AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

CMS-1744-IFC: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Summary

All regulations are applicable beginning March 1, 2020

Increase Hospital Capacity-CMS Without Walls

- Temporary rule to allow hospitals to transfer patients to outside facilities including ASCs, inpatient rehab hospitals, hotels, and dormitories while still receiving hospital payment under Medicare
- CMS provides additional flexibilities beginning on March 1, 2020 related to the PHE for COVID-19 specifies "if routine services are provided under arrangements outside the hospital to its inpatients, these services are considered as being provided by the hospital."
- ASCs can contract to provide hospital services in partnership with a local healthcare system, or enroll and bill as hospitals during the emergency declaration as long as they are consistent with their state's Emergency Preparedness or Pandemic Plan
    - Under this temporary flexibility, ASCs can perform trauma surgeries, cancer procedures, and other essential surgeries
- Physician-owned hospitals will be permitted under CMS waiver to increase their number of beds without sanctions
- New guidelines established for the creating of exclusive COVID-19 testing and screening sites at healthcare systems, hospitals, and in communities
    - Outlines circumstances under which a hospital ED can implement testing and screening in drive-through and off-campus sites
- Medicare specific for COVID-19 testing: lab technicians will be paid to travel to beneficiaries' homes to collect testing specimens
    - In certain cases, hospitals and other entities will also be allowed this flexibility to test at home and in community-based settings

Rapidly Expand the Healthcare Workforce

- Blanket waiver to allow hospitals to provide benefits and support to their medical staffs, including multiple daily meals, laundry service for personal clothing, and childcare services while the staff is at the hospital providing patient care
- Expanding provider enrollment in Medicare by allowing local private practice clinicians and their trained staff to apply for temporary enrollment
- Medical residents will have greater flexibility to provide services under both in-person supervision and virtual (audio/video) supervision by a teaching physician
- CMS will allow teaching physicians to interact with residents through real-time audio/visual technology to furnish assistance and direction in patient treatment
- All levels of office/outpatient E/M visits provided in primary care centers may be provided under virtual direct supervision
    - PFS payment may be for interpretation of diagnostic test and radiology when performed by a resident under virtual direct supervision

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
PHONE 202.546.4430

        - These guidelines apply to psychiatric services as well
- Medicare will make payment under the PFS for teaching physician services when a resident provides telehealth services to beneficiaries under the direct supervision of the teaching physician which is provided via audio/visual communications
- Similarly, a resident can furnish services remotely due to quarantine under direct supervision
- Resident services (moonlighting) not related to their approved GME programs which are performed in the inpatient setting of a hospital in which they have their training program are considered separately billable physician services with payment under the PFS
- Allow broader use of verbal order as opposed to written orders by hospital physicians to decrease time spent on non-patient facing activities
- Waived the requirement for nurses to conduct on-site visits every two weeks for home health and hospice, including to evaluate the work of aides

Patients Over Paperwork

- Temporarily eliminating paperwork requirements, including waiving the requirement that hospitals have written policies in process and visitation of patients in COVID-19 isolation
- Medicare will now cover respiratory-related devices and equipment for any medical reason determined by clinicians
- Suspension of additional requests for information related to oversight activities from providers, healthcare facilities, Medicare Advantage, Part D prescription plans, and States
- Modification of the Part C and D Star Ratings to account for the disruption to data collection and measure scores caused by the pandemic

Further Promote Telehealth in Medicare

- CMS is expanding telehealth sites of service to include home, nursing or assisted living facilities
- 80 additional services can now be furnished via telehealth including ED visits, initial nursing facility and discharge visits, and home visits
    - Must be provided by a clinician that is allowed to provide telehealth
- Providers can evaluate patients using audio-only
- Telehealth visits considered to fulfill much of the face-to-face requirements for clinicians to see patients at inpatient rehab facilities, hospice, and in-home health
    - Reiterates use of commonly available interactive apps with audio/visual capabilities to perform telehealth visits
- Reimbursement at same rate as if service were furnished in-person
    - If a physician practicing in an office setting sees patients via telehealth, they would be paid the non-facility fee
    - If a physician practicing in an outpatient provider-based clinic of a hospital sees patients via telehealth, they would be paid the facility rate
- CMS seeking input on whether there are other services where telehealth could mitigate the exposure risk and where there is clear clinical benefit in furnishing the service remotely

