

A PROVIDER'S GUIDE: Federal Telehealth Policy and Requirements During COVID-19

Rapid developments with the COVID-19 pandemic have resulted in a set of broad expansions of telehealth policy, including key changes to both public and private payer payment policies, at least for the duration of this emergency period. This guide is meant to help healthcare providers and organizations get up to speed quickly on these changes and key components of telehealth payment at the federal level. Please keep in mind that events and policies are changing rapidly, and that this document will be updated frequently as new information and policies become available/are enacted.

Center for Medicare and Medicaid Services (CMS)

Blanket Waivers to all States under Section 1135 of the Social Security Act (SSA)

CMS has modified requirements under the COVID-19 Emergency Declaration under Section 1135 of the Social Security Act for the entire country. In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements, called 1135 waivers. There are different kinds of 1135 waivers, including Medicare blanket waivers.

When there's an emergency, sections 1135 or 1812(f) of the SSA allow us to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver. When there's an emergency, CMS can also offer health care providers other flexibilities to make sure Americans continue to have access to the health care they need.

<https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

Initial changes made that impact the delivery of telehealth services during the emergency are summarized below:

1. Waives requirements that out of state providers be licensed in the state where they are providing services when they are licensed in another state—applies to Medicare and Medicaid.
2. Allows for temporary Medicare billing privileges for non-enrolled providers, waiving application fee, criminal background check; postpones all revalidation actions for enrolled providers; allows providers to bill for services outside their state of enrollment; expedites existing applications for enrollment.
3. Allows for waiver applications from states to deal with the public health emergency under Section 1135 of the Social Security Act.
4. Removed limitations on where Medicare patients are eligible to receive telehealth services. All patients are eligible for telehealth services regardless of where they live (previously only those who live in rural areas were eligible for telehealth), and patients may receive these services at their home.
5. CMS will not enforce the requirement that patients have a previously established relationship with a provider in order to receive telehealth services, i.e. new patients may receive these services.
6. Allows for the use of phones with audio and video capabilities to provide billable services. Effective with the additional waivers discussed below, there are now some services that may be provided to a phone that only has audio-only capabilities (CPT 98966-98968, 99441-99443).

This resource was developed in collaboration with the Center for Connected Health Policy (CCHP), and was made possible by a grant from the Office for the Advancement of Telehealth, HRSA, DHHS

March 30, 2020—On March 30, 2020, CMS made further rules and waivers of federal requirements to ensure the health system has the capacity to fully respond to the emergency. These changes are intended to assist in further promoting the use of telehealth in Medicare. An overview of the changes from CMS is available at: [Summary of COVID-19 Emergency Declaration Waivers & Flexibilities for Health Care Providers \(PDF\)](#)

General Services

1. CMS expanded the types of telehealth services that can be furnished through telehealth
 - a. These include emergency department visits (levels 1 to 5); initial and subsequent observation and observation discharge day management; initial hospital care and hospital discharge day management; initial nursing facility visits and nursing facility discharge day management; critical care services; domiciliary, rest home, or custodial care services; home visits; inpatient neonatal and pediatric critical care; Intensive Care Services; Care Planning for patient with Cognitive Impairment; Psychological and Neuropsychological testing; Physical and Occupational Therapy; Radiation Treatment Management Services; and Licensed Clinical Social Worker, Clinical Psychologist, Physical Therapy, Occupational Therapy, and Speech Language Pathology can be paid as Medicare telehealth services. **The full list of billable telehealth services and codes is available at:** <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
2. Virtual Check-In services are now allowed with patients who have not had a previous relationship with their provider, i.e. new patients (G2010, G2012).
 - a. Virtual Check-Ins allow patients to talk to a doctor or certain other practitioners, like nurse practitioners or physician assistants, using a device like a phone, integrated audio/video system, or captured video image without going to the doctor's office. Providers may respond using: Phone; Audio/visit; Secure text messages; Email; or Use of a patient portal (<https://www.medicare.gov/coverage/virtual-check-ins>). CMS expects that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation.
3. In addition, LCSWs, Clinical Psychologists, Physical Therapists, Occupational Therapists, and Speech Language Pathologists can provide e-visits (G2061-G2063).
E-visits allow patients to talk to their provider using an online patient portal without going to the office. In addition to those named above, practitioners who may furnish these services include: Doctors, Nurse practitioners, and Physician Assistants (<https://www.medicare.gov/coverage/e-visits>). Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.
4. Remote patient monitoring may be used for COVID-19 patients and those with other acute and chronic conditions and can now be provided to patients with only one disease (99091, 99457-58, 99473-74, 99493-94).
5. CMS is also allowing a broad range of clinicians, including physicians, to provide visits through audio-only phones for those without a phone with video capabilities or without an internet connection (98966-98968, 99441-99443).
6. CMS is also allowing commonly used interactive apps with audio capabilities for telehealth visits.

