

Summary: CMS' Interim Final Rule on CARES Act
Compiled March 31, 2020

The American College of Physicians has compiled a high-level summary of [CMS' Interim Final Rule on the CARES Act](#) which is retroactive to **March 1st** and which portions are most relevant to internal medicine physicians and their practices.

Telephone Calls

CMS will provide reimbursement for CPT codes 99441 – 99443, which are telephone evaluation and management services provided by a physician to an established patient, parent, or guardian 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. It is available to new and established patients, and CMS will not audit to determine whether a prior relationship existed.

99441 (Telephone evaluation and management service by a physician or other qualified health care professional 5-10 minutes)	wRVU – 0.25	\$14.44
99442 (Telephone evaluation and management service by a physician or other qualified health care professional 11-20 minutes)	wRVU – 0.50	\$28.15
99443 (Telephone evaluation and management service by a physician or other qualified health care professional 21-30 minutes)	wRVU – 0.75	\$41.14

Telehealth

CMS is **not** changing their definition of what they consider to be telehealth (interactive telecommunications systems). They are making a temporary exception: ***“For the duration of the public health emergency as defined in § 400.200 of this chapter, Interactive telecommunications system means 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.”*** This carves out space for FaceTime, Skype, and others during the public health emergency (PHE). Additional guidance is provided by the [HHS OIG](#).

In terms of the site of service requirement, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person. In line with this CMS is also approving the use of the CPT telehealth modifier, modifier 95, be applied to claim lines that describe services furnished via telehealth . This will allow CMS to make appropriate payment for services furnished via Medicare telehealth which, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person.

CMS is also temporarily adding a number of services to the list of telehealth services for the duration of the PHE. The agency will also remove frequency limitations for subsequent inpatient visits and subsequent nursing facility visits furnished via Medicare telehealth. The HHS Office for Civil Rights (OCR) is exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype. There will be no penalties for waiving/reducing cost-sharing for non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

Level Selection for Office/Outpatient E/M Visits When Furnished via Medicare Telehealth

The office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter. CMS is also temporarily removing any requirements regarding documentation of history and/or physical exam in the medical record. The agency is maintaining the current definition of MDM.

Patient Check-ins

CMS is making G-codes G2010 & G2012 available to new and established patients. These codes may be reported only if they do not result in a visit. Additionally, patient consent may be maintained at the time of the visit by auxiliary staff. CMS will not conduct oversight to ensure a patient relationship existed beforehand for codes 99421-23.

Direct Supervision

In instances where direct supervision is required by physicians and at teaching hospitals, it can be provided using real-time interactive audio and video technology.

Home Health

CMS noted that an individual shall be considered to be “confined to home” (homebound) for the purposes of home health benefits eligibility if they have been diagnosed with or are expected to have COVID-19 or if it is medically contraindicated for the patient to leave the home. CMS is amending the regulations on an interim basis to provide HHAs with the flexibility, in addition to remote patient monitoring, to use various types of telecommunications systems in conjunction with the provision of in-person visits.

Hospice

CMS is amending the hospice regulations on an interim basis to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patient’s terminal illness and related conditions without jeopardizing the patient’s health or the health of those who are providing such services during the PHE for the COVID-19 pandemic.

Rural Health Centers & FQHCs

CMS is expanding the services that can be included in the payment for HCPCS code G0071 to include e-visit codes. The agency is also revising the payment rate for HCPCS code G0071 to include the national non-facility payment rates for these three new codes. Effective for services furnished on or after March 1, 2020 and throughout the PHE for the COVID pandemic, the payment rate for HCPCS code G0071 will be the average of the PFS national non-facility payment rate for HCPCS code G2012 (communication technology-based services), HCPCS code G2010 (remote evaluation services), CPT code 99421, CPT code 99422, and CPT code 99423. The face-to-face requirements are to be waived for these services. All virtual communication services that are billable using HCPCS code G0071 will also be available to new patients that have not been seen in the RHC or FQHC within the previous 12 months.

Remote Patient Monitoring (RPM) Codes

The agency noted that RPM codes can be used for new and established patients. CMS is also finalizing that consent to receive RPM services can be obtained once annually, including at the time services are

furnished, during the duration of the PHE for the COVID-19 pandemic. Additionally, RPM codes can be used for acute and chronic conditions.

CMS provides payment for seven CPT codes in the Remote Physiologic Monitoring (RPM) code family.

CPT code 99091 (Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation requiring a minimum of 30 minutes of time).

CPT codes 99453 (Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment),

CPT code 99454 (Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days),

CPT code 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes).

CPT code 99458 Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes,

CPT code 99473 (Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration)

CPT code 99474 (Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient).

Advanced Payments Program for Part A Providers and Part B Suppliers

This CMS [Fact Sheet](#) provides more details on how to access advance payments during the COVID-19 emergency. For practices that are not Part A providers or Part B suppliers, you may qualify for small business loans from the [Paycheck Protection Program](#).

CMS is expanding access to funds in order to ameliorate cash flow problems in medical practices and suppliers impacted by the 2019 Novel Coronavirus (COVID-19) pandemic. The Accelerated and Advance Payment Program is only for the duration of the PHE. Details on the eligibility, and the request process are outlined below. The information below reflects the passage of the CARES Act (P.L. 116-136).

What are Accelerated/Advance Payments?

It is a payment to provide necessary funds due to a disruption in claims submission and/or claims processing. CMS is authorized to provide accelerated or advance payments to any Medicare provider/supplier who submits a request to their Medicare Administrative Contractor (MAC) and meets the required qualifications.

Who is Eligible and How do I Access Funds?

