

April 2, 2020

CMS Releases Regulations and Additional Waivers to Respond to COVID-19 Public Health Emergency

On March 30, the Centers for Medicare and Medicaid Services (CMS) promulgated an interim final rule with comment period and additional waivers to ensure the healthcare system can respond to the expected surge in COVID-19 patients and providers can continue to treat those without the virus safely. The changes aim to increase hospital capacity, expand the health care workforce, improve access to telehealth services, and reduce the regulatory burden on providers. A link to the rule can be found [here](#). The regulations are retroactively applicable beginning March 1, 2020.

Since the beginning of this public health emergency (PHE), SGIM has been advocated to ensure that members can continue to provide high quality care to patients as well as support the training of the next generation of general internists. The expanded authorities CMS provides help address both these issues.

A summary of these key changes follows. Note that these apply to the Medicare program only and private insurers may not adopt these changes.

TELEHEALTH AND OTHER PAYMENT PROVISIONS

Payment for Medicare Telehealth Services

Since March 17, CMS has been expanding access to telehealth services on a temporary and emergency basis pursuant to waiver authority granted in the Coronavirus Preparedness and Response Supplemental Appropriations Act. In the IFC, the agency is adding 80 services to the list of eligible telehealth services, eliminating frequency limitations and other requirements associated with particular telehealth services, and clarifying payment rules that apply to other services furnished through telecommunication technologies that can reduce exposure risk to COVID-19.

Site of Service Differential for Medicare Telehealth Services

Under the waiver authority, Medicare telehealth services can be furnished to patients wherever they are located, including in the patient's home. The agency recognizes that as physicians practices transition a significant portion of their services from in-person to telehealth services, the relative cost of providing services may not be significantly different than if these services were provided in-person (i.e. physicians' offices will continue to employ nursing staff just as they would have when providing in-person services). Therefore, the agency will assign the payment rate that would have been paid under the Physician Fee Schedule (PFS) as if the services were furnished in-person.

To implement this change on an interim basis, when billing for telehealth services, physicians and practitioners should report the point-of-service (POS) that would have been reported had the service been performed in-person. CMS also is finalizing the use of the telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished by telehealth.

Adding Services to the List of Medicare Telehealth Services

CMS has an established process for adding or deleting services to the list of Medicare telehealth services covered under Sec. 1834(m)(4)(F)(ii). Services can fall into one of the following categories:

- Category 1: services that are similar to professional consultations, office visits and office psychiatry visits that are currently on the list of telehealth services.
- Category 2: services that are not similar to those on the current list of telehealth services but that demonstrate a clinical benefit to the patient.

CMS is adding over 80 services to the list of telehealth services for the duration of the PHE, for telehealth services with dates of service beginning on March 1, 2020. A full list of services, including the additions made in the interim final rule, can be found [here](#).

Telehealth Modalities and Cost-sharing

Clarifying Telehealth Technology Requirements

CMS is revising the regulatory definition of interactive telecommunication systems to add an exception for the duration of the PHE, by adding the following language:

“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.”

Beneficiary Cost-sharing

On March 17, the Office of Inspector General (OIG) issued a [policy statement](#) that notified physicians and other practitioners that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations that Medicare beneficiaries may owe for telehealth services furnished consistent with the then applicable coverage and payment rules. This policy applies to a number of 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.

Direct Supervision by Interactive Telecommunications Technology

Many services paid under the PFS can be paid when provided under a level of physician or non-physician practitioner (NPP) supervision rather than personal performance. In many cases, the supervision requirements in physician office settings necessitate the presence of the physician or NPP in a particular location, usually in the same location as the beneficiary when the service is provided.

The agency recognizes that in certain cases, technology will allow appropriate supervision without the physical presence of a supervising physician. In the context of the PHE, given the risks of exposure, the immediate potential risk to needed medical care, the increased demand for health care professionals, and the widespread use of telecommunications technology, the agency finds that individual practitioners are in the best position to make decisions based on their clinical judgement in particular circumstances.

Therefore, CMS is revising the definition of direct supervision to allow, for the duration of the PHE, direct supervision to be provided using real-time interactive audio and video technology. **The agency seeks comments on whether there should be any guardrails and what kind of risk this policy might introduce for beneficiaries while reducing risk of COVID-19 spread.** This change is limited to only the

manner in which the supervision requirement can be met, and does not change the underlying payment or coverage policies related to the scope of Medicare benefits, including Part B drugs.

Remote Physiologic Monitoring (RPM)

The typical patient receiving RPM services are patients with chronic conditions, such as diabetes, high blood pressure, and COPD. In this rule, CMS clarifies that the RPM codes listed above can be used for physiologic monitoring of patients with acute and/or chronic conditions.

RPM services are considered to be communication technology-based services (CTBS) and historically, these services are billable for only established patients, however during the COVID-19 public health emergency, CMS is allowing these services to be delivered to new patients as well. Practitioners must receive verbal consent from Medicare beneficiaries to provide CTBS and RPM services. This requirement will prevent scenarios where beneficiaries are unexpectedly surprised by copays for services that do not involve the typical in-person, face-to-face service that a patient receives during an office visit. During the COVID-19 emergency, CMS is finalizing that consent to receive RPM services can be obtained once annually, including at the time services are furnished. CMS suggests that the practitioner review consent information with the beneficiary, obtain verbal consent, and then document that verbal consent was obtained.

Telephone Evaluation and Management (E/M) Services

During CY 2008 rulemaking, the CPT Editorial Panel created six CPT codes to describe E/M services furnished by a physician or a qualified healthcare professional via telephone or online. In the effort of reducing exposure risks in association with the COVID-19 public health emergency, CMS believes there are certain circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate. CMS believes that the existing telephone E/M codes listed above are the best way to recognize the relative resources to furnish these services. The agency notes these codes do not represent full E/M services.

The three CPT codes 99441-99443 that describe physician work will be paid during this PHE. These services can be billed for new and established patients.

Level Selection for Office/Outpatient E/M Visits When Furnished Via Medicare Telehealth (pg. 135)

For office/outpatient visits delivered via telehealth during the PHE, CMS is revising its policy to allow providers to select the level of a visit based on MDM or time with time defined as all of the time associated with the E/M on the day of encounter. Providers will also not be required to document history and/or physical exam in the medical record. This policy is similar to the E/M documentation policy scheduled to be implemented on January 1, 2021. Despite the similarity, the agency is maintaining the current definition of MDM and using the times available in the [public use file](#).

TRAINING PROVISIONS

Application of Teaching Physician and Moonlighting Regulations during the PHE for the COVID-19 Pandemic

Revisions to Teaching Physician Regulations during a PHE for the COVID-19 Pandemic

Current policy requires PFS payment made only if the teaching physician is present during the key portion of any service or procedure for which payment is sought if a resident participates in a service furnished in a teaching setting. In response to stakeholders' concern and for the duration of the COVID-19 emergency, CMS is amending the teaching physician regulations to allow the teaching physician to provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service. CMS recognizes that if the teaching physician or resident is under quarantine or at home, it could limit the number of practitioners available to provide health care services to Medicare patients.

Currently, under the primary care exception (PCE) certain lower and mid-level office/outpatient E/M services provided in certain primary care centers are exempt from the physical presence requirement. The teaching physician must provide direct supervision. Therefore, CMS is finalizing policy, on an interim basis, to allow that all levels of an office/outpatient E/M service provided in primary care centers may be provided under direct supervision of the teaching physician by interactive telecommunications technology. Furthermore, CMS will allow PFS payment to be made for the interpretation of diagnostic radiology and other diagnostic tests when the interpretation is performed by a resident under direct supervision of the teaching physician by interactive telecommunications technology. The teaching physician must still review the resident's interpretation. **CMS seeks comment on their belief that direct supervision by interactive telecommunications technology is appropriate during the COVID-19 emergency.**

CMS lists exceptions to this policy. For example, the teaching physician must be present in the case of surgical, high-risk, or other complex procedures, including procedures performed through an endoscope. The teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. **CMS seeks comment on other possible procedures that should be exempt from this policy.**

Application of the Expansion of Telehealth Services to Teaching Physician Services

On March 17, 2020, CMS announced the expansion of telehealth services on a temporary and emergency basis. This expansion allows Medicare to pay for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere across the country including in a patient's place of residence.

CMS believes that "allowing Medicare payment for services billed by the teaching physician when the resident is furnishing services, including office/outpatient E/M services provided in primary care centers, via telehealth under direct supervision by interactive telecommunications technology would allow residents to furnish services remotely to patients who may need to be isolated for purposes of exposure risk based on presumed or confirmed COVID-19 infection, and as a result, would increase access to services for patients." Therefore, for the duration of the COVID-19 PHE, the agency will allow Medicare payment under the PFS for teaching physician services when a resident furnishes telehealth services to beneficiaries under direct supervision of the teaching physician by interactive telecommunications technology. Additionally, Medicare may make payment under the PFS for services billed under the PCE by the teaching physician when a resident furnishes telehealth services to beneficiaries under the direct supervision of the teaching physician by interactive telecommunications technology. **CMS seeks comment on their belief that direct supervision by interactive telecommunications technology is appropriate during the COVID-19 emergency.**

Payment under the PFS for Teaching Physician Services when Resident under Quarantine

CMS recognizes that there may be circumstances in which a resident may need to furnish services while under quarantine. Therefore, CMS is also finalizing for the duration of the COVID-19 emergency that Medicare may also make payment under the PFS for teaching physician services when the resident is furnishing these services while in quarantine under direct supervision of the teaching physician by interactive telecommunications technology. CMS believes this revised policy will limit exposure risks of COVID-19 while also preventing limited access to physician services.

Revisions to Moonlighting Regulations during a PHE for the COVID-19 Pandemic

“A licensed resident physician is considered to be “moonlighting” when they furnish physicians’ services to outpatients outside the scope of an approved graduate medical education (GME) program.”

In response to the current COVID-19 emergency, stakeholders have requested that CMS allow residents to furnish physicians’ services to patients in the inpatient setting outside of the scope of their approved GME programs in the hospital where they have their training. Currently, there is a greater demand for physicians to respond to patient needs, such as furnishing services to patients in inpatient settings who have either a presumed or confirmed COVID-19 infection. Consequently, CMS is amending CFR 42 § 415.208 and finalizing for the duration of the COVID-19 emergency that the services that are not related to residents’ approved GME programs and are performed in the inpatient setting of a hospital in which they have their training program are in fact separately billable physicians’ services and Medicare payment can be made under the PFS.

Counting of Resident Time During the PHE for the COVID-19 Pandemic

Hospitals may claim residents for IME and DGME purposes for the time the resident is providing care to hospital patients at home or in the home of a patient as long as they are performing care duties within the scope of the approved residency requirements and meets the physician supervision requirements outlined earlier in the rule.