CMS Interim Final Rule Response to the COVID-19 Pandemic Public Health Emergency
CMS-1744-IFC
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Introductory Summary and Background

On March 30, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the Interim Final Rule with comment period (IFC) for policy and regulatory revisions in response to the COVID-19 Public Health Emergency (PHE). This ruling adds to and changes many of the recent expansions and waivers of the provisions previously outlined by CMS since the PHE was initiated.

Within the interim final rule CMS explained the ruling was temporary, meaning the expanded provisions are only in effect for the duration of the PHE. Once the PHE is ended, the expanded waivers will also end, and it will be a return to normal practice as seen before the declaration of the PHE.

Highlights of the changes by CMS are included in this summary and include items such as added codes to the telehealth list of designated services, removing limitations on the frequency of reporting designated services, claims submission for telehealth services, change in the definition of direct supervision, and teaching physician adjustments. Some of these changes contradict initial guidance by CMS; therefore, providers need to be aware that process or policy at the beginning of the pandemic may be different as of March 30, 2020.

In addition to the interim final rule, CMS also published several other declaration blanket waivers and factsheets on March 30, 2020 by provider type, which also in a succinct manner outline the changes and information to be aware of. Statements included in these additional transmittals are provided in this summary as well, as some contain additional clarification and support of the changes enacted by CMS during the PHE.

CMS Interim Final Rule

The interim final rule is located in its entirety at the following link:
https://www.cms.gov/files/document/covid-final-ifc.pdf

This document in PDF form is 221 pages in length. The format of the following information is intended to serve as a summary to the finalized changes and readers are encouraged to view the document in its entirety for further details.

Billing for Telehealth Services

CMS made a dramatic change to how telehealth services are billed during the PHE. These changes are due to CMS recognizing that many physician practices are transitioning services from in-person or face-to-face to telehealth visits. By making these necessary changes, the actual cost to the practice may not be significantly different in the resources and staffing needed to provide the now telehealth services. CMS expects that most physician practices will continue to employ nurses to engage with and coordinate pre- and post-care related to the telehealth visit. Due to this and essentially the elimination of the traditional originator site, which under traditional telehealth medicine does have a reimbursement factor calculated, CMS will now reimburse physician practices for telehealth services as if they were furnished in person. A physician who performs a telehealth visit in a non-facility setting will be paid per the rate established for that CPT®/HCPCS code at the non-facility MPFS rate. Additionally, a physician performs a telehealth visit in an outpatient facility or provider-based setting will be paid at the facility rate for the CPT®/HCPCS code reported.

CMS now instructs providers to bill for the respective telehealth CPT®/HCPCS codes under the place of service (POS) where the service was rendered**.** For example, a physician in an office/freestanding facility will bill the telehealth service using **POS 11**, not POS 02 as previously instructed. Instead, the physician will apply **modifier 95** to the line item to identify the service was provided by telehealth. In the hospital or provider-based setting the physician will report **POS 19 or 22** to designate the outpatient on or off-campus location of services and apply **modifier 95** to the line item on the claim.

Services Added to Telehealth List

Another significant change by CMS is the inclusion of many more codes to the approved list of telehealth services. Typically, this list is finalized each year under the scheduled Medicare Physician Fee Schedule (MPFS) ruling. In response to the need for more services to be provided by telehealth to reduce risk to Medicare beneficiaries and medical staff, CMS has added several services as requested by stakeholders during this time. The updated list of telehealth services, which are retroactive to March 1, 2020, can be found at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. The following is a summation of some of the additions.

CPT® 90953, 90959 and 90962 – End Stage Renal Disease (ESRD) Related Services

The addition of CPT® codes 90953, 90959, and 90962 *(ESRD related services monthly…with 1 face-to-face visit by a physician or other qualified health care professional per month)* to the list of telehealth approved services were chosen as a result of criteria in which services that were not similar to those on the current list of telehealth services needed to be added. CMS assessed whether the service is accurately described by the corresponding code when furnished via telehealth; and whether the use of telecommunications to furnish the service demonstrated clinical benefit to the patient.

