POWERS

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ATTORNEYS AT LAW

MEMORANDUM

To: **Powers Clients and Friends**

From: **Powers Health Group**

Date: **May 7, 2020**

Subject: **Centers for Medicare and Medicaid Services (CMS) Interim Final Rule (IFR) on COVID-19 Public Health Emergency (PHE) Waivers**

On April 30, 2020, CMS issued a display copy of an Interim Final Rule (IFR) to clarify certain policies and make regulatory changes in response to the COVID-19 PHE. At the same time, CMS announced new waiver authorities under the CARES Act and released other documents to further clarify policies during the pandemic. The significant changes are summarized below.

➢ Medicare Payment for Services at Hospital Temporary Expansion Locations

Prior to the PHE, a hospital that relocated an on-campus outpatient department to an off-campus location, or relocated an "excepted" (i.e., one that billed as a hospital outpatient department prior to November 2, 2015) off-campus outpatient department to another off-campus location would be paid at 40% of the OPPS rate. CMS allows hospitals that relocated to an off-campus location to apply for an extraordinary circumstances exception so that they can continue to be paid at the full OPPS rate.

Beginning March 1, 2020 and for the duration of the PHE, CMS has developed a streamlined process for hospitals to obtain this exception when they relocate entire departments to another location, relocate entire departments to several locations (including a patient's home), or relocate some services provided in a department to another location (with some services still being provided in the original location). Hospitals that relocate an on-campus or excepted off-campus department may continue to receive the full OPPS rate if they email their CMS Regional Office (RO) with the following information: the hospital's CCN, the address of the current outpatient department, the address of the relocated outpatient department, the date on which the hospital began furnishing services at the new outpatient department, a brief justification for the relocation and role of the relocation in the hospital's response to COVID-19, and an attestation that the relocation is not inconsistent with the state's emergency preparedness or pandemic plan. CMS states that it "expects" hospitals to include an explanation of why the new location (including relocations to a patient's home) is appropriate. Hospitals must email the RO within 120 days of beginning to furnish and bill for services at the relocated site. It is still unclear whether hospitals will be required to submit a separate email for each patient home that the hospital makes provider-based, but CMS stated that additional information on this issue will be provided soon. Hospitals are not required to amend their 855A enrollment forms for the relocated sites.

- **Clarification on Providing Certain Outpatient Services in Temporary Expansion Locations or Patients' Homes**

The IFR provides clarifications on Medicare policy related to furnishing certain services in temporary expansion locations, including patients' homes.

- **Outpatient Therapy, Education and Training, Including Partial Hospitalization**

Medicare does not typically allow non-physicians to bill for services such as psychoanalysis, psychotherapy, diabetes self-management training, and medical nutrition therapy, except as services billed as "incident to" physician services or as hospital outpatient services. In the IFR, CMS clarifies that these services may be provided in a temporary expansion location, which includes a patient's home, if the location functions an outpatient department of the hospital. The services may only be billed by a hospital if: the services are provided by hospital staff, ordered by a physician, and supervised by a physician consistent with state licensure and related requirements. If they are provided by staff of a physician, the physician should bill for the services as incident to the physician's services. CMS has published a list on its website of the outpatient therapy, counseling, and educational services that a hospital may provide in a temporary expansion location during the PHE.

CMS clarifies that Medicare will reimburse for partial hospitalization program (PHP) services provided in a temporary expansion location (including patients' homes) of a hospital (provided the location is provider-based to a hospital) or to registered outpatients of a community mental health center (CHMC). CMS states that certain PHP services can now be provided by a hospital or CHMC through telehealth: 1) individual psychotherapy; 2) patient education; and 3) group psychotherapy. CMS states that it expects that these services will be provided using technology that involves both audio and video. In cases in which the patient does not have access to audio/video technology, use of audio-only technology is permissible. CMS has published a list of PHP services that may be provided by a hospital or CHMC in a temporary expansion location.

- **In-person Clinical Services in Temporary Expansion Locations**

Certain services provided in hospital outpatient departments do not include a separate professional fee. These services include wound care, chemotherapy administration, and drug administration. CMS clarifies that, under the PHE waivers, the general supervision requirements for these services may be satisfied without the physician being present. CMS also clarified that the general supervision requirements will be met without the physician being present for non-surgical extended duration therapeutic services (NSEDTS), which typically require direct supervision at the start of the service. If the patient is also receiving home health services, the hospital services and home health services may not overlap.

- **Telehealth Waivers and Clarifications**

  - **Expansion of Telehealth Waiver to Include New Types of Clinical Professionals**

Physical therapists, occupational therapists, speech language pathologists, and other clinical professionals with Medicare billing rights will now be able to furnish services via telehealth. This will allow Medicare beneficiaries to receive these services in their homes for the duration of the PHE. The expanded waiver authority is retroactive to March 1, 2020, and CMS has expanded the list of eligible telehealth services to include therapy and other services. CMS also announced that during the PHE it will exercise its authority to add eligible telehealth services using a sub-regulatory process rather than through rulemaking. This will make it easier for new telehealth services to be covered.

  - **Hospital Originating Site Fees**

CMS will reimburse hospitals the telehealth originating site fee of $26.65 when a hospital-based practitioner furnishes services via telehealth to a registered hospital outpatient in the patient's home if the hospital has made the patient's home a provider-based department of the hospital. This change, which applies to services performed on or after March 1, 2020, puts hospitals on a more equal footing with clinics and physician practices with respect to reimbursement for telehealth services.

  - **Billing for Evaluation and Management (E/M) Services Based on Time**

During the PHE, CMS will allow outpatient visit codes to be based on medical decision making or time, even if counseling and coordination of care are not 50% of the visit. CMS announced that practitioners should use the times set forth in the CPT Code descriptors in selecting the E/M level when coding based on time rather than the times posted on the CMS website. This simplifies billing and ensures consistency with CPT descriptors.

  - **Increased Payment for Audio-Only Phone Calls**

Recognizing that many Medicare patients do not have access to, or do not know how to use, audio/visual communication systems such as smart phones or still rely on landlines, Medicare has increased payment for telehealth E/M services with audio-only communications technology to the same amounts that it pays for established patient E/M codes. Physicians and QHPs should continue to bill the 99441-99443 codes; however, payment will increase from a range of $14-$41 to about $46-$110, depending on the length of the service. These codes cannot, however, be used if there was an E/M visit within the previous 7 days for the same problem or the phone call results in an E/M service or procedure within the next 24 hours (or soonest available appointment).

- **Audio-Only Psychotherapy**

Effective March 1, 2020, psychotherapy services can be provided via audio-only communications. Practitioners should consult the CMS list for psychotherapy and related services that can be furnished via audio-only communications.

- **Telehealth and Opioid Treatment Programs (OTPs)**

CMS announced that physicians or qualified health professionals (QHPs) could provide the therapy and counseling portions of the weekly bundled OTP service using audio-only communications rather than a two-way telecommunication system. CMS will also allow periodic assessments to be furnished through two-way telecommunication systems, or through telephone calls if a two-way telecommunication system is not available. OTP physicians and QHPs should use clinical judgment in determining whether a periodic assessment can be adequately performed over a telephone call.

- **Remote Patient Monitoring (RPM) Services for COVID-19 Patients**

To address needs of patients with COVID-19, CMS will allow providers to report the RPM Codes (CPT codes 99453, 99454, 99457, 99458 and 99091) for monitoring services that last less than 16 days but at least two days, and only for monitoring of patients with a suspected or confirmed diagnosis of COVID-19.

- **Direct Graduate Medical Education (DGME) and Indirect Medical Education Payment (IME) Changes**

  - **Holding Hospitals Harmless from Reductions in IME Payments Due to Increases in Bed Counts**

Teaching hospitals receive an IME payment that is based, in part, on the ratio of full-time equivalent (FTE) residents to the hospital's available bed days during the cost reporting period. Inpatient rehabilitation facilities (IRFs) and inpatient psychiatric facilities (IPFs) receive a similar adjustment, known as the teaching status adjustment, which is also based on the number of available beds. In general, the IME and teaching status adjustment payments decrease as a provider's number of available beds increases.

CMS will hold providers harmless for increased bed capacity due to the PHE. CMS is revising the IME regulation to state that beds temporarily added during the PHE are excluded IME payment calculations and a hospital's bed count during the PHE will be the bed count on the day before the PHE. For IRFs and IPFs, CMS will freeze the value of the teaching status adjustment at the amount that it was the day before the PHE was declared.

- **DGME and IME Payments for Time Spent by Residents at Another Hospital during the PHE**

DGME payments, like IME payments, increase if the hospital's count of FTE residents increases. Under pre-PHE rules, if a hospital sends a resident to another hospital, the sending hospital may not include any resident time at the receiving hospital in its DGME and IME FTE counts. The receiving hospital may count the resident's time in its FTE counts. If the receiving hospital is not a teaching hospital, CMS calculates a DGME per-resident amount (PRA) for the hospital, which is used to calculate the receiving hospital's DGME payments and cannot be updated except for inflation.

During the PHE, if a hospital sends a resident to another hospital, the sending hospital can include the time that the resident spends at the receiving hospital in its DGME and IME FTE counts. CMS has issued other COVID-19 waivers permitting hospitals to treat patients at offsite locations, and the sending hospital can also count time at these waiver locations of the receiving hospital. To count the time at the receiving hospital, the sending hospital must include the resident's time in the FTE counts both immediately before and after the resident goes to the receiving hospital. Also, either the sending or receiving hospital must be treating COVID-19 patients, but the residents do not have to treat COVID-19 patients in order for the sending hospital to count their time. The receiving hospital would not count the resident's time. If the receiving hospital is not a teaching hospital, it would not receive a PRA as a result of accepting residents during the PHE.

- **Durable Medical Equipment (DME) Interim Pricing in the CARES Act**

Section 3712 of the CARES Act revised payment rates for durable medical equipment (DME) during the PHE by postponing scheduled reductions related to the competitive bidding program (CBP). Some rural, non-CBP areas currently receive a "blended rate" for DME items and services under the CBP program, scheduled to expire at the end of 2020, which combines traditional fee schedule pricing with new, lower, competitively bid rates. The CARES Act extended the current 50-50 blended rate for DME furnished in rural, non-CBP areas through the duration of the PHE (or, if the PHE ends earlier, through the current date of December 31, 2020). CMS states that this blended rate increases payments for DME by approximately 66% over the rates furnished in non-rural areas. Additionally, the CARES Act revised the payment rates for DME furnished in non-rural, non-CBP areas at a 75-25 blended rate, which CMS estimates would increase payments for DME in these areas by approximately 33%. However, ambiguous language in the statute suggested two possible dates for the implementation of this blended rate. The IFR implements these higher fee schedule amounts retroactively from March 6, 2020, through the duration of the PHE.

- **Changes Related to Inpatient Rehabilitation Hospitals and Units (IRFs) and Long-Term Acute Care Hospitals (LTCHs)**

  - **CARES Act Waiver of the "3-Hour Rule" for IRFs**

Inpatient rehabilitation hospitals and units (IRFs) are traditionally required to apply an "intensity of therapy" test for eligible admissions to IRFs, including that Medicare beneficiaries participate in at least three hours per day (or 15 hours per week) of rehabilitation therapy. CMS initially waived this requirement in the first round of regulatory flexibilities issued in March 2020 and the CARES Act mandated the waiver. The April 30 IFR rescinds the initial waiver that was superseded by the CARES Act and clarifies that the "three-hour rule" requirement is waived during the PHE regardless of whether a patient was admitted for standard IRF care or to relieve acute care hospital capacity.

  - **Freestanding IRF Coverage and Classification Exemptions for Admissions to Provide Surge Capacity**

CMS is amending the freestanding IRF coverage requirements at 42 C.F.R. § 412.622(a)(3), (4), and (5), and making corresponding changes to the classification criteria for freestanding IRFs at 42 C.F.R. § 412.29(d), (e), (h), and (i), to add exceptions for care solely to relieve acute care hospital capacity in a state (or region) that is experiencing a surge during the PHE. Freestanding IRFs must add a "DS" modifier to the patient identifier number to identify patients who are being treated solely to provide surge capacity for an acute care hospital. Medicare will pay freestanding IRFs at the IRF PPS rates for patients with the "DS" modifier. These flexibilities are only permitted during certain phases of the PHE, as described at page 81 of the display copy of the IFR.

  - **Medicare Payment to LTCHs**

CMS reiterated that all LTCH admissions during the PHE will be paid the higher LTCH PPS standard Federal rate.

