS press release:

<https://www.cms.gov/files/document/covid-final-ifc.pdf>

<https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

<https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>

<https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>

Further Promote Telehealth in Medicare

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. During the public health emergencies, individuals can use interactive apps with audio and video capabilities to visit with their clinician for an even broader range of services. Providers also can evaluate beneficiaries who have audio phones only.

These temporary changes will ensure that patients have access to physicians and other providers while remaining safely at home.

Providers can bill for telehealth visits at the same rate as in-person visits. Telehealth visits include emergency department visits, initial nursing facility and discharge visits, home visits and therapy services, which must be provided by a clinician who is allowed to provide telehealth. New as well as established patients now may stay at home and have a telehealth visit with their provider.

CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health.

CMS is making it clear that clinicians can provide remote patient monitoring services to patients with acute and chronic conditions, and can be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.

In addition, CMS is allowing physicians to supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence.

Place of Service

To implement this change on an interim basis, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. Because CMS currently uses the POS code on the claim to identify Medicare telehealth services, CMS is finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth.

Telephone Calls

CMS hopes to reduce exposure risks associated with the public health emergency (PHE) for the COVID-19 pandemic. CMS believes there are many circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate yet not fully replace a face-to-face visit. The agency believes that the existing telephone Evaluation and Management (E/M) codes, in both description and valuation, are the best way to recognize the relative resource costs of these kinds of services. Therefore, CMS is finalizing, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443. Here are the interim work RVUs for those codes:

- 0.25 for CPT code 98966;
- 0.50 work RVUs for CPT code 98967; and
- 0.75 for CPT code 98968.

- 0.25 for CPT code 99441;
- 0.50 for CPT code 99442; and
- 0.75 for CPT code 99443.

CMS is finalizing the HCPAC and RUC-recommended direct PE inputs which consist of three minutes of post-service RN/LPN/MTA clinical labor time for each code.

CMS believes it is important during the public health emergency to extend these services to both new and established patients. While some of the code descriptors refer to "established patient," during this emergency, CMS is exercising discretion on an interim basis to relax enforcement of this aspect of the code descriptors.

Selection of E/M Level

On an interim basis, CMS is revising its policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on 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; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 Physician Fee Schedule final rule. It remains CMS' expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care. To reduce the potential for confusion, CMS is maintaining the current definition of MDM. Note that currently there are typical times associated with the office/outpatient E/Ms, and CMS is finalizing those times as what should be met for purposes of level selection. This policy only applies to office/outpatient visits furnished via Medicare telehealth, and only during the PHE for the COVID-19 pandemic.

NCDs and LCDs (National/ Local Coverage Determinations)

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

To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish a service, procedure or any portion thereof, CMS is finalizing, on an interim basis, that the chief medical officer or equivalent of the facility can authorize another physician specialty or other practitioner type to meet those requirements; this is during the PHE for the COVID-19 pandemic. 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 authorize that such supervision requirements do not apply during the PHE for the COVID-19 pandemic.

Teaching Physician Regulations

More practitioners are increasingly being asked to assist with the COVID-19 response. Therefore, on an interim basis for the duration of the PHE for the COVID-19 pandemic, CMS is amending the teaching physician regulations to allow that, as a general rule, the requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology. In other words, the teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service. Specifically, CMS believes that when use of such real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means, the teaching physician's ability to furnish assistance and direction could be met without requiring that physician's physical presence for the key portion of the service.

Surgical High Risk

The regulations describing PFS payment for teaching physician services do have additional exceptions for specific policies. For example, in the case of surgical, high-risk or other complex procedures, the teaching physician must be present during all critical portions of the procedure

and immediately available to furnish services during the entire service or procedure. In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing. Given the complex nature of these procedures and the potential danger to the patient, even in the context of the PHE for the COVID-19 pandemic and the inherent exposure risks for patients and physicians, CMS believes that the requirements for physical presence for either the entire procedure or the key portions of the service, whichever are applicable, are necessary for patient safety. Thus, the exceptions during the public health emergency for the COVID-19 pandemic 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.

Diagnostic Services

CMS will allow PFS payment to be made for 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.

Quarantined Residents

Medicare may also make payment under the PFS for teaching physician services when the resident is furnishing these services while in quarantine under direct supervision of the teaching physician by interactive telecommunications technology.

Moonlighting

CMS is amending regulations to 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. Payment can be made for these services under the PFS provided that they are identifiable physicians' services and meet the conditions of payment for physicians' services to beneficiaries in providers, that the resident is fully licensed to practice medicine, osteopathy, dentistry or podiatry by the state in which the services are performed, and that the services are not performed as part of the approved GME program.