Additional E/M Visits

CMS added several more evaluation and management (E/M) visit codes to the approved list of telehealth services. CMS did stress to providers to select the E/M code that best represents the service and the code

selected would generally align with the physician location and status of the patient. For example, if the patient is an inpatient, then the inpatient codes are utilized for reporting purposes. Additional added codes include:

- Initial Observation (99217-99220)
- Subsequent Observation (99224-99226)
- Same Day Observation (99234-99236)
- Initial Inpatient Care (99221-99223)
- Hospital Discharge Management (99238-99239)
- Critical Care (99291-99292)

Under normal circumstances some of the added visits include limitations on the frequency that can be billed. During the time of the PHE, CMS is lifting the restriction on the frequency of visits furnished via telehealth. Visits like the subsequent inpatient visits (99231-99233) during this interim, will no longer include the restrictions in the frequency the inpatient can be seen subsequent to the initial visit.

Visits for ESRD Monthly Capitation Services

In the 2005 MPFS Final Rule, ESRD services were added to the telehealth list. At that time, it was required a clinical "hands on" examination of the vascular access site be performed by the physician, clinical nurse specialist, nurse practitioner or physician assistant. On an interim basis, CMS is allowing the required clinical examination to be provided as a Medicare telehealth service during the PHE.

In addition, ESRD patients receiving at home dialysis were required to receive a face-to-face visit at least monthly during the initial three months; and at least once every three consecutive months after the initial three months, all without the use of telehealth. On an interim basis, CMS will ease enforcement of this requirement. CPT® codes 90951-90970, when furnished by Medicare telehealth, are affected by these policies.

Technology Requirements of Telehealth Services

CMS is revising the definition of "interactive telecommunication system" during this PHE to mean *"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".* In addition, regarding HIPAA violations, CMS will be providing "*enforcement discretion"* and waiving penalties against healthcare providers that are treating patients in the good faith through technologies like FaceTime, Skype, Zoom, etc. Even though penalties will not be imposed, the various entities (HHS, OIG, and DOJ) will continue to monitor any fraud, abuse, or scams of Medicare and its beneficiaries during this PHE.

Selecting Appropriate Level of Telehealth Visit

CMS noted documentation of the telehealth visits should reflect the work that is performed; however, it is difficult given the telehealth approach to conduct a physical exam of the patient or support at least 50 percent of the visit was spent in coordination and care for some practitioners. CMS is adjusting the requirements for outpatient E/M services by telehealth to be based on medical decision making (MDM) or time and remove

documentation requirements of the history and/or physical exam in the medical record. The definition of MDM remains the same.

These changes to the outpatient telehealth services are similar to what will be enacted beginning January 1, 2021. The only differences at this time, the criteria levels for MDM will continue as they are now. Use of time will be based on the total time associated with the E/M on the day of the encounter and based on the time values currently assigned to the outpatient E/M codes (99201-99215). These adjustments are only for the outpatient E/M visits performed under telehealth. If an outpatient E/M is performed in-person, the normal criteria and documentation standards will apply.

Changes in Supervision

Supervision in the Office/Freestanding Facility

Ongoing measures by CMS to lessen exposure to patients and providers has also resulted in an interim update to the definition of direct supervision as it applies under MPFS. Normally, direct supervision in the office/freestanding facility is defined as *"Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services."*

CMS for the duration of the PHE is defining direct supervision under MPFS to be provided through interactive real-time audio-video telecommunication technology. This would allow the physician to provide real-time assistance and direction throughout a procedure or service by allowing them to see and interact with the staff member and patient without adding any unnecessary exposure. It is important to note, the supervision adjustments are meant as a minimum requirement. There may be circumstances in which the physical presence of the physician with the patient in the same location is necessary and more appropriate. CMS stresses in these types of scenarios the physician and facility must make the best decision given the situation, even if this means potential exposure due to the nature of the scenario.