FQHCs and RHCs

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1. Rural Health Clinics and Federally Qualified Health Centers may provide visiting nursing services to an individual's home anywhere in their services areas as a home health agency and the revised definition of homebound will apply with the allowed telehealth services.
2. CMS is waiving the requirement that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the FQHC or RHC is in operation. RHCs and FQHCs must have one of the following staff members available to provide care at all times the clinic or center is open: physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or psychologist.
3. CMS is modifying the requirement that physicians must provide medical directions for the clinic or center's health care activities and consultation for, and medical supervision of, the health care staff **only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law**. The physician, either in person or through telehealth, must continue responsibility for providing medical direction and medical supervision of the remaining health care staff.

Telehealth to the Home

1. Individuals may receive care in their homes through telehealth, including for those in a nursing or assisted living facility.
 - a. CMS is waiving the requirement for physicians and other practitioners to perform in-person visits for nursing home residents and allowing visits to be conducted through telehealth where appropriate.

Specific Populations

1. Home health and hospice providers may provide more of the approved services through telehealth as long as it is part of the plan of care and does not replace needed in-person services or visits.
 - a. Home Health-Individuals with medical contraindications (having a condition that makes them susceptible to contract COVID-19) or with suspected or confirmed COVID-19 in need of services will be considered homebound and qualify for the Medicare Home Health benefit.
 - b. Home Health-CMS is allowing Home Health Agencies to perform Medicare-covered initial assessments and to determine patients' homebound status remotely or by record review; CMS is also waiving the requirement that a nurse must conduct an onsite visit at least every two weeks, including for the supervision of Home Health Aides while encouraging virtual supervision.
 - c. Home Health-In addition, Occupational Therapists may perform the initial and comprehensive assessment for all patients receiving therapy services to the extent permitted under state law regardless of whether occupational therapy is the service establishing eligibility.
 - d. Hospice-CMS is also temporarily waiving the requirement that hospices use volunteers.
 - e. Hospice-CMS is also waiving the requirement that nurses conduct onsite visits every two weeks to supervise aides.
 - f. End-Stage Renal-CMS is modifying the requirement that all dialysis see a medical provider at least monthly for an in-person visit if the patient is stable, and recommending using telehealth such as phone calls to ensure patient safety.
 - g. End-Stage Renal-CMS is waiving requirements for in-person monitoring of patient's home adaptation.

2. CMS is allowing telehealth visits to fulfill face-to-face visit requirement of at least three days per week at inpatient rehabilitation facilities; hospice patient recertification; and home health visits within the 30-day episode of care.
 - a. Medicare is allowing physicians to provide initiation of care planning and monthly physician visits for End Stage Renal Disease and for Dialysis home visits through telehealth and waiving some time period requirements.
 - b. CMS is also waiving requirements that physicians and non-physician practitioners perform in-person visits for nursing home residents and is allowing visits to be conducted, as appropriate, via telehealth.
 - c. Organizations participating in the Medicare Diabetes Prevention Program are allowed to use alternative delivery options, including virtual make-up sessions as necessary.
3. A number of services no longer have limitations on the number of times they can be provided by telehealth:
 - a. Inpatient visits may occur more frequently than previously allowed, including subsequent inpatient visits; subsequent skilled nursing facility visit; critical care consults; End Stage Renal Disease visits; National or Local Coverage Determination visits; Annual Consent may be obtained at the same time as visits; and visits for nursing home residents may occur as appropriate via telehealth.
4. CMS is waiving the requirement that prevents a physician from delegating a task when the regulations require that the physician must perform it personally, allowing the physician to delegate any tasks under their supervision to a physician assistant, nurse practitioner, or clinical nurse specialist that meet applicable definitions to provide this service or is licensed as such by the state and acting within their scope of practice and as long as such delegation is not prohibited by state law or facility policy.