Increase Hospital Capacity – CMS Hospitals Without Walls

CMS will allow communities to take advantage of local ambulatory surgery centers that have canceled elective surgeries, per federal recommendations. Surgery centers can contract with local healthcare systems to provide hospital services, or they can enroll and bill as hospitals during the emergency declaration as long as they are not inconsistent with their state's Emergency Preparedness or Pandemic Plan. The new flexibilities will also leverage these types of sites to decant services typically provided by hospitals such as cancer procedures, trauma surgeries and other essential surgeries.

CMS will now temporarily permit non-hospital buildings and spaces to be used for patient care and quarantine sites, provided that the location is approved by the state and ensures the safety and comfort of patients and staff. This will expand the capacity of communities to develop a system of care that safely treats patients without COVID-19, and isolate and treat patients with COVID-19.

CMS will also allow hospitals, laboratories and other entities to perform tests for COVID-19 on people at home and in other community-based settings outside of the hospital. This will both increase access to testing and reduce risks of exposure. The new guidance allows healthcare systems, hospitals, and communities to set up testing sites exclusively for the purpose of identifying COVID-19-positive patients in a safe environment.

In addition, CMS will allow hospital emergency departments to test and screen patients for COVID-19 at drive-through and off-campus test sites.

During the public health emergency, ambulances can transport patients to a wider range of locations when other transportation is not medically appropriate. These destinations include community mental health centers, federally qualified health centers (FQHCs), physicians' offices, urgent care facilities, ambulatory surgery centers and any locations furnishing dialysis services when an end-stage renal disease (ESRD) facility is not available.

Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms and procedure rooms. For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the public health emergency.

In addition, hospitals can bill for services provided outside their four walls. Emergency departments of hospitals can use telehealth services to quickly assess patients to determine the most appropriate site of care, freeing emergency space for those who need it most. New rules ensure that patients can be screened at alternate treatment and testing sites which are not subject to the Emergency Medical Labor and Treatment Act (EMTALA) as long as the national emergency remains in force. This will allow hospitals, psychiatric hospitals and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19.

Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital

CMS wishes to give hospitals that provide services to Medicare beneficiaries flexibility to respond effectively to the serious public health threats posed by COVID-19. CMS recognizes the urgency of this situation, and understands that its current policy may inhibit use of capacity in settings that might otherwise be effective in the efforts to mitigate the impact of the pandemic on Medicare beneficiaries and the American public. Thus, CMS is changing its under arrangements policy during the PHE for the COVID-19 pandemic so that hospitals are allowed broader flexibilities to furnish inpatient services, including routine services outside the hospital.

However, CMS emphasized that it is not changing its policy that a hospital needs to exercise sufficient control and responsibility over the use of hospital resources in treating patients.

Rapidly Expand the Healthcare Workforce

Local private practice clinicians and their trained staff may be available for temporary employment since nonessential medical and surgical services are postponed during the public health emergency. CMS' temporary requirements allow hospitals and healthcare systems to increase their workforce capacity by removing barriers for physicians, nurses and other clinicians

to be readily hired from the local community as well as those licensed from other states without violating Medicare rules.

These healthcare workers can then perform the functions they are qualified and licensed for, while awaiting completion of federal paperwork requirements.

CMS is issuing waivers so that hospitals can use other practitioners, such as physician assistants and nurse practitioners, to the fullest extent possible, in accordance with a state's emergency preparedness or pandemic plan. These clinicians can perform such services ordering tests and medications that may have previously required a physician's order where this is permitted under state law.

CMS is waiving the requirements that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician. This will allow CRNAs to function to the fullest extent allowed by the state, free up physicians from the supervisory requirement and expand the capacity of both CRNAs and physicians.

CMS also is issuing a blanket waiver to allow hospitals to provide benefits and support to their medical staffs, such as multiple daily meals, laundry service for personal clothing or child care services while the physicians and other staff are at the hospital and engaging in activities that benefit the hospital and its patients.

CMS will also allow healthcare providers (clinicians, hospitals and other institutional providers, and suppliers) to enroll in Medicare temporarily to provide care during the public health emergency.

Put Patients over Paperwork

CMS is temporarily eliminating paperwork requirements and allowing clinicians to spend more time with patients. Medicare will now cover respiratory-related devices and equipment for any medical reason determined by clinicians so that patients can get the care they need; previously Medicare only covered them under certain circumstances.

During the public health emergency, hospitals will not be required to have written policies on processes and visitation of patients who are in COVID-19 isolation. Hospitals will also have more time to provide patients a copy of their medical records.

CMS is providing temporary relief from many audit and reporting requirements so that providers, healthcare facilities, Medicare Advantage health plans, Medicare Part D prescription drug plans and states can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

This is being done by extending reporting deadlines and suspending documentation requests that would take time away from patient care.