1. Beneficiary Location for Telehealth Services

Medicare can pay for many types of office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence. Additionally, the HHS OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

2. Additional Telehealth Services Covered by Medicare

Clinicians are allowed to provide more than 135 new telehealth services, including: emergency department visits, initial and subsequent observation, initial hospital care and hospital discharge day management, initial nursing facility visits, critical care services, intensive care services, therapy services.

3. Virtual Check-Ins, Remote Evaluations, & E-Visits

Clinicians can provide virtual check-in, remote evaluation of patient-submitted video/images, and e-visit services to both new and established patients. These services were previously limited to established patients. Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits, virtual check-ins, and remote evaluations. A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients.

4. Remote Patient Monitoring

Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease.

5. Eligible Practitioners

 CMS is waiving the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

6. Practitioner Locations

 CMS is waiving the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) must be enrolled as such in the Medicare program, 2) must possess a valid license to practice in the State which relates to his or her Medicare enrollment, 3) is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.

7. Allowing FQHCs and RHCs to Serve as Distant Sites for Telehealth

 FQHCs and RHCs may serve as distant site practitioners to furnish telehealth services. Medicare pays for these telehealth services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. These services are excluded from both the FQHC prospective payment system and the RHC all-inclusive rate calculation.

8. Audio-Only Telehealth for Certain Services

CMS is waiving the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.

9. Temporary Expansion Locations for RHCs and FQHCs

CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) for the duration of the PHE.

10. Bed Count for Provider-Based RHCs and RHC Payment Limit

RHCs that are provider-based to a hospital with fewer than 50 beds are exempt from the national RHC payment limit. For the duration of the PHE, the number of beds prior to the start of the PHE will be the official hospital bed count for application of this policy so that hospitals are not discouraged from increasing bed capacity if needed.

11. Cost Reporting

CMS is delaying the filing deadline of certain cost report due dates due to the COVID19 outbreak. We are currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The revised extended cost report due date for FYE 12/31/2019 will be August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 2020.

12. “Stark Law” Waivers

 The physician self-referral law (also known as the “Stark Law”) prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in short, a physician cannot refer a patient to any entity with which he or she has a financial relationship. On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law regulations. These blanket waivers apply to financial relationships and referrals that are related to the COVID-19 emergency. The remuneration and referrals described in the blanket waivers must be solely related to COVID-19 Purposes, as defined in the blanket waiver document. Under the waivers, CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law.

13. Provider Enrollment

CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment: » Waive certain screening requirements. » Postpone all revalidation actions. » Expedite any pending or new applications from providers.

14. Advance Beneficiary Notice of Noncoverage (ABN) Use Extension

 The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service - FFS) beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued to transfer potential financial liability to the Medicare beneficiary in certain instances. [Note: Skilled nursing facilities (SNFs) issue the ABN to transfer potential financial liability for items/services expected to be denied under Medicare Part B only.] The ABN, Form CMS-R-131, and instructions have been approved by the Office of Management and Budget (OMB) for renewal. Due to COVID-19 concerns, CMS has expanded the deadline for use of the renewed ABN, Form CMS-R-131 (exp. 6/30/2023). At this time, the renewed ABN will be mandatory for use on 1/1/2021. The renewed form may be implemented prior to the mandatory deadline.

15. Medicare Physician Supervision Requirements

For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology. Also, “direct” physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and CAHs. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.

16.Practitioner Locations

CMS waives the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) must be enrolled as such in the Medicare program, 2) must possess a valid license to practice in the State which relates to his or her Medicare enrollment, 3) is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.

17. Home Nursing Visits

 RHCs and FQHCs can provide visiting nursing services to a beneficiary’s home with fewer requirements, making it easier for homebound beneficiaries to receive care.

18. Certain Staffing Requirements for RHCs and FQHCs

 42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates.

19. Physician Supervision of NPs in RHCs and FQHCs

42 C.F.R. 491.8(b)(1). CMS is modifying the requirement that physicians must provide medical direction for the clinic’s or center’s health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center’s health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff.

20. Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)

CMS is modifying the 60-day limit in section 1842(b)(6)(D)(iii) of the Social Security Act to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency plus an additional period of no more than 60 continuous days after the PHE expires. On the 61st day after the PHE ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock.

21. Accelerated/ Advance Payments

 In order to provide additional cash flow to healthcare providers and suppliers impacted by COVID-19, CMS expanded and streamlined the Accelerated and Advance Payments Program, which provided conditional partial payments to providers and suppliers to address disruptions in claims submission and/or claims processing subject to applicable safeguards for fraud, waste and abuse. Under this program, CMS made successful payment of over $100 billion to healthcare providers and suppliers. As of April 26, 2020, CMS is reevaluating all pending and new applications for the Accelerated Payment Program and has suspended the Advance Payment Program, in light of direct payments made available through the Department of Health & Human Services’ (HHS) Provider Relief Fund. Distributions made through the Provider Relief Fund do not need to be repaid. For providers and suppliers who have received accelerated or advance payments related to the COVID-19 PHE, CMS will not pursue recovery of these payments until 120 days after the date of payment issuance. Providers and suppliers with questions regarding the repayment of their accelerated or advance payment(s) should contact their appropriate Medicare Administrative Contractor (MAC).

