Interim Final Rule: Revisions due to COVID-19 PHE

CMS released an Interim Final Rule on Monday, March 30, 2020, titled: **"Medicare and Medicaid Programs: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency."** The rule gives individuals and entities that provide services to Medicare beneficiaries "needed flexibilities to respond effectively to the serious public health threats" posed by the spread of COVID-19. Regulations outlined in this rule are retroactive to March 1, 2020 and last for the duration of the declared public health emergency (PHE).

Telehealth

Background: On March 17, 2020, CMS announced the expansion of telehealth services on a temporary and emergency basis during the declared COVID-19 PHE. Most telehealth services under Medicare are reported using codes that describe face-to-face services, but are furnished using audio/video, real-time communication technology instead of in-person. Beginning March 6, 2020, Medicare will pay for telehealth services, including office, hospital, and other visits furnished by physicians and other eligible providers (**not** PTs, OTs, and SLPs) to patients located anywhere in the country, including in the patient's home.

In this Interim Final Rule, CMS is adding, on a temporary basis, many CPT codes related to services provided and billed by physicians and certain non-physician practitioners in various settings including the ED, observation, hospital care, nursing facility visits, critical care services, physician home visits, intensive care services, ESRD, psychological testing, radiation treatment and more.

Although this rule does not add PTs, OTs and SLPs to the eligible provider list for telehealth, it does add CPT codes typically billed by therapists to the approved code list for telehealth services. CMS states that although therapists are not included as eligible providers of telehealth by statute, the "potential benefits for circumstances when these services might be furnished by eligible distant site practitioners" outweighs any confusion that may arise by having the codes "approved" but the typical providers of the services "not approved."

CPT codes added to the approved telehealth code list on a temporary basis, during the PHE, include the following:

- 97161, 97162, 97163 and 97164 – PT Initial Eval and Re-evaluation
- 97165, 97166, 97167 and 97168 – OT Initial Eval and Re-evaluation
- 97110, Therapeutic exercise
- 97112, Neuromuscular reeducation
- 97116, Gait training
- 97535, Self-care/home management
- 97750, Physical performance test
- 97755, Assistive technology assessment
- 97760, Orthotics management and training, initial encounter
- 97761, Prosthetic training, initial encounter

- 92521, 92522, 92523 and 92524 – Speech-language evaluations
- 92507, Treatment of speech

To reiterate, these codes are now approved to be delivered via telehealth, but NOT by PTs, OTs or SLPs. Eligible providers who could provide these services during the PHE include physicians, nurse practitioners, and physician assistants.

NOTE: Per information published by the APTA, the therapy associations are pursing this issue with CMS. Advocacy efforts are ongoing.

Telehealth services, for the duration of the PHE, must be delivered via an Interactive Telecommunications System, defined as multimedia equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site provider. The HHS Office of Civil Rights (OCR) is exercising "enforcement discretion and waiving enforcement penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communication technologies, such as FaceTime or Skype, during the PHE for the COVID-19 pandemic."

Communication Technology-Based Services (CTBS)

Background: In the CY 2019 and 2020 Medicare Physician Fee Schedule Final Rules, CMS finalized separate payment for a number of services that can be furnished via "telecommunications technology," but are not telehealth services. These services include services such as "virtual check-ins" and "e-visits," and as finalized in these prior rules, apply to established patients only and for practitioners other than PTs, OTs and SLPs.

- G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation and follow-up with the patient within 24 business hours, 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.
- G2012: Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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; 5-10 minutes of medical discussion.
- 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- 99422: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

- G2061: Qualified nonphysician healthcare professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- G2062: Qualified nonphysician healthcare professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- G2063: Qualified nonphysician healthcare professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

In the context of the COVID-19 PHE, CMS has determined that these codes should not be limited to established patients only. And, **for the duration of the PHE, HCPCS codes G2010, G2012, G2061, G2062 and G2063 are available to PTs, OTs and SLPs to provide and bill to Medicare Part B for both new and established patients.** These codes have been designated as "sometimes therapy" codes, and therefore will require the GP, GO and GN modifiers.

These G codes have rates assigned via the 2020 fee schedule which will vary by location. Approximate rates (non-facility price) are:

- G2010: $12.27
- G2012: $14.80
- G2061: $12.27
- G2062: $21.65
- G2063: $33.92

Direct Supervision by Interactive Telecommunications Technology (Incident-to)

Services furnished and billed incident to a physician require the direct supervision of the physician. As currently defined, "direct supervision" means that the physician must be present "in the office suite and immediately available" to provide assistance and direction. CMS states that given the current circumstances under the PHE, the physical proximity of the physician or practitioner may not be possible without additional risks for both the provider and for the patient. Therefore, **CMS is revising the definition of direct supervision (for physicians/practitioners) to allow supervision to be provided via "real-time interactive audio and video technology" for the duration of the COVID-19 PHE.**

Of note, CMS is allowing similar supervision allowances for pulmonary rehab and cardiac rehab. *CMS does not specify a similar allowance for supervision of therapist assistants in private practice.* APTA is seeking clarification from CMS on this issue.

Homebound Status

An individual is considered to be "confined to the home" if he/she has a condition, due to an illness or injury, that restricts or limits the ability to leave the home. **In this rule, CMS states, "The definition of "confined to the home" (that is, "homebound") allows patients to be**

considered "homebound" if it is medically contraindicated for the patient to leave the home."

For example, in the case of the COVID-19 pandemic, this definition would apply for patients where:

(1) a physician has determined it is medically contraindicated for the patient to leave his/her home because of a confirmed or suspected diagnosis of COVID-19, or
(2) where a physician has determined it is medically contraindicated for the patient to leave home because of an increased risk of contracting COVID-19.