Workforce

1. CMS has waived the requirement for Medicare and Medicaid that physicians and non-physician practitioners be licensed in the state where they are providing services with certain conditions, although state requirements still apply.
2. For services requiring the direct supervision by the physician or other practitioner, the physician supervision may be provided virtually using real-time audio/video technology.
3. CMS is waiving the requirement that Medicare patients in the hospital be under the care of a physician and that the physician be on call at all times, allowing for the use of physician assistants and nurse practitioners to the fullest extent possible (as long as this is not in conflict with a state's emergency preparedness or pandemic plan).
4. If a medical resident is providing care from home or in a patient's home within the scope of the approved residency program and with appropriate physician supervision requirements, the hospital may claim the resident for indirect medical education and direct graduate medical education payment purposes.
5. Teaching physicians may provide services with medical residents virtually through audio/video real-time communications technology, excluding surgical, high risk, interventional, other complex services provided through an endoscope, or anesthesia services.

Medicare Advantage/Payment

- 1) CMS is allowing Medicare Advantage Plans the ability to expand telehealth services beyond those included in their approved 2020 benefits.

Federally Qualified Health Centers and Rural Health Clinics-On April 17, 2020, CMS released MLN Matters Special Edition Number SE20016, titled “New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE).” They indicate that in order to provide as much support as possible to RHCs and FQHCs and their patients during the COVID-19 public health Emergency, both Congress and the Centers for Medicare & Medicaid Services (CMS) have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and CMS will make additional discretionary changes as necessary to assure that RHC and FQHC patients have access to the services they need during the pandemic.

Distant Sites: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. RHCs and FQHCs can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE. Distant site telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). A list of these is available at <https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip>.

The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that CMS develop payment rates for these services that are similar to the national average payment rates for comparable telehealth services under the PFS. Payment to RHCs and FQHCs for distant site telehealth services is set at \$92, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs and FQHCs must put Modifier “95” (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. RHCs will be paid at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. **These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate. RHCs and FQHCs do not need to resubmit these claims for the payment adjustment.**

For telehealth distant site services furnished between July 1, 2020, and the end of the COVID-19 PHE, RHCs and FQHCs will use an RHC/FQHC specific G code, G2025, to identify services that were furnished via telehealth. RHC and FQHC claims with the new G code will be paid at the \$92 rate. Only distant site telehealth services furnished during the COVID-19 PHE are authorized for payment to RHCs and FQHCs. If the COVID-PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 PFS average payment rate for these services, weighted by volume for those services reported under the PFS. Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rates but must be reported on the appropriate cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled “Cost Other Than RHC Services.” FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled “Other FQHC Services”.

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Since telehealth distant site services are not paid under the RHC AIR or the FQHC PPS, the Medicare Advantage wrap-around payment does not apply to these services. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.

During the COVID-19 PHE, CMS will pay all of the reasonable costs for any service related to COVID-19 testing, including applicable telehealth services, for services furnished beginning on March 1, 2020. For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries. For services in which the coinsurance is waived, RHCs and FQHCs must put the “CS” modifier on the service line. **RHC and FQHC claims with the “CS” modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1. Coinsurance should not be collected from beneficiaries if the coinsurance is waived.**