Supervision applies to the technical work by the ancillary staff. For services which have both and technical and professional component and are not included in the expanded telehealth list of services, the physician is still expected to personally provide the necessary and required work in the office/freestanding facility. This change is limited only to the manner in which the supervision requirement is met. It does not change the payment or coverage policies related to Medicare benefits.

Diagnostic Services

As with the above-mentioned changes to supervision under MPFS, CMS is also adjusting language relative to diagnostic services. In the hospital, on or off-campus outpatient setting, the minimum level of supervision for therapeutic services is currently general supervision. The physician does not have to be personally present but must be generally available for the technical services provided. For diagnostic services, supervision is assigned typically in alignment with the payment under MPFS. To lessen the potential of exposure, CMS is amending the

definition of direct supervision for hospital services during the PHE to conform with those under MPFS. Due to the concern that services could be limited to patients who need them, CMS is allowing for diagnostic services assigned direct supervision to be provided by through interactive real-time audio-video telecommunication technology.

Teaching Physician

Under normal circumstances, the teaching physician is personally present with the resident when key portions of services are provided to the patient. At this time, CMS believes to continue to require a teaching physician to be personally present with a resident may provide added risk and limit access to services unnecessarily under MPFS. To prevent this and any potential for spread of any infectious disease, CMS is amending requirements related to teaching physicians.

During the PHE, the presence of the teaching physician can be met through direct supervision utilizing interactive real-time audio-video telecommunication technology or through physical presence. This type supervision also extends to the interpretation of diagnostic radiology and other tests when performed by a resident and oversight by the teaching physician. There may situations where the resident is conducting a telehealth visit with the patient while simultaneously being supervised by the teaching physician using interactive real-time audio-video telecommunication technology.

There are exceptions to this, when the procedure is high-risk or complex (surgical, high-risk, interventional, or other complex procedures, those performed through an endoscope and anesthesia services), the teaching physician must be present during the critical portions of the procedure and immediately available to furnish services during the procedure or service.

National and Local Coverage Determination Requirements

For the duration of the PHE, if a National Coverage Determination (NCD) or Local Coverage Determination (LCD) including articles, requires a service or procedure to be performed face-to-face or in-person for evaluation and assessment, these requirements will not apply during the PHE. CMS will not enforce clinical indications for coverage across several items; however, at the conclusion of the PHE, the enforcement will be enacted for clinical indications of coverage.

In addition, if an NCD or LCD specifies a practitioner type or specialty physician to furnish a specific service, on the interim basis the chief medical officer or equivalent at a facility will have the authority to designate another physician or practitioner type to meet the requirements. This also includes those NCDs, LCDs, and articles which specify the required physician or physician specialty to supervise other practitioners, professionals, or qualified personnel.

Comments to Interim Final Rule

CMS is moving forward without delay the implementation of the finalized provisions in the interim final rule. The rules as outlined are retroactive to March 1, 2020. CMS is providing a 60-day public comment period as well but neglected to list the deadline within the interim final rule. Comments can be submitted electronically at http://www.regulations.gov.

Physical Location of the Physician

Within a separate transmittal released by CMS, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers,* there is additional information related to the changes enacted by CMS in response to the PHE. Specifically related to the location of the physician when providing telehealth services.

CMS states the following with regard to the location and billing for the physician who is providing telehealth services, "*Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location."* For those services not listed as part of the telehealth expanded services, the physician would still need to provide the services as outlined per the service. This means for some services, like those specific to radiation oncology, diagnostic, or interventional radiology, if there is a professional component of the code, the service is provided in person by the physician. Only those codes listed on the expanded list of telehealth services, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes, can be provided through interactive real-time audio-video telecommunication technology.

Additional Links to CMS Transmittals and Resources

There are several transmittals by CMS which also summarize and provide additional information for providers. The following links will take stakeholders directly to the additional transmittals.

Coronavirus Waivers & Flexibilities
https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

Hospitals: CMS Flexibilities to Fight COVID-19
https://www.cms.gov/files/document/covid-hospitals.pdf

List of Telehealth Services
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes