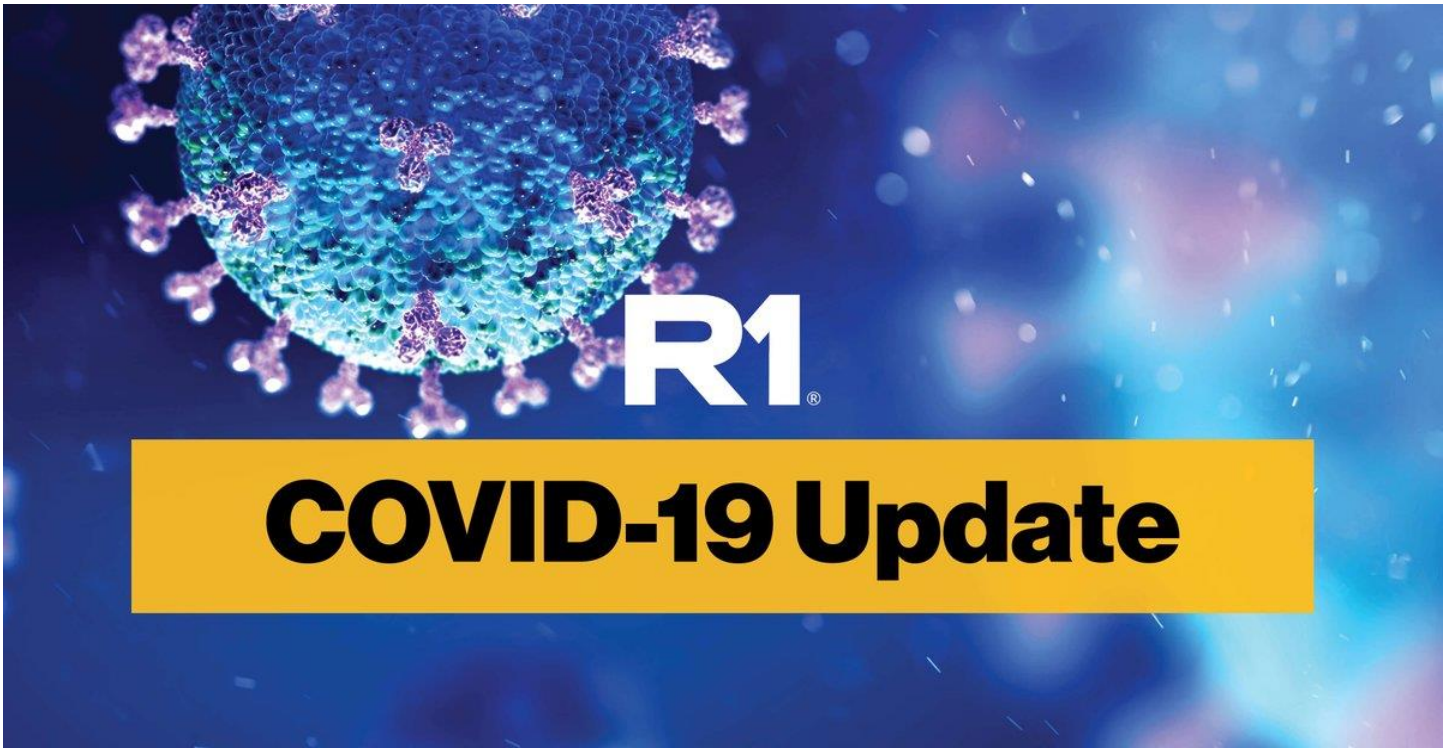

Medicare Physician Regulatory Review | Volume II | April 6, 2020

Important Information for Providers

On March 30, 2020, the Centers for Medicare and Medicaid Services (CMS) released an Interim Final Rule with Comment Period and additional Medicare waivers and policy changes in response to the 2019 Novel Coronavirus Disease (COVID-19).

With these changes, providers now have more flexibility to respond to patients' needs and prevent further spread of the COVID-19 virus during the Public Health Emergency (PHE). CMS provided 80 additional telehealth codes, revised guidance on Place of Service codes to allow higher payments to office-based physicians, expanded most virtual care services to include new patients, and enabled physicians to provide "direct supervision" to nonphysician practitioners and residents through interactive telecommunications technology. The updates are effective for services beginning March 1, 2020.