Virtual Communication Services: Payment for virtual communication services now include online digital : evaluation and management services. Online digital evaluation and management services are non-face-to-face, patient-initiated, digital communications using a secure patient portal. The online digital evaluation and management codes that are billable during the COVID-19 PHE are: 99421, 99422, and 99423. To receive payment for the new online digital evaluation and management (CPT codes 99421, 99433, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), RHCs and FQHCs must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for these 5 codes. Claims submitted with G0071 on or after March 1 and for the duration of the PHE will be paid at the new rate of \$24.76, instead of the CY 2020 rate of \$13.53. **MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid before the claims processing system was updated.**

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

RHCs and FQHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, the area typically served by the RHC, and the area included in the FQHC service area plan, is determined to have a shortage of HHAs, and no request for this determination is required. RHCs and FQHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.

Updated May 4, 2020

April 30, 2020-On April 30, 2020, CMS made a second round of substantial changes to rules and waivers of federal requirements to ensure the health system has the capacity to fully respond to the emergency. These actions are informed by requests from healthcare providers as well as by the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act. CMS’s goals during the pandemic are to:

- 1) expand the healthcare workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the local community or other states;
- 2) ensure that local hospitals and health systems have the capacity to handle COVID-19 patients through temporary expansion sites (also known as the CMS Hospital Without Walls initiative);
- 3) increase access to telehealth for Medicare patients so they can get care from their physicians and other clinicians while staying safely at home;

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- 4) expand at-home and community-based testing to minimize transmission of COVID-19 among Medicare and Medicaid beneficiaries; and
- 5) put patients over paperwork by giving providers, healthcare facilities, Medicare Advantage and Part D plans, and states temporary relief from many reporting and audit requirements so they can focus on patient care.

For the duration of the COVID-19 emergency, CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telehealth services. Prior to this change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. Now, other practitioners are able to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider-based department of the hospital. Examples of such services include counseling and educational service as well as therapy services. This change expands the types of healthcare providers that can provide using telehealth technology.

Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

CMS previously announced that Medicare would pay for certain services conducted by audio-only telephone between beneficiaries and their doctors and other clinicians. Now, CMS is broadening that list to include many behavioral health and patient education services. CMS is also increasing payments for these telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about \$14-\$41 to about \$46-\$110. The payments are retroactive to March 1, 2020.

Until now, CMS only added new services to the list of Medicare services that may be furnished via telehealth using its rulemaking process. CMS is changing its process during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible. This will speed up the process of adding services.

As mandated by the CARES Act, CMS is paying for Medicare telehealth services provided by rural health clinics and federally qualified health clinics. Previously, these clinics could not be paid to provide telehealth expertise as “distant sites.” Now, Medicare beneficiaries located in rural and other medically underserved areas will have more options to access care from their home without having to travel

Since some Medicare beneficiaries don’t have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, CMS is waiving the video requirement for certain telephone evaluation and management services, and adding them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get these services.

Specifically, CMS made the following changes on April 30th to rules and regulations related to the provision of telehealth services (<https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>):

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- **Eligible Practitioners.** Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. **The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services.** This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.
- **Audio-Only Telehealth for Certain Services.** Pursuant to authority granted under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for 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 (see designated codes <https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes>). 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.

Rural Health Clinics and Federally Qualified Health Centers- CMS is waiving the requirement that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the requirement that a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates.

CMS is also modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

CMS is waiving the requirement that RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries.

*Community Mental Health Centers-*There have also been important changes related to Community Mental Health Centers. CMS is waiving the specific requirement that prohibits CMHCs from providing partial hospitalization services and other CMHC services in an individual's home so that clients can safely shelter in place during the PHE while continuing to receive needed care and services from the CMHC.

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This waiver is a companion to recent regulatory changes (**not yet released**) that clarify how CMHCs should bill for services provided in an individual's home, and how such services should be documented in the medical record. While this waiver will now allow CMHCs to furnish services in client homes, including through the use of using telecommunication technology, CMHCs continue to be, among other things, required to comply with the non-waived provisions requiring that CMHCs: 1) assess client needs, including physician certification of the need for partial hospitalization services, if needed; 2) implement and update each client's individualized active treatment plan that sets forth the type, amount, duration, and frequency of the services; and 3) promote client rights, including a client's right to file a complaint.