- **Delay of Quality Reporting for IRFs, LTCHs, Home Health Agencies (HHAs), and Skilled Nursing Facilities (SNFs)**

CMS announced that it is delaying the release of updated versions of the IRF Patient Assessment Instrument, LTCH Continuity Assessment Record and Evaluation Data Set, and HHA's Outcome and Assessment Information Set Instrument to enable these providers to continue using the current versions of their assessment instruments. For SNFs, CMS is delaying the compliance dates for the collection and reporting of the Transfer of Health (TOH) Information to Provider-Post-Acute Care and TOH Information to Patient-Post-Acute Care quality measures (collectively, the "TOH Information Measures") and the Standardized Patient Assessment Data Elements (SPADEs).

IRFs and LTCHs will begin collecting data on the TOH Information Measures beginning with discharges on October 1st of the year that is at least one full fiscal year (FY) after the end of the PHE. IRFs and LTCHs will begin collecting data on the SPADEs for admissions and discharges

(admissions only for certain SPADEs) on October 1st of the year that is at least one full FY after the end of the PHE.

HHAs will begin collecting data on the TOH Information Measures with discharges and transfers on January 1st of the year that is at least one full calendar year (CY) after the end of the PHE. HHAs will begin collecting data on the SPADEs beginning with the start of care, resumption of care, and discharges (start of care only for certain SPADEs) on January 1st of the year that is at least one full CY after the end of the PHE.

SNFs will begin collecting data on the TOH Information Measures with discharges on or after October 1st of the year that is at least two full FYs after the end of the PHE. Similarly, SNFs will begin collecting data on the SPADEs beginning with admissions and discharges (admissions only for certain SPADEs) on October 1st of the year that is at least two full FYs after the end of the PHE.

- **Delaying Merit-based Incentive Payment System Qualified Clinical Data Registry (QCDR) Measure Approval Criteria**

In response to concerns raised by the Physician Clinical Registry Coalition, which is managed by Powers and others, CMS is delaying the implementation of the new measure testing and data collection requirements for Qualified Clinical Data Registries (QCDRs) for one year. CMS notes that during this one-year delay, it will continue to apply its current review processes for ensuring that QCDR-created quality measures are valid, reliable, and align with the goals of the Meaningful Measure initiative, and to identify performance gaps.

- **Exceptions for Hospital Value-Based Purchasing (VBP) Program**

CMS is modifying the Hospital VBP Program Disaster/Extraordinary Circumstance Exception (ECE) ECE policy to permit the agency to grant blanket exceptions if CMS determines that an extraordinary circumstance has affected an entire region or locale. If a hospital located in one of these areas does not report the minimum number of cases and measures required to calculate a VBP score for the hospital, CMS will exclude that hospital from the VBP Program for that year.

CMS is granting an ECE for all hospitals for the following reporting measures:

1) NHSN HAI measures and HCAHPS survey data for Q4 2019, Q1 2020, and Q2 2020.
2) Qualifying claims data from the mortality, complications, and Medicare Spending per Beneficiary measures for Q1 2020 and Q2 2020.

- **Therapy Assistants Permitted to Furnish Maintenance Therapy**

For services paid under Medicare Part B, CMS traditionally requires physical or occupational therapists (PTs and OTs), not physical therapy assistants (PTAs) or occupational therapy assistants (OTAs), to perform therapy that is medically necessary to maintain, prevent, or slow the

deterioration of a patient's condition ("maintenance therapy"). Under the IFR, PTs and OTs will receive Part B reimbursement for maintenance therapy that is delegated to PTAs or OTAs when clinically appropriate.

- **Medical Staff Privileges in Ambulatory Surgical Centers (ASCs)**

ASCs are required to "periodically" reappraise the privileges granted to medical staff, and to review and amend (if appropriate) the scope of procedures performed in the ASC. CMS is waiving these requirements during the PHE.

- **Non-Physician Orders for Home Health Benefits/Coverage of Home Glucose Monitors**

The IFR implements § 3708 of the CARES Act, which allows NPs, CNSs, and PAs to order Medicare home health benefits, which previously required a physician order. The IFR makes similar changes related to home health benefits under the Medicaid program. These changes are effective March 1, 2020, and will not expire at the end of the PHE. During the PHE, CMS will not be enforcing Local Coverage Determination (LCD) requirements related to the need for continuous glucose monitors, allowing more patients to have these monitors at home. This enforcement discretion applies only during the PHE and follows CMS' March 30 notice that it would not enforce LCDs or National Coverage Determinations (NCDs) related to clinical indications for respiratory, home anticoagulation, and infusion pumps.

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If you have any questions about the IFR, please contact the Powers attorney with whom you normally work.