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From Rehmann Healthcare Consultants

Just released March 31, 2020! CMS is no longer requiring POS 02 for telehealth services during this Public Health Emergency, however report the place of service consistent with what would have been reported. Modifier 95 should be reported on the claim.

CMS has also released new specimen collection codes for COVID-19 testing:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

As COVID-19 crisis expands, CMS boosts telehealth further and relaxes rules

With the federal government projecting many more deaths due to the COVID-19 coronavirus pandemic, CMS is doubling down on telehealth services, adding inpatient, observation, critical care, and many more E/M codes to its telehealth-eligible list. The agency is also taking unprecedented action to relax a slew of other unrelated regulations, including physician supervision requirements, state licensing rules, and Stark self-referral law.

The goals of these actions, which are staggering in their breadth and scope – affecting nearly every facet of the CMS regulatory framework and instantly eliminating longstanding rules – are to ensure that local health systems can build up their surge capacity for COVID-19 cases, expand the size of the healthcare workforce, increase safe patient accessibility to care via telehealth, and relax the administrative and compliance burden on providers. “Made possible by President Trump’s recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration,” CMS states in a lengthy press release announcing the new policies.

Below is a summary of the major highlights:

Medicare telehealth services: CMS has opened the floodgates in terms of services that are temporarily eligible to be furnished via telehealth. To report these codes as telehealth services, use Place of Service code “02” on the claim form. Providers may now waive Medicare copayments for telehealth services to Part B (original) Medicare patients. CMS is also eliminating telehealth frequency limitations for subsequent hospital care services

and skilled nursing visits (99231-99233 and 99307-99310 respectively). The following services are now billable via telehealth:

- Emergency department visits (99281-99285)
- All observation codes (99217-99220; 99224-99226; 99234-99236)-
- All hospital care (inpatient) codes (99221-99223; 99238 and 99239)
- Critical care and inpatient neonatal/pediatric critical care (99291 and 99292; 99468-99473; 99475 and 99476)
- Domiciliary, rest home, and custodial care services (99237 and 99238; 99334-99337)
- Home visits (99341-99345; 99347-99350)
- Intensive care services (99477 and 99478)
- Care planning for patients with cognitive impairment (99483)
- Psychology and neuropsychological testing (96130-96133; 96136-96139)
- PT/OT services (97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Radiation treatment management (77427)

Furthermore, virtual check-ins (G2010, G2012) are billable for new and established patients (formerly only established patients were eligible). Licensed clinical social worker, clinical psychologist, physical therapy, occupational, and speech language pathology can now bill for e-visits (G2061-G2063). A broad range of clinicians including physicians can bill for telephone services (98966-98968; 99441-99443). Finally, the issue of patient consent for telehealth services has been clarified; CMS says that "annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished."

Supervision and enrollment: CMS is relaxing supervision requirements across the board:

- Direct physician supervision can now be provided virtually using real-time audio/video technology.
- Auxiliary personnel may enter a contractual agreement with the practitioner who bills Medicare to provide services that would ordinarily be rendered on an incident-to basis and receive payment directly from the billing practitioner without submitting claims to Medicare.
- Medicare patients in the hospital no longer need to be under the care of a physician, meaning that other providers including nurse practitioners and physician assistants can fill that role.
- Providers no longer need to be licensed in the state where they are providing services. State laws will still apply, but CMS is waiving the Medicare requirement regarding state licensure. Providers must still be enrolled with Medicare and licensed in the state relating to their Medicare enrollment.

- CMS has created toll-free hotlines for providers to enroll and receive temporary Medicare billing privileges. All revalidation actions are postponed, and all new and pending enrollment applications will be expedited.
- For telehealth visits, providers may render telehealth services from their home without having to report their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.

Stark Law and compliance: Certain referrals and claims will be permitted that would ordinarily violate the Stark self-referral law:

- Hospitals can pay above or below fair market value to rent equipment or receive services from physicians (or vice versa). For example, a practice could rent or sell needed equipment and supplies to a hospital at a price lower than what the practice would charge another party. Or a hospital may provide physicians space on their campus at no charge if the physicians treat patients seeking care at the hospital who are not appropriate for emergency department care or admission.
- Hospitals can provide benefits to their clinicians such as daily meals, laundry service, or child care services while those clinicians are treating patients.
- Physician-owned hospitals can temporarily increase the number of licensed beds and operating rooms even though this would normally violate Stark, in order to surge capacity due to the COVID-19 crisis.

Other changes: CMS is altering multiple other aspects of its regulatory scheme as follows:

- CMS is expanding its Accelerated and Advance Payment Program to increase cash flow to providers affected by COVID-19. All Medicare Administrative Contractors will review requests for advance payments within 7 calendar days of receiving the requests.
- Medicare national and local coverage determinations (NCDs and LCDs) that restrict the use of respiratory devices, oxygen and oxygen equipment, home infusion pumps and home anticoagulation therapy can be ignored at the discretion of clinicians. CMS will cover non-invasive ventilators, respiratory assist devices and CPAP devices based on clinician assessments of patients even if the assessed conditions and circumstances do not meet NCD/LCD guidelines.
- Signature requirements are waived for Part B drugs and durable medical equipment when a signature can't be obtained. Supplies still need to document date of delivery and that a signature could not be obtained due to COVID-19.
- The Merit-based Incentive Payment System (MIPS) categories for the 2019 reporting year can be reweighted at providers' request if they claim they were adversely affected by the COVID-19 pandemic. This would potentially allow affected providers to ensure a neutral MIPS payment adjustment for the 2021 payment year. CMS is also adding one new Improvement Activity for the 2020 MIPS reporting year, for providers who participate in a clinical trial utilizing a drug or

biological to treat a COVID-19 patient and then report their findings to a clinical data repository or clinical data registry.

- Medicare allow extensions for appeals filing for Part B, Medicare Advantage, and Part D claims. Medicare contractors and entities will be allowed to utilize all flexibilities available in the appeals process as if good cause requirements are satisfied, whether they were or were not.

The complete CMS release can be found at: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf.

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