- The limit on the use of critical care consultation codes via telehealth of once per day are being lifted, allowing providers to bill for critical care consultations remotely multiple times per day
- Home health agencies have greater flexibility to provide telehealth when it does not replace needed in-person visits as ordered by the plan of care
- For those Medicare beneficiaries who are determined by a physician to stay at home as a result of a medical contraindication or suspected or confirmed COVID-19, and are determined to need skilled services, they will be considered homebound and qualify for the Medicare Home Health Benefit
- Virtual check-in services can now be provided to both new and established patients by physicians
- Remote patient monitoring services for both chronic conditions and COVID-19 can be provided by clinicians

Telehealth Modalities and Cost-Sharing

- For the duration of the public health emergency (PHE) for COVID-19, CMS is adding an exception to the definition of "interactive telecommunications system" to allow for the use of mobile phones that have audio/video capability
    - The temporary new definition is "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"
- During the pandemic, consent to receive telehealth services may be obtained at the same time the services are furnished
- Requirement stands that when brief communication technology-based service originates from a related E/M service provided within the previous 7 days by the same provider, this service would be considered bundled into the previous E/M service
- Direct supervision definition altered for duration of PHE to state that necessary presence of the physician includes virtual presence through real-time audio/video communication when the use is indicated to reduce exposure risks for patients or providers
- For the duration of the COVID-19 pandemic, a patient is considered "homebound" when a physician has determined that it is medically contraindicated for a beneficiary to leave the home because they have a confirmed or suspected COVID-19 diagnosis, or if 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 them more susceptible to contracting COVID-19
    - Self-quarantine for one's own safety would not be considered "homebound" unless a physician certifies that
- Two new HCPCS codes created for COVID-19 testing by independent labs: G2023 and G2024
- Opioid treatment programs (OTP) programs can furnish the therapy and weekly counseling portions of weekly bundles through audio-only communication

CMMI Models

- Comprehensive Care for Joint Replacement (CJR) Performance Year 5 extended to March 31, 2021
- Updating the CJR model policy for extreme and uncontrollable circumstances to be applicable to episodes impacted by the current PHE
    - Applying certain financial safeguards to CJR participant hospitals that have a CCN primary address located in an emergency area for episodes that overlap with the emergency period
    - 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 begins or that occurs through the termination of the emergency period, actual episode payments are capped at the target price determined for that episode
    - Applying equal financial safeguards for both fracture and non-fracture episodes during the COVID-19 pandemic

Remote Physiologic Monitoring

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- Remote Physiologic Monitoring (RPM) services can be furnished to **new patients**, as well as established patients, and that consent to receive RPM services can be obtained once annually
    - CMS recommends that the health care provider review the consent information with the patient, obtain their consent, and document it in the medical record
    - CMS clarifies that these RPM services can be used for patients with both acute and/or chronic conditions

Telephone Evaluation and Management Services

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- Creates separate payment for CPT codes 98966-98968, and CPT codes 99441-99443.
    - CMS finalized work RVUs of 0.25 for CPT code 98966, 0.50 work RVUs for CPT code 98967, and 0.75 for CPT code 98968 (as recommended by the AMA Health Care Professionals Advisory Committee (HCPAC)), and work RVUs of 0.25 for CPT code 99441, 0.50 for CPT code 99442, and 0.75 for CPT code 99443 (as recommended by the AMA Relative Value Scale Update Committee (RUC)).
    - CMS finalized HCPAC and RUC-recommended direct PE inputs (this includes 3 minutes of post-service RN/LPN/MTA clinical labor time for each code)
    - CMS is extending these services to **both new** and established patients and will relax enforcement of the code descriptors

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

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- All outpatient hospital therapeutic services will only need a minimum level of general supervision to be consistent with general supervision requirements that apply for most outpatient hospital therapeutic services
- CMS defines general supervision as "a procedure that 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."*

Application of Certain National Coverage Determination and Local Coverage Determination

Requirements During the PHE for the COVID-19 Pandemic

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

1. Face-to-face and In-person Requirements
    - Explains 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."
2. Clinical Indications for Certain Respiratory, Home Anticoagulation Management and Infusion Pump Policies
    - CMS explained it will not enforce clinical indications required for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs.
3. Requirements for Consultations or Services Furnished by or with the Supervision of a Particular Medical Practitioner or Specialist
    - CMS authorizes the "chief medical officer or equivalent of the facility can authorize another physician specialty or other practitioner type to meet NCD and LCD
    - requirements during the PHE for the COVID-19 pandemic."
    - CMS clarified that "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."