In addition, CMS is waiving the requirement that a CMHC provides at least 40 percent of its items and services to individuals who are not eligible for Medicare benefits. Waiving the 40 percent requirement will facilitate appropriate timely discharge from inpatient psychiatric units and prevent admissions to these facilities because CMHCs will be able to provide PHP services to Medicare beneficiaries without restrictions on the proportion of Medicare beneficiaries that they are permitted to treat at a time. This will allow communities greater access to health services, including mental health services.

Changes relevant to the remaining four goals are outlined below:

- *Diagnostic Testing*-Under the new waivers and rule changes, Medicare will no longer require an order from the treating physician or other practitioner for beneficiaries to get COVID-19 tests and certain laboratory tests required as part of a COVID-19 diagnosis. During the Public Health Emergency, COVID-19 tests may be covered when ordered by any healthcare professional authorized to do so under state law. To help ensure that Medicare beneficiaries have broad access to testing related to COVID-19, a written practitioner's order is no longer required for the COVID-19 test for Medicare payment purposes.

Pharmacists can work with a physician or other practitioner to provide assessment and specimen collection services, and the physician or other practitioner can bill Medicare for the services. Pharmacists also can perform certain COVID-19 tests if they are enrolled in Medicare as a laboratory, in accordance with a pharmacist's scope of practice and state law.

CMS will pay hospitals and practitioners to assess beneficiaries and collect laboratory samples for COVID-19 testing, and make separate payment when that is the only service the patient receives. CMS also announced that Medicare and Medicaid are covering certain serology (antibody) tests. Medicare and Medicaid will cover laboratory processing of certain FDA-authorized tests that beneficiaries self-collect at home.

- *Increase Hospital Capacity - CMS Hospitals Without Walls*-Under its Hospitals Without Walls initiative, CMS is giving providers flexibility during the pandemic to increase the number of beds for COVID-19 patients while receiving stable, predictable Medicare payments. In addition, inpatient psychiatric facilities and inpatient rehabilitation facilities can admit more patients to alleviate pressure on acute-care hospital bed capacity without facing reduced teaching status payments. Similarly, hospital systems that include rural health clinics can increase their bed capacity without affecting the rural health clinic's payments. CMS is excepting certain requirements to enable freestanding inpatient rehabilitation facilities to accept patients from acute-care hospitals experiencing a surge, even if the patients do not require rehabilitation care. This makes use of available beds in freestanding inpatient rehabilitation facilities and helps

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acute-care hospitals to make room for COVID-19 patients. CMS is highlighting flexibilities that allow payment for outpatient hospital services -- such as wound care, drug administration, and behavioral health services -- that are delivered in temporary expansion locations, including parking lot tents, converted hotels, or patients' homes (when they're temporarily designated as part of a hospital). Under current law, most provider-based hospital outpatient departments that relocate off-campus are paid at lower rates under the Physician Fee Schedule, rather than the Outpatient Prospective Payment System (OPPS). CMS will allow certain provider-based hospital outpatient departments that relocate off-campus to obtain a temporary exception and continue to be paid under the OPPS. Importantly, hospitals may also relocate outpatient departments to more than one off-campus location, or partially relocate off-campus while still furnishing care at the original site. Long-term acute-care hospitals can now accept any acute-care hospital patients and be paid at a higher Medicare payment rate, as mandated by the CARES Act. This will make better use during the pandemic of available beds and staffing in long-term acute-care hospitals.

