Washington Severe Storms, Straight-line Winds, Flooding, Landslides, and Mudslides – Available Waivers for Washington 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 March 2026 for certain telehealth services. The following blanket waivers and other flexibilities are in effect through the end of the 2025 Washington Flooding Public Health Emergency (PHE) declaration signed 12/23/2025, retroactively from 12/09/2025, 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.

- **Medicare Telehealth - Originating Sites**. CMS is waiving certain Medicare telehealth payment requirements to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas and patients in their homes will be eligible for telehealth services

- **Housing Acute Care Patients in Excluded Distinct Part Units**. During the PHE, CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatients. The Inpatient Prospective Payment System (IPPS) hospital bills for the care and annotates the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

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.

Long Term Care Facilities/Skilled Nursing Facilities/Home Health

- **Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs).** CMS issued a blanket waiver to long-term care hospitals (LTCHs) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which allows these facilities to be paid as LTCHs. In addition, during the applicable waiver time period, CMS has determined it is appropriate to issue a blanket waiver to hospitals not yet classified as LTCHs, but seeking classification as an LTCH, to exclude patient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which must be met in order for these hospitals to be eligible to participate in the LTCH PPS. Hospitals should add the "DR" condition code to applicable claims.

- **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.

- **Detailed Information Sharing for Discharge Planning for Home Health Agencies.** CMS is waiving the requirements of 42 CFR § 484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post- acute care provider by using and sharing data that includes, but is not limited to, (another) home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. This temporary waiver provides facilities with the ability to expedite the discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements.

- **Waive Onsite Visits for HHA Aide Supervision.** CMS is waiving the requirements at 42 CFR§ 484.80(h), which require a nurse to conduct an on-site visit every two weeks. This waiver is also temporarily suspending the 2-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. CMS will end this waiver at the conclusion of the PHE.

- **Training and Assessment of Aides.** CMS has been waiving the requirement at 42 CFR § 418.76(h)(2) for Hospice and 42 CFR § 484.80(h)(1)(iii) for HHAs, which require a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to

make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency. CMS is postponing completion of these visits. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE.

- **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 receive home care.

- **12-hour Annual In-service Training Requirement for Home Health Aides.** CMS is waiving the requirements at 42 CFR § 484.80(h), which require a nurse to conduct an on-site visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an on-site visit every two weeks, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the 2-week aide supervision by a registered nurse for home health agencies' requirement at 42 CFR § 484.80(h)(1), but virtual supervision is encouraged during the period of the waiver.