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

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- Office/Outpatient E/M level selection for telehealth services can be based on MDM or time (time is defined as all of the time associated with the E/M on the day of the encounter)
    - CMS clarifies that it is maintaining the current definition of MDM and is removing any documentation requirements for the history and/or physical exam in the medical record, with respect to this proposal

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

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- Permits a hospital that is "paying the resident's salary and fringe benefits for the time that the resident is at home or in the home of a patient that is already a patient of the physician or hospital, but performing patient care duties within the scope of the approved residency program, to claim that resident for IME and DGME purposes."

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

CMS is "modifying the calculation of the 2021 and 2022 Part C and D Star Ratings to address the expected disruption to data collection posed by the PHE for the COVID-19 pandemic" by:

1. Replacing the "2021 Star Ratings measures calculated based on HEDIS and Medicare CAHPS data collections with earlier values from the 2020 Star Ratings."
2. Establishing how it will calculate or assign "Star Ratings for 2021 in the event that CMS' functions become focused on only continued performance of essential Agency functions and the Agency and/or its contractors do not have the ability to calculate the 2021 Star Ratings;"
3. Modifying the current rules for the "2021 Star Ratings to replace any measure that has a data quality issue for all plans due to the COVID-19 outbreak with the measure-level Star Ratings and scores from the 2020 Star Ratings;"
4. Clarifying that in the event that "CMS is unable to complete HOS data collection in 2020 (for the 2022 Star Ratings)," it will replace "the measures calculated based on HOS data collections with earlier values that are not affected by the public health threats posed by COVID-19 for the 2022 Star Ratings;"
5. Removing guardrails for the 2022 Star Ratings; and
6. Expanding the existing hold harmless provision for the Part C and D Improvement measures to include all contracts for the 2022 Star Ratings.

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

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- CMS is amending 42 CFR 440.70 to allow licensed practitioners practicing within their scope of practice, such as NPs and PAs, to order Medicaid home health services
    - CMS clarifies that this change "applies to who can order Medicaid home health nursing and aide services, medical supplies, equipment and appliances and physical therapy, occupational therapy or speech pathology and audiology services."

Merit-based Incentive Payment System (MIPS) Updates

CMS is adding the below new improvement activity to the Improvement Activities Inventory for the CY 2020 performance period.

- CMS clarifies that "to receive credit for this clinical improvement, clinicians must report their findings through an open source clinical data repository or clinical data registry."

TABLE 1: New Improvement Activity for the MIPS CY 2020 Performance Period

Activity ID:	**IA_ERP_XX**
Subcategory:	Emergency Response And Preparedness
Activity Title:	COVID-19 Clinical Trials
Activity Description:	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. For more information on the COVID-19 clinical trials we refer readers to the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19.
Weighting:	High

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- The MIPS automatic extreme and uncontrollable circumstances policy will apply to MIPS eligible clinicians for the 2019 MIPS performance period/2021 MIPS payment year
- For the 2019 MIPS performance period, CMS is extending the deadline to apply for reweighting the quality, cost, improvement activities, and Promoting Interoperability (PI) performance categories, based on extreme and uncontrollable circumstances from December 31, 2019 to April 30, 2020
    - CMS clarifies that this extended deadline of April 30, 2020 aligns with the MIPS data submission deadline extension
    - CMS clarifies that this deadline is only available to clinicians that demonstrate they have been adversely affected by the COVID-19 pandemic
- CMS creates the following exception for the 2019 performance period/2021 MIPS payment year:
    - "If a MIPS eligible clinician demonstrates through an application submitted to CMS that they have been adversely affected by the PHE for the COVID-19 pandemic, but also submits data for the quality, cost, or improvement activities performance categories, the performance categories for which data are submitted would still be reweighted (subject to CMS' approval of the application), and the data submission would not effectively void the application for reweighting" and that similar modifications will be made for the Promoting Interoperability (PI) performance category

Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital During the Public Health Emergency (PHE) for the COVID-19 Pandemic

On an interim basis, with respect to the PHE for the COVID-19 pandemic, CMS finalized new policy that:

- Provides additional flexibilities beginning on March 1, 2020 that specifies "if routine services are provided under arrangements outside the hospital to its inpatients, these services are considered as being provided by the hospital."

*All text in quotes are direct excerpts from the CMS rule (https://www.cms.gov/files/document/covid-final-ifc.pdf)