- *Healthcare Workforce Augmentation*-To bolster the U.S. healthcare workforce amid the pandemic, CMS is working to remove barriers for hiring and retaining physicians, nurses, and other healthcare professionals to keep staffing levels high at hospitals, health clinics, and other facilities. Since beneficiaries may need in-home services during the COVID-19 pandemic, nurse practitioners, clinical nurse specialists, and physician assistants can now provide home health services, as mandated by the CARES Act. These practitioners can now (1) order home health services; (2) establish and periodically review a plan of care for home health patients; and (3) certify and re-certify that the patient is eligible for home health services. Previously, Medicare and Medicaid home health beneficiaries could only receive home health services with the certification of a physician. These changes are effective for both Medicare and Medicaid. CMS will not reduce Medicare payments for teaching hospitals that shift their residents to other hospitals to meet COVID-related needs, or penalize hospitals without teaching programs that accept these residents. This change removes barriers so teaching hospitals can lend available medical staff support to other hospitals. CMS is allowing physical and occupational therapists to delegate maintenance therapy services to physical and occupational therapy assistants in outpatient settings. This frees up physical and occupational therapists to perform other important services and improve beneficiary access. Consistent with a change made for hospitals, CMS is waiving a requirement for ambulatory surgery centers to periodically reappraise medical staff privileges during the COVID-19 emergency declaration. This will allow physicians and other practitioners whose privileges are expiring to continue taking care of patients.
- *Put Patients Over Paperwork/Decrease Administrative Burden*-CMS is working to ease federal rules and institute new flexibilities to ensure that states and localities can focus on caring for patients during the pandemic and that care is not delayed due to administrative red tape. CMS is allowing payment for certain partial hospitalization services – that is, individual psychotherapy, patient education, and group psychotherapy – that are delivered in temporary expansion locations, including patients' homes. CMS is temporarily allowing Community Mental Health Centers to offer partial hospitalization and other mental health services to clients in the safety of their homes. Previously, clients had to travel to a clinic to get these intensive services. Now, Community Mental Health Centers can furnish certain therapy and counseling services in a client's home to ensure access to necessary services and maintain continuity of care. CMS will

not enforce certain clinical criteria in local coverage determinations that limit access to therapeutic continuous glucose monitors for beneficiaries with diabetes. As a result, clinicians will have greater flexibility to allow more of their diabetic patients to monitor their glucose and adjust insulin doses at home.

Accountable Care Organizations-In addition, CMS is making changes to the Medicare Shared Savings Program to give accountable care organizations (ACOs) greater financial stability and predictability during the COVID-19 pandemic. Because the impact of the pandemic varies across the country, CMS is making adjustments to the financial methodology to account for COVID-19 costs so that ACOs will be treated equitably regardless of the extent to which their patient populations are affected by the pandemic. CMS is also forgoing the annual application cycle for 2021 and giving ACOs whose participation is set to end this year the option to extend for another year. ACOs that are required to increase their financial risk over the course of their current agreement period in the program will have the option to maintain their current risk level for next year, instead of being advanced automatically to the next risk level.

CMS is also permitting states operating a Basic Health Program to submit revised BHP Blueprints for temporary changes tied to the COVID-19 public health emergency that are not restrictive and could be effective retroactive to the first day of the COVID-19 public health emergency declaration. Previously, revised BHP Blueprints could only be submitted prospectively.

Please note that there are additional changes that affect specific provider types outlined in the blanket waiver overview documents and provider-specific fact sheets. CMS has re-issued its overview of blanket waivers, highlighting changes made on April 30, at <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>. Changes related to the April 30 blanket waivers are highlighted in red throughout the document. Providers with additional regulatory or rule changes include: long-term care (Skilled Nursing Facilities and Nursing Facilities); Home Health Agencies; Hospice; Hospitals (including Critical Access Hospitals); and Ambulatory Surgical Centers. The overview document outlining all blanket waivers along with other relevant documents including provider-specific fact sheets related to the waivers and with other information that have been updated with **new information as of April 30, 2020** are available at <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers> for:

- Physicians and Other Practitioners;
- Ambulances;
- Hospitals;
- Teaching Hospitals, Teaching Physicians, and Medical Residents;
- Long-Term Care Facilities
- Home Health Agencies
- Hospices
- Inpatient Rehabilitation Facilities
- Long-Term Care Hospitals
- Rural Health Clinics and Federally Qualified Health Centers
- Laboratories
- End Stage Renal Disease Facilities
- Durable Medical Equipment
- Medicare Diabetes Prevention Program; and
- Medicare Advantage and Part D Plans.

