2025 Texas Severe Storms, Straight-Line Winds, and Flooding – Available Waivers for Texas Health Care Providers in Affected Counties

CMS is empowered to take proactive steps to help providers through waivers issued pursuant to section 1135 of the Social Security Act (the Act). In addition, the statute provides for discretionary SNF coverage authority under section 1812(f) of the Act, and extended coverage until September 2025 for certain telehealth services. The following blanket waivers and other flexibilities are in effect through the end of the Texas Flooding public health emergency declaration of Texas signed 07/08/2025, retroactively from 07/02/2025, or when no longer needed. Despite the availability of blanket waivers, suppliers and providers should strive to return to their normal practice as soon as possible.

Blanket waivers DO NOT need to be submitted via the CMS 1135 Waiver Portal (https://cmsqualitysupport.servicenowservices.com/cms_1135) or via notification to the CMS Survey & Operations Group and are applied automatically by surveyors.

Medical and Other Health Services

- **Eligible Telehealth Practitioners.** CMS is waiving the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2), which specify the types of practitioners who may bill for their services when furnished as Medicare telehealth services from a distant site. The waiver of these requirements expands the types of health care professionals who can furnish distant site telehealth services to include all those who are eligible to bill Medicare for their professional services. As a result, a broader range of practitioners, such as physical therapists, occupational therapists, and speech language pathologists can use telehealth to provide many Medicare services.

- **Audio-Only Telehealth for Certain Services.** Pursuant to authority granted under 1135(b)(8), CMS is waiving the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3) for the use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services. Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

- When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.

  This also allows CMS to temporarily extend the 10-business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30 business days to provide notice to the Competitive Bidding Implementation Contractor of any subcontracting arrangements. CMS will notify DMEPOS Competitive Bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. **Note:** CMS will provide notice of any changes to reporting timeframes for future events.

Replacement Prescription Fills

- Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the disaster or emergency.

Note:

CMS has clarified that no federal 1135 waiver is required for cross-state medical practice during public health emergencies because existing CMS regulations already defer to state law regarding physician licensure reciprocity, with no federal requirement mandating practitioners be licensed in their specific state of Medicare enrollment or practice location. Since many states have independently relaxed their licensure laws to facilitate interstate practice during emergencies. CMS determined that state-led solutions are sufficient, and the federal waiver is unnecessary and redundant. The existing regulatory framework already provides adequate flexibility to support emergency response efforts without additional federal intervention.

Hospice and Home Health

- **Comprehensive Assessments.** CMS is waiving certain requirements at 42 CFR § 418.54 related to updating comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment found at 42 CFR § 418.54(d). Hospices must continue to complete the required assessments and updates; however, the timeframes for updating the assessment may be extended from 15 to 21 days.

- **Initial Assessments.** CMS is waiving the requirements at 42 CFR § 484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long-term care facilities and allow clinicians to focus on caring for patients with the greatest acuity.

- **Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients.** CMS is waiving the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary blanket waiver allowed any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care.

- **Reporting.** CMS is providing relief to HHAs on the timeframes related to OASIS Transmission through the following actions below:
    - Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
    - Modifying the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.

- **CMS is waiving the requirements at CFR 418.76(h)(1) and CFR 418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1) for HHAs**, which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the two-week aide supervision by a registered nurse for home health agencies' requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver. All postponed annual onsite assessments (direct observation) for each aide that provides services on behalf of the agency must be completed by these professionals no later than 60 days after the expiration of the PHE.