CMS Interim Final Rule Two COVID-19 PHE Response
CMS-5531-IFC
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Introductory Summary and Background

On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the second part of 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 second IFC, 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, unless otherwise indicated.

CMS Interim Final Rule Two

The Interim Final Rule Two is located in its entirety at the following link:
https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

This document in PDF form is 279 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. Further changes could be released by CMS which could impact or modify the regulations contained within this summary.

Telehealth Services Expansion

CMS has made additional adjustments to telehealth services during the PHE based on stakeholders' comments after the March IFC. Evaluation and Management (E/M) services have been provided mainly by telephone only, as Medicare beneficiaries do not always have the technology to do a video visit or refuse to do a video visit. CMS noted the use of telephone visits are used for medical discussions and not administrative or non-medical discussions with the patient.

To account for telephone or audio-only visits, CMS has adjusted the Relative Value Units (RVUs) assigned to CPT® codes 99441-99443 (telephone E/M services by a physician or other health care provider who may report E/M services). The updated RVUs is a crosswalk from established values for codes 99212-99214 for Work and Direct Practice Expense. The values for the Direct Practice Expense are as follows: 99212 to 99441; 99213 to 99442; and 99214 to 99443. The values of Work RVUs for the telephone codes during the PHE are: 99441 = 0.48; 99442 = 0.97; and 99443 = 1.50.

Codes 90951-90970 (End Stage Renal Disease (ESRD) related services) do not fall under the audio-only interaction services requirement, and therefore must be provided with real-time audio-video capabilities.

CMS also indicated in IFC version 2 they would be adjusting how codes are added to the telehealth list in response to the PHE. The telehealth code table CMS has been provided and adjusted in the IFCs represent the majority of services that would be appropriate to provide to Medicare beneficiaries for telehealth services during the PHE, according to CMS. There may be other services which may need to be added during the PHE. In the event additions need to be made, CMS will use a subregulatory process rather than notice and comment rulemaking. The full code list can be downloaded at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Selecting Appropriate Level of Telehealth Visit Based on Time

In the March COVID-19 IFC, CMS identified the use of time as the criteria for selecting the appropriate level of telehealth visits. Public use files were identified with the time values to use. However, those values do not always match the time values identified in the CPT® definitions for E/M codes 99201-99215. CMS agreed the time value discrepancies can be confusing. Therefore, CMS finalized for the duration of the PHE, time used as the criteria for the office/outpatient code selection will be based on the times listed in the CPT® code descriptor.

CMS also revised the policy to clarify the definition of time as all the time associated with the E/M on the day of the office/outpatient encounter. Selection for office/outpatient E/M services when furnished via telehealth can be based on MDM or time, as finalized in the first IFC.

Documentation of Services

CMS stated all members of the medical team can now document in the medical record when providing healthcare services during the PHE. This will allow more flexibility and allowance of clinician availability. The documentation would be reviewed and approved by the appropriate clinician.

In addition, providers who can furnish and bill for Medicare services, regardless of whether they are in a teaching role, may review, sign and date documentation rather than re-document notes made by other physicians, residents, nurses, students or other members of the medical team. This is for the duration of the PHE only.

Teaching Physician Supervision

As a part of the initial IFC, CMS provided waivers for the supervision 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.

During the comment period, stakeholders asked for additional waivers specific to the supervision of residents by teaching physicians. There are situations in which the teaching physician is unable to be physically available, so the request was made that the teaching physician could review the service with the resident during or immediately after the service through virtual or remote means using real-time audio-video technology. After consideration, CMS is allowing the teaching physician to direct the care provided by the resident, and to do so by review the service with the resident during or immediately after the service through virtual or remote means using real-time audio-video technology.

Provider-Based Departments

Based on provisions listed in the Bipartisan Act of 2015, any department within the 250-yard limitation are considered on-campus and paid at the Hospital Outpatient Prospective Payment System (HOPPS) rate. Provider-based departments which were established before November 2, 2015, but outside the 250-yard limitation, were excepted by CMS. This means they continue to be reimbursed similar to the on-campus outpatient department. Any provider-based department established after November 2, 2015 and more than 250 yards from main building of hospital are considered nonexcepted and are paid under a different fee schedule, the rates are 40 percent of the HOPPS rate.

One of the other provisions in the Bipartisan Budget Act of 2015, is that if an on-campus or excepted provider-based department (PBD) were to move the location outside the 250-yard limitation, the exception would be lost and reimbursement would follow the alternate rates seen by those that are nonexcepted.

In response to hospitals needing to shift services to allow for COVID-19 positive patients to be separated from non-positive patients or allow for the room to be taken over by the influx of positive patients, CMS is extending the status of on-campus and excepted provider-based departments for the duration of the PHE. This means if the shift occurred on or after March 1, 2020, the change in location will not impact reimbursement and rates will still be the HOPPS full rate as long as the shift in location was consistent with their state's emergency preparedness or pandemic plan. If it was not, then the exception is not extended for the duration of the PHE.

All hospitals that relocate services due to the state's pandemic response must contact their CMS Regional Office, by email, of the hospital's CMS Certification Number (CCN), with the address of the current PBD, address(es) of the temporary location(s), the date they began providing services at the new location, and an attestation the relocation is in alignment with the state's pandemic response or emergency preparedness plan. This also includes when the PBD is relocated to the patient's home.

As part of the waiver included in this second Interim Final Rule, CMS is allowing for the patient's home to be considered a PBD. These services could not be provided by telehealth as they do require clinical staff to be present in-person. Additionally, physician supervision must still be met. Services like non-surgical extended duration therapeutic services (NSEDTs) fall under therapeutic services and could be provided under general supervision where appropriate.

If the patient is registered as an outpatient with the hospital and services are provided and billed as PBD at the patient's home or temporary expansion location, the home cannot also be used for delivery of home health services or designated as one for the same time period. This is because home health services cannot be provided in the hospital setting and the patient's home in this scenario is classified as a hospital setting.

Any provided services will still require the necessary orders, documentation, and medical necessity to support the services. Supervision must be provided by the physician or NPP who has the appropriate state licensing and scope of practice. Services provided to the patient in their home are billed just like those in an off-campus excepted PBD, by applying modifier PO to codes. As with moving the PBDs off-campus, if services are moved to a patient's home, this must also be included in information submitted to the CMS Regional Office notification.

National and Local Coverage Determination Requirements

In this second Interim Final Rule, CMS is addressing what appears to be a misinterpretation of statements made in the initial Interim Final Rule. CMS under a waiver initially indicated only certain services, which were listed in the National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs), requiring in-person or face-to-face encounters would not apply during the PHE.

Per CMS, some stakeholders are questioning if the waivers in the initial Interim Final Rule allow for services to be provided to beneficiaries without following the reasonable and necessary statutory requirements. CMS stated in this second Interim Final Rule, unless expressly stated by CMS in regulatory guidance, most items and services must be reasonable and necessary. The services provided must be appropriate to the diagnosis or treatment for the patient. This also includes the requirement that all physicians and practitioners document the medical necessity for all services. Each medical record must still support what took place with the patient to then also support the potential billing of services provided.

Additional Links to CMS Transmittals and Resources

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