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| CMS Manual System | Department of Health & Human Services (DHHS) |
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 10160 | Date: May 22, 2020 |
| | Change Request 11805 |

SUBJECT: Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of the policies in the CY 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules (IFC) entitled Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC) and Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program (CMS-5531-IFC).

EFFECTIVE DATE: June 12, 2020

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 12, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|--------------|---|
| N/A | N/A |

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

| | | | |
|-------------|--------------------|--------------------|-----------------------|
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I. GENERAL INFORMATION

A. Background: This Change Request (CR) provides a summary of the policies in the interim final rule with comment period (IFC) entitled Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC); and in the IFC entitled Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program (CMS-5531-IFC).

In the event of a declared public health emergency (PHE), the United States Secretary of Health has the authority to temporarily waive or modify application of certain Medicare requirements during the emergency period. A PHE was declared by the Secretary on January 31, 2020, for the 2019 Novel Coronavirus (COVID-19). In addition, the President declared a national emergency concerning COVID-19 on March 13, 2020.

The purpose of this Change Request (CR) is to provide a summary of the recent policy changes to the Medicare Physician Fee Schedule (MPFS) during the PHE. The Centers for Medicare & Medicaid Services (CMS) has recently issued two (IFCs) that revised payment policies and Medicare payment rates for services furnished by physicians and nonphysician practitioners (NPPs) that are paid under the MPFS during the PHE.

B. Policy: This Change Request provides a summary of the payment policies, revisions to the MPFS, and other policy changes related to Medicare Part B payment, as part of the PHE for the COVID-19 pandemic under the following IFCs:

Regulation number CMS-1744-IFC: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, went on display on the CMS website on March 31, 2020.

Regulation number CMS-5531-IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program, went on display on the CMS website on April 30, 2020.

These changes are applicable to services furnished during the PHE.

Medicare Telehealth Services

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (the Act)

Pursuant to the waiver authority added under section 1135(b)(8) of the Act by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, to facilitate the use of telecommunications technology

as a safe substitute for in-person services, CMS has added, on an interim basis, many services to the list of eligible Medicare telehealth services. This list of added services included initial inpatient and nursing facility visits, emergency department visits, initial and subsequent observation services, inpatient nursing facility and observation discharge day management home visits, and a number of physical therapy, occupational therapy, and speech language pathology services.

On an interim basis, CMS eliminated several requirements associated with particular services furnished via telehealth, and clarified several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks. Specifically, we eliminated frequency limitations for subsequent inpatient and nursing facility visits and critical care consults, and instructed practitioners to identify whatever place of service they would have had the service occurred in person, and to append the 95 modifier to the claim to identify it as Medicare telehealth. This is to assure that the payment rate would be equal to that which ordinarily would have been paid under the PFS were the services furnished in-person.

NOTE: Critical Access Hospitals (CAH) method II should continue to report Distant Site services with modifier GT.

Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations and Required “Hands-on” Visits for End Stage Renal Disease (ESRD) Monthly Capitation Payments

For ESRD Monthly Capitation Payments, CMS elected to exercise enforcement discretion regarding the statutory requirement that for ESRD services furnished via telehealth there be a monthly "hands on" evaluation of the vascular access site for the first three months of home dialysis and once every 3 months thereafter. CMS is instead permitting the required clinical examination to be furnished as a Medicare telehealth service during the PHE for the COVID-19 pandemic.

Telehealth Modalities

Based on feedback from the physician community, CMS clarified that for the PHE for the COVID-19 pandemic, Interactive telecommunications system means multimedia communications equipment. The multimedia communications equipment includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. CMS informed practitioners that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations during the PHE for the COVID-19 pandemic.

Communication Technology-Based Services (CTBS)

For communication technology based Services (CTBS) for the duration of the PHE for the COVID-19 pandemic, CMS established that these services, which may only be reported if they do not result in a visit, including a telehealth visit, can be furnished to both new and established patients. This is to allow these services to be available to as large a population of Medicare beneficiaries as possible, given that the need for an in-person visit could represent an exposure risk for vulnerable patients in the context of the COVID-19 pandemic. CMS also finalized on an interim basis during the PHE for the COVID-19 pandemic that, while consent to receive these services must be obtained annually, it may be obtained at the same time that a service is furnished. CMS expanded the range of practitioners eligible to bill for certain online assessment and management services from practitioners who could independently bill for E/Ms to practitioners who cannot, so that, for example, licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists may bill for these services when applicable. On an interim basis, during the PHE for the COVID-19 pandemic, CMS broadened the availability of HCPCS codes G2010 and G2012 that describe remote evaluation of patient images/video and virtual check-ins to recognize that in the context of the PHE for the

COVID-19 pandemic, practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists might also utilize virtual check-ins and remote evaluations instead of other, in-person services within the relevant Medicare benefit to facilitate the best available appropriate care while mitigating exposure risks.

Direct Supervision by Interactive Telecommunications Technology

For the duration of the PHE for the COVID-19 pandemic, CMS revised the definition of direct supervision to allow direct supervision to be provided using real-time interactive audio and video technology. We recognize that given the risks of exposure, in some cases, technology would allow appropriate supervision without the physical presence of a physician. We note that in specifying that direct supervision includes virtual presence through audio/video real-time communications technology that this can include instances where the physician enters into a contractual arrangement for auxiliary personnel as defined in federal regulations at §42 CFR 410.26(a)(1), to leverage additional staff and technology necessary to provide care that would ordinarily be provided incident to a physicians' service (including services that are allowed to be performed via telehealth). Additionally, we note that 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.

Telephone Evaluation and Management (E/M) Services (CPT codes 99441-3 and 98966-8)

CMS finalized, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 99441 through 99443 and 98966 through 98968, which describe E/M and assessment and management services furnished via telephone. While the code descriptors for these services refer to an "established patient", during the COVID-19 PHE, we are exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. As these audio-only services are being furnished primarily as a replacement for care that would otherwise be reported as an in-person or telehealth visit using the office/outpatient E/M codes, we are crosswalking the values for CPT codes 99441, 99442, and 99443 to 99212, 99213, and 99214, respectively.

Additionally, given our understanding that these audio-only services are being furnished as substitutes for office/outpatient E/M services, we recognize that they should be considered as telehealth services, and are adding them to the list of Medicare telehealth services for the duration of the PHE.

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

CMS has revised our policy to specify that the following changes, which are scheduled to become effective on January 1, 2021 under policies finalized in the CY 2020 PFS Final Rule, will be effective for the duration of the PHE for the COVID-19 pandemic: the office/outpatient E/M level selection for office/outpatient E/M services when furnished via telehealth can be based on medical decision making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. Additionally, we finalized on an interim basis for the duration of the PHE for the COVID-19 pandemic, that the typical times for purposes of level selection for an office/outpatient E/M are the times listed in the CPT code descriptor.

Updating the Medicare Telehealth List

CMS finalized on an interim basis, for the duration of the COVID-19 PHE, that updates to the Medicare telehealth list would be done on an ongoing, sub-regulatory basis.

For more information regarding Telehealth services, please contact Emily Yoder at 410-786-1804.

Remote Physiologic Monitoring (RPM) Services (CPT codes 99453, 99454, 99457, 99458)

CMS made several changes to RPM policies in response to the PHE for COVID-19. (1) We removed the requirement that there be an established patient-practitioner relationship. Both new and established patients can receive RPM services. (2) We modified the requirement that consent must be obtained prior to furnishing the RPM service. Instead, consent can be obtained at the time services are furnished and by individuals providing RPM services under contract to the ordering physician or qualified healthcare professional. (3) We clarified that RPM services can be used for physiologic monitoring of patients with acute and/or chronic conditions. (4) We confirmed that RPM services can be furnished under general supervision. (5) For CPT codes 99453 and 99454, we modified the number of days that data must be collected from the required 16 days to fewer than 16 days in a 30-day period as long as the other code requirements are met.

For more information regarding RPM, please contact Liane Grayson at 410-786-6583.

Supervision of Diagnostic Tests by Certain Nonphysician Practitioners

For the duration of the COVID-19 PHE, CMS finalized on an interim basis changes to the regulations governing diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests. These changes allow nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives to provide the appropriate level of supervision required for the performance of diagnostic tests paid under the PFS. Furthermore, these interim changes will continue to ensure that these nonphysician practitioners may order, furnish directly, and, now supervise the performance of diagnostic tests, subject to applicable State law, during the COVID-19 PHE.

For more information regarding supervision by NPP's, please contact Regina Walker-Wren at 410-786-9160.

Application of Teaching Physician Regulations

Under current rules, Medicare payment is made for services furnished by a teaching physician involving residents only if the physician is physically present for the key portion of the service or procedure or the entire procedure, where applicable. For the duration of the COVID-19 PHE, CMS finalized on an interim basis, that teaching physicians may use audio/video real time communications technology to interact with the resident through virtual means, which would meet the requirement that they be present for the key portion of the service, including when the teaching physician involves the resident in furnishing Medicare telehealth services. Teaching physicians involving residents in providing care at primary care centers can provide the necessary direction, management and review for the resident's services using audio/video real time communications technology. Residents furnishing services at primary care centers may furnish an expanded set of services to beneficiaries, including levels 4-5 of an office/outpatient E/M visit, telephone E/M, care management, and communication technology-based services. These flexibilities do not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services. This allows teaching hospitals to maximize their workforce to safely take care of patients.

For more information regarding teaching physician regulations, please contact Christiane Labonte at 410-786-7237.

Resident Moonlighting

Under current rules, Medicare considers the services of residents that are not related to their approved graduate medical education programs and performed in the outpatient department or the emergency department of a hospital as separately billable physicians' services. For the duration of the COVID-19 PHE, CMS finalized on an interim basis, that Medicare also considers the services of residents that are not related to their approved GME programs and furnished to inpatients of a hospital in which they have their training program as separately

billable physicians' services.

For more information regarding resident moonlighting, please contact Christiane Labonte at 410-786-7237.

Outpatient Physical and Occupational Therapy Services: Expanded Use of Therapy Assistants Allowed for Maintenance Therapy Services

Our current policy for outpatient Part B physical therapy and occupational therapy services requires the physical therapist (PT) or occupational therapist (OT) to personally carry out the services of a maintenance program – more commonly known as maintenance therapy – when these services are needed to maintain, prevent or slow the deterioration of a patient's functional status as part of the maintenance program's plan. For the duration of the COVID-19 PHE, CMS finalized on an interim basis, that PTs and OTs are permitted to delegate to therapy assistants, when clinically appropriate, the responsibilities to furnish maintenance therapy services. We believe this is consistent with feedback we heard from therapists and therapy providers on scope of practice issues and better aligns with maintenance therapy services furnished in the Part A-paid skilled nursing facility and home health settings. We believe this flexibility will free-up PTs and OTs to furnish other services requiring their assessment skills to COVID-19 related services including communication technology-based services that were made available for physical therapists, occupational therapists and speech-language pathologists during the PHE.

For more information regarding outpatient physical and occupational therapy services, please contact Pam West at 410-786-2302.

Therapy Services-Student Documentation

In the CY 2020 PFS final rule, CMS simplified medical record documentation requirements and finalized a general principle to allow the physician, physician assistant, or the advanced practice registered nurses, who furnish and bill for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team. For the duration of the COVID-19 PHE, CMS finalized on an interim basis, 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.

For more information regarding student documentation, please contact Sarah Leipnik at 410-786-3933.

Opioid Treatment Programs (OTPs)

In light of the PHE for the COVID-19 pandemic, in CMS-1744-IFC, CMS revised our regulations at 42 CFR 410.67(b)(3) and (4) to allow the therapy and counseling portions of the weekly bundles of services furnished by OTPs, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology during the PHE for the COVID-19 pandemic if beneficiaries do not have access to two-way audio/video communications technology, provided all other applicable requirements are met.

In addition to the flexibilities described above, in CMS-5531-IFC, CMS revised our regulations at 42 CFR 410.67(b)(7) on an interim final basis to allow periodic assessments to be furnished during the PHE for the COVID-19 pandemic via two-way interactive audio-video communication technology. In addition, in cases where beneficiaries do not have access to two-way audio-video communications technology, the periodic assessments may be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology, provided all other applicable requirements are met. We believe this change is

necessary to ensure that beneficiaries with opioid use disorders are able to continue to receive these important services during the PHE for the COVID-19 pandemic.

For more information regarding Opioid Treatment Programs, please contact Lindsey Baldwin at 410-786-1694.

Ordering COVID-19 Diagnostic Laboratory Tests

Having recognized the critical importance of expanding COVID-19 testing, for the duration of the PHE for the COVID-19 pandemic, CMS has finalized removing the requirement that certain diagnostic tests are covered only under the order of a treating physician or non-physician practitioner (NPP). This will allow any healthcare professional authorized to do so under State law to order COVID-19 diagnostic laboratory tests (including serological and antibody tests). Because the symptoms for coronavirus, influenza, and respiratory syncytial virus are often the same, such that concurrent testing for all three viruses is warranted, this provision will also apply to influenza and RSV tests only when they are furnished in conjunction with a medically necessary COVID-19 diagnostic laboratory test to establish or rule out a COVID-19 diagnosis or identify an adaptive immune response to SARS-COV-2.

CMS has made conforming changes to the documentation and record keeping requirements for lab tests that would not be relevant in the absence of a treating physician's or NPP's order. When an order is written for the test, CMS expects the ordering or referring National Provider Identifier information on the claim form under current requirements.

When furnished without a physician's or NPP's order, the laboratory conducting the test(s) is required to directly notify the patient of the results, and meet other applicable test result reporting requirements.

CMS has finalized new specimen collection fees for COVID-19 testing under the PFS. Physicians and NPPs must use CPT code 99211 to bill for a COVID-19 symptom and exposure assessment and specimen collection provided by clinical staff (such as pharmacists) incident to the physician's or NPP's services. This applies to all patients, not just established patients. The direct supervision requirement may be met through virtual presence of the supervising physician or practitioner using interactive audio and video technology. Cost sharing will not apply.

Pharmacists Providing Services Incident To Physician/NPP Services

CMS clarified explicitly the existing policy that pharmacists may provide services incident to, and under the appropriate level of supervision of, the billing physician or NPP, if payment for the services is not made under Medicare Part D. This includes providing the services in accordance with the pharmacist's state scope of practice and applicable state law.

For more information regarding services provided incident to, please contact Ann Marshall at 410-786-3059.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

| Number | Requirement | Responsibility | | | | | | | | |
|---------|--|----------------|---|-------|-------------|---------------------------|-------|-------|-------|-------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Other |
| | | A | B | H H H | | F I S S | M C S | V M S | C W F | |
| 11805.1 | Contractors shall be aware of the policies published in the interim final rules with comment regulation numbers CMS-1744-IFC (Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency) and CMS-5531-IFC (Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program), which are summarized with this change request. | X | X | X | | | | | | |

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---------|---|----------------|---|-------|-------------|---------|
| | | A/B MAC | | | D M E M A C | C E D I |
| | | A | B | H H H | | |
| 11805.2 | MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter. | X | X | X | | |

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---------------------------------|---|
|---------------------------------|---|

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Kersell, 410 786-2033 or Kathleen.Kersell@cms.hhs.gov , Julie Adams, 410-786-8932 or julie.adams@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

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