Part A providers and Part B suppliers:

1. Must have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider/supplier request form,
2. Not be in bankruptcy,
3. Not be under active medical review or program integrity investigation, and
4. Not have any outstanding delinquent Medicare overpayments.

Qualified providers/suppliers can request a specific amount using an Accelerated or Advance Payment Request form provided on each MAC's website. Most providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period. Each MAC will work to review and issue payments within 7 calendar days of receiving the request.

When Will I Have to Repay CMS?

Repayment of these accelerated/advance payments is expected to begin 120 days after the date of issuance of the payment. The repayment timeline is broken out by provider type below:

- Inpatient acute care hospitals, children's hospitals, certain cancer hospitals, and Critical Access Hospitals (CAH) have up to one year from the date the accelerated payment was made to repay the balance.
- All other Part A providers and Part B suppliers will have 210 days from the date of the accelerated or advance payment was made to repay the balance. The payments will be recovered according to the process described below.

Recoupment and Reconciliation:

- The provider/supplier can continue to submit claims as usual after the issuance of the accelerated or advance payment. Providers/suppliers will receive full payments for their claims during the delay period. At the end of the delay period, the recoupment process will begin and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advanced payment. Thus, instead of receiving payment for newly submitted claims, the provider or supplier's outstanding accelerated/advance payment balance is reduced by the claim payment amount. This process will be automatic. All other Part A providers not listed above and Part B suppliers will have up to 210 days for the reconciliation process to begin.
- For the small subset of Part A providers who receive Period Interim Payment (PIP), the accelerated payment reconciliation process will happen at the final cost report process (180 days after the fiscal year closes). A step by step application guide can be found below. More information on this process will also be available on your MAC's website.

Step-by-Step Guide on How to Request Accelerated or Advance Payment

Complete an Accelerated/Advance Payment Request form and submit it to your servicing MAC via mail or email. These forms vary by contractor and can be found on each individual MAC's website. CMS has established COVID-19 hotlines at each MAC that are operational Monday – Friday to assist you with accelerated payment requests. You can contact the MAC that services your geographic area.

Contact your designated [MAC](#) to apply for the accelerated and advanced payment program.

What Information is Needed to Apply?

You will need to complete the entire form, including the following:

- A. Provider/supplier identification information:
 - Legal Business Name/Legal Name;

- Correspondence Address;
 - National Provider Identifier (NPI); and
 - Other information as required by the MAC.
- B. Amount requested based on your need:
- Most providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period.
- C. Reason for request:
- Please check box 2 (“Delay in provider/supplier billing process of an isolated temporary nature beyond the provider’s/supplier’s normal billing cycle and not attributable to other third party payers or private patients.”); and
 - State that the request is for an accelerated/advance payment due to the COVID-19 pandemic.

The form must be signed by an authorized representative of the provider/supplier.

Quality Payment Program (QPP) Updates

Merit-Based Incentive Payment System (MIPS)

CMS modified its extreme and uncontrollable circumstances policy. First, it extended the deadline from Dec. 31, 2019 to **April 30, 2020** (or a later date as specified by CMS) for COVID-19-related hardships **only**. Second, for the 2019 performance period, if a MIPS clinician, group (or virtual group) submits a COVID-19-related hardship exception application but also submits data, the performance categories for which data are submitted would still be reweighted. Due to this, the data submission would not void the hardship exception application.

CMS also added one new improvement activity for the CY 2020 performance period related to the COVID-19 PHE. This improvement activity promotes clinician participation in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection. To receive credit for this clinical improvement, clinicians must report their findings through an open source clinical data repository or clinical data registry.

Alternative Payment Models (APMs)

CMS broadened program parameters, uncontrollable circumstances policies, and extended deadlines for three models as outlined below. CMS does not establish broad flexibilities, deadline extensions, or accommodations for APMs more generally, though it “recognizes current regulations may be insufficient and additional actions may be necessary ... [and] will consider additional rulemaking to amend or suspend APM QPP policies as necessary in light of the public health emergency due to COVID-19.”

For the Medicare Shared Savings Program, CMS modified the extreme and uncontrollable circumstances policy to cover all ACOs that may be unable to completely and accurately report 2019 quality data due to the COVID-19 pandemic (not just during the performance year itself). For financial reconciliation for the 2020 performance year, CMS will

reduce the amount of an ACO's shared losses by the percentage of total months of the performance year affected by an extreme and uncontrollable circumstance (March through the end of the COVID-19 PHE). CMS notes that it will update ACO benchmarks using national and regional trends that include any changes arising from the COVID-19 pandemic and clarifies that for MIPS APMs, the ACO, or APM Entity will be scored unless all assigned clinicians and groups either do not submit any data, or submit hardship exception applications for the Promoting Interoperability and Quality Categories.

For the Medicare Diabetes Prevention Program (MDPP), CMS will permit certain beneficiaries to obtain the set of MDPP services more than once per lifetime to allow beneficiaries to remain eligible for MDPP services despite a temporary break in service, attendance, or weight loss achievement. CMS will also waive the limit to the number of virtual make-up sessions, so long as they are requested by the beneficiary and furnished consistently with CDC standards. The Agency will allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis or suspend in-person services and resume services at a later date, within certain parameters. Virtual make-up visits will not count toward weight loss goals, only attendance.

For the Comprehensive Care for Joint Replacement (CJR) Model, CMS will extend the length of Performance Year 5 by three months such that the model will end on March 31, 2021 rather than Dec. 31, 2020. CMS also changed the extreme and uncontrollable circumstances policy to account for all participant hospitals affected by the COVID-19 pandemic.