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- State Medicaid and Basic Health Programs
- Medicare Shared Savings Program Participants

Accelerated/Advance Payments

In order to increase cash flow to providers, CMS has expanded its Accelerated and Advance Payment Program, intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. Requests must be submitted to the appropriate Medicare Administrative Contractor meeting the required qualifications. MACs will provide payment within seven calendar days and the time period for repayment is extended: (<http://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf>).

CMS is also extending deadlines for certain cost reporting (please see appropriate provider fact sheet for confirmation by provider type).

Stark Law/Physician Self-Referral

CMS has made certain blanket waivers of sanctions under the Stark Law, effective March 1. CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. Specific areas of non-enforcement are outlined in the blanket waiver document at: <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Spotlight>.

Section 1135 Waivers to Individual States

Missouri, Oklahoma, and Kansas all have requested and received waivers under section 1135 for specific actions not covered in the blanket waivers detailed above. Examples that CMS provided of the types of waivers individual states might request include: waiving prior authorization requirements; permitting out of state providers to provide care in their state to Medicaid enrollees; and suspend certain provider enrollment and revalidation requirements. Details about Missouri and Kansas' waivers, along with other state actions that impact the delivery of telehealth services, are available on the state policy document available on the Heartland Telehealth Resource Center website: <http://heartlandtrc.org/covid-19>.

Copies of the waivers under Section 1135 to individual states are available at:

<https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/federal-disaster-resources/index.html>

Home and Community-Based—1915(c) Waivers

Appendix K is a standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. CMS has approved amendments to Home and Community-Based Services (HCBS) waivers for the states of Oklahoma and Kansas through Amendments requested in Appendix K, and effective beginning January 26th (Kansas) or January 27th (Oklahoma), 2020 through December 31, 2020. Appendix K documents detailing the approved waivers is available at: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html>.

Interim Final Rule

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On April 1, CMS submitted an interim final rule that includes many of the temporary changes in response to the emergency outlined above. The Center for Connected Health Policy and Public Health Institute have created a table with the areas in the interim final rule with particular importance to the provision of telehealth services crosswalked to CMS guidance that has been released—“Interim Final Rule April 1, 2020,” available at: <https://www.cchpca.org/sites/default/files/2020-04/INTERIM%20FINAL%20RULE%20%20%20GUIDANCE%20CROSS%20REFERENCE%20APRIL%201%202020%20FINAL.pdf>.

Provisions include:

- Includes additional eligible service codes-page 19-34, 40;
- Provides additional codes for therapy services (not allowed for PT, OT, Speech-Language Pathologists)-page 34-40
- Removes frequency of service limitations-page 41-44;
- Allows certain End Stage Renal Disease exams to occur through telehealth-page 45-48;
- Defines telecommunications system to allow for smart phones with video for telehealth services-page 48-49;
- Allows direct supervision through audio/visual telecommunications of patients and diagnostic and therapeutic services-page 58-59, 79;
- Expands the definition of homebound-page 61-62;
- Expands telehealth for hospice services-page 73-75;
- Allows for new patients to receive care through telehealth-page 52;
- Allows the delegation of obtaining consent and allows it to be obtained at time of service-page 51-54;
- Defines additional codes that can be furnished by LCSWs, clinical psychologists, physical therapists, occupational therapists, or speech language pathologists-page 54-55;
- Allows for remote physiological monitoring to new patients-page 121;
- Allows for telephone-only visits and the provision of a limited set of billing codes-page 122-125;
- Allows residents to provide services via telehealth with televideo supervision and allows for teaching physician supervision of residents through interactive telecommunications technology-page 106-108.

Place of Service-The rule also clarifies Place of Service codes for Medicare telehealth billing, outlined in pages 13-15 of the document. In this section, CMS states, “we are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS that would have been reported had the service been reported in person” (Page 15). Providers doing so should use the modifier 95 to indicate the service took place through telehealth, but the claim should be paid the same as if it occurred in person. Providers may still use place of service code 02 and will be paid the facility rate if they do so.