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law. CMS announced an expansion of the accelerated payment program (APP), which provides emergency funding to providers to address cash-flow issues based on historical payments when there is disruption in claims submission and/or claims processing. CMS is expanding the program for all Medicare providers throughout the country during the PHE. The payments can be requested by hospitals, doctors, durable medical equipment suppliers and other Medicare Part A and Part B providers and suppliers.

CMS Resources:

- Telehealth & Telemedicine Tool Kit
- Interim Final Rule
- CMS Coronavirus Waivers & Flexibilities
- Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
- EMTALA
- Provider Enrollment FAQ
- MLN Special Edition Article for Interim Final Rule
- Accelerated and Advance Payment Program FAQ

Medicare Telehealth Services

CMS made numerous changes to Medicare Telehealth Services for the duration of the COVID-19 PHE. These changes supplement, and in some cases supersede, previous guidance received from the agency. Below is an updated table of several prominent as they appear before and after COVID-19.

Requirement	Before COVID-19 PHE	During COVID-19 PHE
Patient Location, or "Originating Site"	Patients were required to be located in specific areas (e.g., rural areas) and specific types of facilities.	Patients may be located **anywhere**, including their own home.
Communication Devices	Devices used for telehealth had to be HIPAA-compliant.	Providers may use popular applications that allow for video chat (e.g., FaceTime, Facebook Messenger video chat, and Google Hangouts). Communication with the patient must be in real-time and include *both* audio and visual components.
Reimbursement	Medicare reimbursed providers at the same amount as if the service were furnished in person. If there is a site differential for a service, Medicare paid for telehealth services at the facility (non-office) rate.	Medicare will reimburse providers for the same amount as if the service were furnished in person. For services with a site differential, telehealth services billed with Place of Service (POS) 02 – *Telehealth*, and telehealth services billed with a facility POS are paid at the facility rate. Telehealth services billed with POS 11 – *Office* are paid at the office rate.
Eligible Providers	Limited to Physicians, Nurse Practitioners, Physician Assistants, Nurse Midwives, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Clinical Psychologists, Clinical Social Workers and Registered Dieticians or Nutrition Professionals	No change to eligible providers during the PHE
Provider Location, or "Distant Site"	The distant site location had to be on provider's Medicare enrollment. ▪ Example: If provider uses his/her home as an office location, home must be listed on enrollment file. A hotel, boat and car are not valid locations. Providers had to be licensed and enrolled in the distant site state.	Practitioners may render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. Licensed physicians and other practitioners may bill Medicare for services provided outside of their state of enrollment.

Documentation Tips for Telehealth Services

Providers should document the following information:

1. The patient consented to receive telehealth services
2. The use of real-time audiovisual communications

Key Point: waiver applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

Newly Eligible Telehealth Services

Starting on March 6, 2020, Medicare can pay for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's place of residence. To facilitate the use of telecommunications technology as a safe substitute for in-person services, CMS, on an interim basis, added many services to the list of eligible Medicare telehealth services, and eliminated frequency limitations and other requirements associated with particular services furnished via telehealth.

During the PHE, certain telehealth services may be reported using codes that describe "face-to-face" services but are furnished using audio/video, real-time communication technology instead of in-person. The list of these eligible telehealth services is published on the CMS website. The following codes were added by CMS to the list of eligible Medicare telehealth services for the duration of the COVID-19 PHE, and are **in addition** to the pre-waiver list of eligible codes:

Service(s)	CPT Code(s)
Emergency Department Visits, Levels 1-5	99281-99285
Initial and Subsequent Observation and Observation Discharge Day Management	99217- 99220; 99224- 99226; 99234- 99236
Initial hospital care and hospital discharge day management	99221-99223; 99238- 99239
Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management	99304-99306; 99315-99316
Critical Care Services	99291-99292
Domiciliary, Rest Home, or Custodial Care services, New and Established patients	99327- 99328; 99334-99337
Home Visits, New and Established Patient, All levels	99341- 99345; 99347- 99350
Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent	99468- 99473; 99475- 99476
Initial and Continuing Intensive Care Services	99477- 994780
Care Planning for Patients with Cognitive Impairment	99483
Psychological and Neuropsychological Testing	96130- 96133; 96136- 96139
Therapy Services, Physical and Occupational Therapy, All levels	97161- 97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507
Radiation Treatment Management Services	77427

Place of Service Codes

- All professional claims for Medicare telehealth services during the PHE should use the Place of Service code **that would have been used if the services had been provided in person** (e.g., 21 – *Inpatient Hospital*; 23 – *Emergency Room – Hospital; 11 – Office*) and include Modifier "95".
- For office visits, Place of Service code 02 – *Telehealth* is still accepted but reimbursed at a lower rate than 11.

