

Summary: CMS' 2nd Interim Final Rule re: COVID-19
as of May 19, 2020

The American College of Physicians has compiled a high-level summary of CMS' second Interim Final Rule based on which portions are most relevant to internal medicine physicians and their practices.

Supervision of Diagnostic Tests by Certain Non-Physician Practitioners

In the interim final rule (IFR), CMS established that during the public health emergency (PHE), practitioners might order, furnish directly, and supervise the performance of diagnostic tests and diagnostic psychological and neuropsychological testing services, subject to applicable state law. CMS is also allowing diagnostic tests to be performed by a physician's assistant (PA) without physician supervision. The agency notes that when ordering diagnostic tests, the physician (or other qualified professional) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. CMS also clarifies that pharmacists can provide services incident to a physician's service.

Documentation

In the IFR, CMS notes that "any individual who has a separately enumerated benefit under Medicare law that authorizes them to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date), rather than re-document, notes in the medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team."

Ordering COVID Tests

CMS details in the IFR that for the duration of the COVID-19 PHE, tests will be covered when ordered by any healthcare professional authorized to do so under state law. Additionally, for the duration of the COVID-19 PHE, CMS will remove the same ordering requirements for a diagnostic laboratory test for influenza virus and other common respiratory viruses. Furthermore, CMS rules that when COVID-19 tests are furnished without a physician's or other practitioner's order during the COVID-19 PHE, the laboratory conducting the tests is required to notify the patient directly of the results. Results must be made available within 24 hours.

Opioid Treatment Programs (OTPs)

During the PHE, CMS notes that periodic assessments can be conducted via telehealth and can be done using audio-only capabilities when video is not available.

Additional Flexibility under the Teaching Physician Regulations

CMS will now allow teaching physicians to review services provided with the resident, during or immediately after the visit. Physicians may conduct these services remotely through virtual means via audio/video real-time communications technology. CMS has also outlined that Medicare may make payment to the teaching physician for additional services when furnished by a resident under the

primary care exception. The primary care exception allows payment to be made for low- to middle-level E/M services provided by a resident when the teaching physician is not present, provided that certain other [requirements](#) are met. The following additional services have been added to the list:

- 99441-43: Telephone E/M services;
- 99495-96: Transitional Care Management (TCM);
- 99421-23: Digital E/M services;
- 99452: Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes;
- G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; and
- G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

Finally, CMS notes that the office/outpatient E/M level selection for services under the primary care exception when furnished via telehealth can be based on medical decision-making (MDM) or time. Time is defined as all of the time associated with the E/M on the day of the encounter. Additionally, the requirements regarding documentation of history and/or physical exam in the medical record do not apply under this exception.

Payment for Audio-Only Telephone Evaluation and Management Services

CMS has announced that it will be cross-walking payment for CPT codes 99441-43 (telephone E/M) to CPT codes 99212-14 (established patients E/M visits), respectively. This means that payment for telephone E/M claims will be exactly the same as that for office visits payments for established patient claims. CMS is also adding CPT codes 99441-43 to the list of telehealth services for the duration of the PHE. The agency notes that these codes should not be used for administrative or other non-medical discussion with the patient. Additionally, CMS explains that practitioners can waive cost sharing, consistent with other guidance the agency has given. While CMS did not make any rule changes regarding documentation and billing requirements, the IFR notes that they will consider changes to billing rules, documentation requirements, or claims edits through future rulemaking.

Medicaid Coverage

In the IFR, CMS rules that it will provide coverage for tests administered in non-office settings, and coverage for laboratory processing of self-collected COVID-19 tests that are FDA-authorized for self-collection. The agency will also permit states to cover laboratory processing of self-collected test systems that the FDA has authorized for home use, without the order of a treating physician or other licensed non-physician practitioner (NPP). However, labs that process tests without a physician's order must disclose the test results directly to patients. This provision is retroactive to March 1, 2020.

Changes to Home Health in the Medicaid Program

CMS debuted changes that will allow other licensed practitioners to order medical equipment, supplies, and appliances in addition to physicians, when practicing in accordance with state laws. This IFR will remove the requirement that the NPPs have to communicate the clinical finding of the face to-face encounter to the ordering physician.

National Coverage Decisions

In this IFR, CMS expands on its last IFR on coverage decisions, noting that the agency will not enforce the clinical indications for therapeutic continuous glucose monitors in local coverage determinations (LCDs) during the PHE.

Antibody Testing

During the PHE for the COVID-19 pandemic, Medicare will cover FDA-authorized COVID-19 serology tests as they are reasonable and necessary for beneficiaries with known current or known prior COVID-19 infection or suspected current or suspected past COVID-19 infection.

Home Health

CMS will allow ordering/certifying physicians, PAs, NPs, and CNSs to certify the need for home health services, retroactive to March 1.

Abortion Coverage

CMS is delaying for 60 days the requirement that Qualified Health Plans bill separately for abortion services.

Nursing Facilities

New regulations from CMS note that, effective immediately, CMS will require facilities to electronically report information about COVID-19 in a standardized format specified by the Secretary. The report should include information on: suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; total deaths and COVID-19 deaths among residents and staff; personal protective equipment and hand hygiene supplies in the facility; ventilator capacity and supplies available in the facility; resident beds and census; access to COVID-19 testing while the resident is in the facility; staffing shortages; and other information specified by the Secretary. Facilities will be required to provide an update at least weekly to the CDC, and the information will be reported publicly. Facilities must inform residents, their representatives, and families of those residing in facilities of confirmed or suspected COVID-19 cases in the facility among residents and staff by certain timelines.

Time Used for Level Selection for Office/Outpatient Evaluation and Management Services Furnished via Medicare Telehealth

CMS clarified in this IFR that typical times for purposes of level selection for an office/outpatient E/M are the times listed in the CPT code descriptor.

Adding Services to the Medicare Telehealth List

CMS will use a sub-regulatory process to refine the services on the telehealth list during the PHE. They have not yet defined what that sub-regulatory process will be.

Payment for COVID Specimen Collection

CMS has finalized on an interim basis that physicians and NPPs' may use CPT code 99211 to bill for services furnished incident to their professional services, for both new and established patients, when clinical staff assess symptoms and collect specimens for purposes of COVID-19 testing. Cost sharing for this service will be waived when all other requirements under section 6002(a) of the Families First Coronavirus Response Act are met. The agency is also establishing a similar code for HOPDs: HCPCS code *C9803 (Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source).*

Remote Patient Monitoring

In the rule, CMS announced that the agency is establishing a policy on an interim final basis for the duration of the PHE to allow remote patient monitoring (RPM) services to be reported for periods of less than 16 days but not less than two days, as long as the other requirements for billing the code are met. CMS notes that it is not currently prepared to alter the payment for RPM because it believes "the overall resource costs for long-term monitoring for chronic conditions assumed under the current valuation would appropriately reflect those for short-term monitoring for acute conditions in the context of COVID-19 disease and exposure risks." Payment for these codes (CPT codes 99454, 99453, 99091, 99457, and 99458) for services less than 16 days but longer than two days is limited to patients who have a suspected or confirmed diagnosis of COVID-19.

Hospital Outpatient Departments and Provider-Based Departments

In the final rule, CMS adopted a temporary extraordinary circumstances relocation exception policy for excepted off-campus PBDs that relocate off-campus during the COVID-19 PHE. The agency is temporarily extending the policy to on-campus provider-based departments (PBDs) that relocate off-campus during the COVID-19 PHE, and permitting the relocating PBDs to continue to be paid under the outpatient perspective payment system (OPPS). CMS is also streamlining the process for relocating PBDs to obtain the temporary extraordinary circumstances policy exception. More information on this new policy can be found [here](#) beginning on page three.

During this time, this allows on-campus PBDs to relocate off-campus and still bill at the OPPS rate – to do so, though, their affiliated hospital must align their PBD relocations with the state's emergency preparedness or pandemic plan to ensure continuity with state efforts.

With regard to telehealth, if a physician at a distant site provides a service to a patient in the HOPD, the hospital is presumed to provide the administrative and clinical support resources. In such circumstances, waivers allow for the originating site facility fee to be paid to the hospital – this would mean that the physician would designate 22 as the site.

In this interim final rule dated April 30, an established patient's home may be considered a PDP of the hospital during the COVID-19 PHE if other applicable requirements (including non-waived conditions of participation) are met. Thus, a physician at a distant location can provide services to that patient in his or her home and still use 22 (on-campus outpatient hospital) as the originating site of service. However,

hospitals can only do this for patients that are already registered as a hospital outpatient, which then allows that patient's home to be designated as a PBD. This cannot be done for new patients; in those cases, the originating site of service is 19 (off-campus outpatient hospital), and therefore only the regular physician fee schedule payment applies.

Medicare Shared Savings Program (MSSP)

To encourage continued participation of MSSP Accountable Care Organizations (ACOs), CMS granted temporary flexibilities in participation options, expanded codes used for beneficiary assignment, and adjusted benchmarks and shared savings/losses calculations to account for the impact of COVID-19 on expenditures.

Participation Flexibilities

- ACOs whose current agreement periods expire at the end of 2020 will have the option to extend their existing agreement period by one year. CMS will provide additional guidance on the process and timeframe for making elections.
- ACOs in the BASIC track may elect to maintain their current level of risk in 2021. CMS will provide additional guidance on the process and timeline for making elections. ACOs that make no election will automatically advance to the next level of the glide path in 2021. ACOs that do elect to remain at their current risk level in 2021 will revert to the level they would have participated in for PY 2022, skipping a level.

Clarification to the Extreme and Uncontrollable Circumstances Hardship Exception

- CMS clarified that the timeframe for mitigating shared losses under the extreme and uncontrollable circumstances exception will start in January 2020 (and continue through the end of the PHE).

Adjustments to Benchmarks and Savings/Losses Calculations

- CMS will exclude all Parts A and B payments for COVID-19 episodes of care triggered by an inpatient admission at an acute care hospital or other eligible healthcare facility, including temporary expansion sites. Specifically, services with ICD-10 code B97.29 (other coronavirus as the cause of diseases classified elsewhere) and discharge dates Jan. 27 – March 31, 2020, and services with ICD-10 code U07.1 (COVID-19) and discharge dates starting April 1 through the duration of the COVID-19 PHE are eligible. Episodes start the month of admission and continue through the month following discharge. This change will affect Parts A and B expenditures “for all purposes,” including shared savings/losses calculations, high/low revenue ACO distinctions, loss sharing limits, regional and national growth rate adjustments and caps, historical benchmarks, and risk adjustment.
- Recouped or accelerated payments and lump sum payments made through the CARES Act Provider Relief Fund will not affect MSSP expenditure calculations.

Expansion of Codes Used in Beneficiary Assignment

- For 2019 and subsequent performance years, services reported on a Federally Qualified Health Center/Rural Health Clinic claim will count as primary care services for purposes of assignment.

- For 2020 and any future years affected by the COVID-19 PHE, the following services that are furnished virtually but not considered Medicare telehealth for which payment has been authorized during the COVID-19 PHE will count as primary care services:
 - HCPCS code G2010 (remote evaluation of patient video/images);
 - HCPCS code G2012 (virtual check-in);
 - CPT codes 99421, 99422, 99423 (e-visits); and
 - CPT codes 99441, 99442, 99443 (telephone E/M services).
- CPT codes 99304-99306 (initial nursing facility stay), 99315-99316 (nursing facility discharge management), 99327-99328 (home visits for new patients), 99334-99337 (home visits for established patients), 99341-99345 (home visits for new patients), and 99347- 99350 (home visits for established patients) will count towards patient assignment when furnished using telehealth beginning March 1, 2020, for the duration of the PHE.

One-Year Delay of MIPS Qualified Clinical Data Registry (QCDR) Measure Approval Criteria

CMS is delaying by one year QCDR measure testing and data collection requirements. QCDR measure developers now have until the 2022 performance year to fully develop and test new measures and collect complete testing results at the clinician level prior to submitting new measures for consideration.