A patient who is exercising "self-quarantine" for his/her own safety would not be considered "confined to the home."

In addition to being "confined to the home," the patient must meet other Medicare coverage criteria to receive home health (HH) services under Medicare Part A during the COVID-19 pandemic. CMS does say that this clarification regarding homebound status is not limited to this current PHE, but would also apply "for other outbreaks of an infectious disease" and any other instances where the condition of the patient is such that leaving home is medically contraindicated.

Use of Technology Under the HH Benefit

CMS is providing HH providers flexibility on an interim basis (i.e., during the current PHE) to use various types of telecommunications systems (technology) in addition to remote patient monitoring, in conjunction with in-person visits. To clarify, visits provided via technology cannot replace an in-person visit.

The use of technology must be related to the skilled services being furnished by the nurse/therapist/therapist assistant to "optimize the services furnished during the home visit…" The use of technology must be included on the HH plan of care, "along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in-person visit…" CMS goes on to say they understand that using technology may result in changes to the frequency or types of visits outlined on the plan of care, and CMS gives the following example in the Interim Final Rule:

> A patient, recently discharged from the hospital after a coronary bypass surgery was receiving HH skilled nursing services three times per week for medication management, teaching, and assessment. The patient developed a fever, cough, sore throat and shortness of breath, and now is confirmed to have COVID-19. The physician has determined this patient can be safely managed at home with HH services. The patient has been prescribed new medications and oxygen at home. The plan of care has been modified to include a skilled nursing visit once per week and a video consultation with the nurse twice per week, to monitor symptoms and obtain oxygen saturation levels that the patient relays to the nurse.

There is no payment for the use of technology in HH, however, agencies can report the costs of telecommunications technology as allowable administrative and general (A&G) costs on an interim basis.

Use of Technology Under the Hospice Benefit

For the duration of the COVID-19 PHE, **CMS is also providing hospice providers flexibility to allow services via telecommunications systems for patients receiving routine home care (RHC)** "if it is feasible and appropriate to do so." The use of such technology must be included on the plan of care, and must be tied to patient-specific needs as identified on the comprehensive assessment. There is no payment beyond the per diem amount for the use of technology. For the purposes of hospice claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim.

Also, **CMS will allow the face-to-face visit for the purpose of hospice recertification to be performed using telecommunications technology** for the duration of the PHE.

Inpatient Rehabilitation Facility Flexibilities

During the COVID-19 pandemic, **CMS is allowing the required three times per week physician face-to-face visits in the inpatient rehabilitation facility (IRF) setting to be conducted via telehealth** (two-way, real time audio/video technology). In addition, CMS is removing the post-admission physician evaluation requirement for all IRFs during the PHE to decrease the amount of time physicians spend on paperwork when patients are admitted. This does not preclude an IRF patient from being evaluated by a rehabilitation physician within 24 hours of admission if the IRF believes the patient's condition warrants it.

The intensive rehabilitation therapy program requirement (i.e., the "3-hour rule," therapy treatments beginning within 36 hours from midnight on the day of admission) remains in place, however, CMS clarifies that in cases where an IRF's program is impacted by the PHE for COVID-19 (e.g., due to staffing disruptions resulting from staff isolation, infection), the IRF "should not feel obligated to meet the industry standards," and should instead note this in the medical record.

Telephone Evaluation and Management Services

Background: In CY 2008, CPT codes were created to represent evaluation and management (E/M) services furnished by a physician or qualified healthcare professional via a telephone or online (CPT 98966-98968, 99441-99443). These codes were assigned a "noncovered" status indicator by CMS at that time because the services were not face-to-face and included language that recognized the provision of services to parties other than the beneficiary (e.g., a guardian).

In this rule, CMS states they do not believe these codes should continue to be "categorically noncovered." And, despite the fact that these services are classified as E/M services in the CPT coding manual, CMS believes they are more closely analogous to virtual check-in services. CMS acknowledges that there are circumstances during this pandemic where prolonged audio-only communication between the patient and the practitioner could be clinically appropriate. **Therefore, CMS is finalizing, on an interim basis for the duration of the PHE, separate payment for CPT codes 98966-98968 and 99441-99443** (although as of April 6, 2020, payment has not been assigned when using the Fee Schedule Lookup Tool).

- 98966: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 98967: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- 98968: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

(*NOTE*: CPT codes 99441-99443 are similar codes to the ones above, but are E/M codes to be billed by a physician or other qualified healthcare professional who may report E/M services.)

CMS will extend these codes to both new and established patients during the pandemic. **CPT codes 98966-98968 may be furnished by PTs, OTs and SLPs** "when the visit pertains to a service that falls within the benefit category of those practitioners." These codes have been designated as "sometimes therapy" codes, and therefore will require the GP, GO, and GN modifiers.

MIPS

In response to the COVID-19 pandemic, CMS extended the 2019 MIPS data submission deadline by 30 days to April 30, 2020, to give eligible clinicians more time to report quality and other data. CMS has also determined that the "MIPS automatic extreme and uncontrollable circumstances policy" will apply to MIPS eligible clinicians who do not submit their MIPS data by April 30, 2020. Under this policy, clinicians who do not submit *any* MIPS

data will have all performance categories reweighted to zero percent, resulting in a neutral payment adjustment. However, if a MIPS eligible clinician submits data in two or more performance categories, their score will be calculated and payment will be adjusted accordingly in 2021.

For more information, access **CMS's Fact Sheet**.

And, the **Interim Final Rule**.