Understanding Site of Service

For Medicare, there are two payment rates for many physicians' services: the facility rate; and the non-facility, or office, rate. The non-facility rate is the single amount paid to a physician or other practitioner for services furnished in their office. The facility rate is the amount generally paid to a professional when a service is furnished in a setting of care, like a hospital, where Medicare is making a separate payment to an entity in addition to the payment to the billing physician or practitioner. This separate payment, often referred to as a "facility fee" reflects the facility's costs associated with the service (clinical staff, supplies and equipment) and is paid in addition to what is paid to the professional through the PFS.

Other Technology-Enabled Services

The Medicare program covers additional technology-enabled services that do not fall under the program's definition of Medicare telehealth services. These include Virtual Check-Ins, e-Visits, Remote Patient Monitoring, On-Site Visits, and Telephone Evaluation and Management (E/M).

Type	✓ **Virtual Check-in**	**e-Visit**	**Remote Patient Monitoring**	**On-site Visits**	**Telephone E/M Services**
Definition	A brief (5-10) minute check-in with a practitioner via telephone or other telecommunication device to decide whether an office visit or other service is needed. May include a remote evaluation of recorded video and/or images submitted by the patient.	A communication between a patient and practitioner through an online patient portal that does not include telephone or other real-time conversations. These digital assessment services are for clinical decisions that otherwise typically would have been provided in the office.	Care management services furnished through technology such as Chronic Care Management and Remote Physiologic Monitoring for both acute and chronic conditions.	Encounters conducted via technology or at a distance, including services provided via video, across a hallway, or through a window in the clinic suite. Medicare considers these in-person visits.	Patient-initiated audio-only prolonged communications lasting longer than a Virtual Check-In; communication does not fully replace a face-to-face visit.
Patients	During the PHE, new or established	Established only	During PHE, new and established	New or established	New or established
Provider	Physicians and advanced practice providers. During PHE, some allied health professionals (e.g., LCSW, PT, OT)	Physicians and advanced practice providers. During PHE, some allied health professionals (e.g., LCSW, PT, OT)	Physicians and other qualified healthcare providers; may bill "incident to" for services of allied health professionals	Physicians and qualified healthcare practitioners	Physicians and qualified healthcare practitioners
Coding	G2012 G2010 If no applicable new patient code is available, use the code for an existing patient.	99421; 99422; 99423 G2061; G2062; G2063	99091, 99457-99458, 99473-99474, 99493-99494, 99457 If no applicable new patient code is available, use the code for an existing patient.	Code as in-person visit.	During PHE, 98966-98968 and 99441-99443.

Medicare Accelerated Payment Program

On March 28, 2020, CMS announced an expansion of their accelerated payment program (APP) pursuant to section 3719 of the CARES Act, which expanded the program to most Medicare physicians and other providers during COVID-19 PHE.

Eligible Providers & Suppliers	Critical Access Hospitals	Inpatient Acute Care Hospitals Children's Hospitals Cancer Hospitals	Physicians Advanced Practice Providers
Amount	Up to 125% for a 6-month period	Up to 100% for a 6-month period	Up to 100% for a 3-month period
Repayment Begins	Claim offset begins at day 121	Claim offset begins at day 121	Claim offset begins at day 121
Repayment Due	Up to 1 year to repay the balance	Up to 1 year to repay the balance	210 days to repay the balance

Eligibility

To qualify for the APP the healthcare provider or supplier must:

1. Have billed Medicare for claims within 180 days immediately prior to the date of the request;
2. Not be in bankruptcy;
3. Not be under active medical review or program integrity investigation; and
4. Not have any outstanding delinquent Medicare overpayments.

Application/Request

Enrolled providers and suppliers may apply through their Medicare Administrative Contractor (MAC) as instructed on each MAC website. Each MAC will work to review and issue payments within seven calendar days of receiving the request.