In addition, CMS has clarified that when a provider is delivering services from their home or another site, rather than their normal location, “there are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their homes. The practitioner is not required to update their Medicare enrollment with the home location. The practitioner should list the home address on the claim to identify where the services were rendered. The discrepancy between the practice location in the Medicare enrollment (clinic/group practice) and the practice location identified on the claim (provider’s home location) will not be an issue for claims payment.”

<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUK>

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[IK_7v4vpAhWMd98KHZpiDdUQFjAAegQIAxAB&url=https%3A%2F%2Fwww.cms.gov%2Ffiles%2Fdocument%2Fprovider-enrollment-relief-faqs-covid-19.pdf&usg=AOvVaw3k1LDH9GcfFnrgbdDuoW3d](https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf)

Legislative Actions—Coronavirus Preparedness and Response (CPR) Supplemental Appropriations Act 2020—HR 6074 and Coronavirus Aid, Relief, and Economic Security Act (CARES)—HR 748

Initial funding and rule and regulation changes occurred through the CPR Supplemental Appropriations Act on March 6, 2020, <https://www.congress.gov/bill/116th-congress/house-bill/6074>. It included changes to facilitate the provision of telehealth services in a section titled, “Telehealth Services During Certain Emergency Periods Act of 2020,” giving the Secretary of Health and Human Services the authority to temporarily waive or modify Medicare requirements related to telehealth services during the emergency period.

The CARES Act is the main federal response to COVID-19 and includes substantial funds, including funding related to the provision of telehealth services and increase telehealth capacity through the purchase of equipment and other methods. The CARES Act includes regulation changes to facilitate the provision of telehealth services as well as substantial funding for various sectors and projects related to the provision of telehealth services. Full text of the Act is available at:

<https://www.congress.gov/bill/116th-congress/house-bill/748?q=%7B%22search%22%3A%5B%22hr+748%22%5D%7D&s=1&r=1>.

HIPAA-Federal Office of Civil Rights

The Federal Office of Civil Rights, responsible for HIPAA compliance and investigation, has indicated that it will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any **non-public facing** remote communication product that is available to communicate with patients.

<https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

Controlled Substances-Drug Enforcement Agency

DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable Federal and State laws.

Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by

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calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy. (<https://www.deadiversion.usdoj.gov/coronavirus.html>)

Anti-Kickback-Office of Inspector General

Reductions or waivers of costs for individuals enrolled in federal health programs such as coinsurance and deductibles have previously not been allowed. During the period of the emergency, OIG will not subject physicians and other practitioners to OIG administrative sanctions for arrangements that reduce these costs as long as they satisfy both of the following conditions:

1. A physician or other practitioner reduces or waives cost-sharing obligations (i.e., coinsurance and deductibles) that a beneficiary may owe for telehealth services furnished consistent with the then-applicable coverage and payment rules.
2. The telehealth services are furnished during the time period subject to the COVID-19 Declaration.

(<https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf>)

SAMHSA

SAMHSA has provided guidance documents for opioid treatment programs and the provision of services to individuals through telehealth and in the home, including medication-assisted treatment, available at: <https://www.samhsa.gov/coronavirus>.

Private Payers

Many private payers are following CMS rule changes and recommendations in terms of allowed and billable services.

Below are links to information from some of the larger private insurers. These links are to national websites, and may not reflect actions or decisions specific to your state.

- Aetna – [COVID-19 Service Enhancements](#)
[COVID-19 Approved Behavioral Health Telemedicine Services](#)
- Ambetter-- <https://www.ambetterhealth.com/coronavirus.html.html>
- Anthem – [COVID-19 Service Enhancements](#)
- Blue Cross and Blue Shield Companies – [COVID-19 Service Enhancements](#)
- Blue Cross and Blue Shield Federal Employee Program – [COVID-19 Service Enhancements](#)
- Centene-- <https://www.centene.com/covid-19-resource-center.html>
- Humana – [COVID-19 Service Enhancements](#)
- United Health Care – [COVID-19 Telehealth Services](#)