22. Temporary Suspension of Medicare Sequestration

 The CARES Act temporarily lifted the Medicare sequester, which reduces payments to providers by 2 percent, from May 1 through December 31, 2020, boosting payments for hospital, physician, nursing home, home health, and other care.

23. COVID-19 Diagnostic Codes11

On February 13 and March 5, CMS announced new HCPCS codes for healthcare providers and laboratories to test patients for SARS-CoV2. Healthcare providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the newly created HCPCS code (U0001). A second new HCPCS code (U0002) 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC can also be used by laboratories and healthcare facilities. Both codes can be used to bill Medicare as well as by other health insurers that choose to utilize and accept the code. Effective April 1, 2020, for dates of service on or after February 4, 2020. Additionally, the AMA created CPT code 87635 for infectious agent detection by nucleic acid tests as well as CPT codes 86769 and 86328 for serology tests. Laboratories performing these tests may bill Medicare for services that occurred after their respective effective dates. There is no cost-sharing for Medicare patients.

24. High-Production Coronavirus Lab Tests

 CMS announced Medicare will nearly double payment for certain lab tests that use high-throughput technologies to rapidly diagnose large numbers of 2019 Novel Coronavirus (COVID-19) cases.13 CMS created the new HCPCS codes U0003 and U0004 so that laboratories conducting testing that uses high-throughput technology can bill this rate for dates of service on or after April 14, 2020.

25. Antibody (Serology) Tests

 During the PHE, Medicare will cover FDA-authorized COVID-19 serology testing (a diagnostic test) for beneficiaries with known current or known prior COVID-19 infection or suspected current or suspected past COVID-19 infection.

26. COVID-19 FAQs on Medicare Fee-for-Service (FFS) Billing

CMS released a Frequently Asked Questions (FAQs) document to supplement previously released FAQs: 1135 Waiver FAQs and Without 1135 Waiver FAQs. The supplemental document can be found here:

<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

27. COVID-19 Provider Burden Relief FAQs

 CMS released a Frequently Asked Questions (FAQs) document regarding provider burden relief, which can be found here:

https://www.cms.gov/files/document/qso-20- 22-asc-corf-cmhc-opt-rhc-fqhcs.pdf

28. Standards of Practice and Flexibilities for Outpatient Settings

CMS released a document providing guidance on infection control and prevention related to COVID-19 in outpatient settings. The document includes FAQs and other considerations, and can be found here:

https://www.cms.gov/files/document/qso-20- 22-asc-corf-cmhc-opt-rhc-fqhcs.pdf

29. Reporting of COVID-19 Clinical Trial Data through the Quality Payment Program

 CMS is encouraging clinicians who participate in the Quality Payment Program (QPP), such as physicians, physician assistants, nurse practitioners, and others, to contribute to scientific research and evidence to fight the COVID-19 pandemic. Clinicians may now earn credit in the Merit-based Incentive Payment System (MIPS), a performance-based track of QPP that incentivizes quality and value, for participation in a clinical trial and reporting clinical information by attesting to the new COVID-19 Clinical Trials improvement activity. This action will provide vital data to help drive improvement in patient care and develop innovative best practices to manage the spread of COVID-19 within communities. CMS has updated the Quality Reporting Document Architecture (QRDA) Category III Implementation Guide to include information for eligible clinicians on this new activity, which can be found here: <https://ecqi.healthit.gov/sites/default/files/2021-CMS-QRDA-III-Eligible-Clinicians-andEP-IG-508.pdf>

30. CMS COVID-19 Stakeholder Engagement Calls

CMS hosts recurring stakeholder engagement sessions to share information related to the agency's response to COVID-19. These sessions are open to members of the healthcare community and are intended to provide updates, share best practices among peers, and offer attendees an opportunity to ask questions of CMS and other subject matter experts. Recordings of these sessions are publicly available for those unable to attend, and can be found here: <https://www.cms.gov/OutreachandEducation/Outreach/OpenDoorForums/PodcastAndTranscripts>

31. CMS Office of Minority Health (CMS OMH): COVID-19 Resources on Vulnerable Populations

 CMS OMH has compiled Federal resources on the 2019 Novel Coronavirus (COVID19) to assist its partners who work with those most vulnerable--such as older adults, those with underlying medical conditions, racial and ethnic minorities, rural communities, and people with disabilities. Those resources can be found here: https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/COVID19-Resources

32. Interim Final Rules and Waivers

CMS regularly updates a webpage that includes Interim Final Rules, waivers, and provider-specific fact sheets related to COVID-19, which can be found here: https://www.cms.gov/about-cms/emergency-preparedness-responseoperations/current-emergencies/coronavirus-waivers