Claims Process

Providers and suppliers should submit claims as usual after the issuance of the advance payment and will receive full payments for their claims during the 120-day delay period. At the end of the 120-day period, the recoupment process will begin automatically, and every claim submitted will be offset from the new claims to reducing the claim payment amount in order to effectuate repayment.

CMS released a fact sheet to walk providers and suppliers though details and updates related to eligibility, funding, claims processing, and repayment and reconciliation. Interested groups should contact their MAC, as follows:

MAC	Area	Request Link/Number
Noridian	AK, AZ, CA, HI, ID, MT, ND, NV, OR, SD, UT, WA, WY, AS, GU, MP	Call 1-866-575-4067 or Email Request Form to PartBAdvancePayments@noridian.com
NGS	CT, IL, ME, MA, MN, NY, NH, RI, VT, WI	Link to Request Form JK J6
WPS	IN, MI, IA, KS, MO, NE	Call 1-844-209-2567 or Email Request Form to AccAdvPymtReq@wpsic.com
Novitas	AR, CO, DE, DC, LA, MS, MD, NJ, NM, OK, PA, TX	Link to Request Form JL JH
CGS	KY, OH	Link to Request Form J15
Palmetto	AL, GA, NC, SC, TN, VA	Links to Request Form Part A JJ JM Part B JJ JM
FCSO	FL, PR, US VI	Link to Request Form JN

Supervision

Many services paid under the Medicare Physician Fee Schedule are reimbursable when provided under a level of physician or nonphysician practitioner (NPP) supervision rather than personal performance. For example, services provided by other auxiliary personnel "incident to" a physician's professional service are billed by the physician. In many cases, the supervision requirements in order to be billed by the physician necessitate the presence of the physician or NPP in a specific physical location, usually, in the same location as the beneficiary when the service is provided.

Under the PHE, the presence of the physician for direct supervision can be satisfied with a virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. CMS believes the use of real-time, audio and video telecommunications technology for a billing practitioner to observe the patient interacting with or responding to the in-person clinical staff through virtual means, and thus, their availability to furnish assistance and direction could be met without requiring the physician's physical presence in that location.

Requirement	Before COVID-19 PHE	During COVID-19 PHE
Incident-to services	The physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.	Payment will be made if direct supervision was provided through a virtual presence using real-time interactive audio and video technology.
Hospital Diagnostic services	Supervision requirements for diagnostic services and the physical location requirements for the physicians vary by service. Some include direct supervision as discussed above.	Payment will be made if supervision was provided through a virtual presence using real-time interactive audio and video technology.
Pulmonary Rehabilitation, Cardiac Rehabilitation, Intensive Cardiac Rehabilitation	The physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.	Payment will be made if supervision was provided through a virtual presence using real-time interactive audio and video technology.

Residents

Generally, if a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made *only if* a teaching physician is present during the key portion of any service or procedure. However, during the PHE, payment may be made for the teaching physician may if present using interactive telecommunications technology.

Resident Service	Before COVID-19 PHE	During COVID-19 PHE
Resident furnishing Primary care office/outpatient E/M	The teaching physician must be present during the portion of the service that determines the level of service billed. The teaching physician must direct the care from such proximity as to constitute immediate availability (that is, provide direct supervision).	Payment will be made for all levels of an office/outpatient E/M service provided in primary care centers if provided under direct supervision of the teaching physician by interactive telecommunications technology
Resident Services	Teaching physician may bill only if physically present for the key portion of the service.	Payment will be made if the teaching physician was be present during the portion of the service that determines the level of service billed using interactive telecommunications technology.
Resident Interpretation of diagnostic radiology and other diagnostic tests	Payment is made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than a resident.	Payment will be made if a resident performs the interpretation of diagnostic radiology and other diagnostic tests when the teaching physician is present through interactive telecommunications technology.
Resident Psychiatry Services	The physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.	Payment will be made if supervision was provided through a virtual presence using real-time interactive audio and video technology. The teaching physician must still review the resident's interpretation.

Medicare Enrollment & State Licensing

Retroactive to March 1, 2020, Medicare is permitting practitioners to render services outside of their state of enrollment, if they have an equivalent license from another State (and are not affirmatively barred from practice in that State or any State a part of which is included in the emergency area).

- This waiver is limited to Medicare, Medicaid, and CHIP
- Despite this federal waiver, state law ultimately governs whether a provider is authorized to provide medical services in a state

For Physicians and Non-Physician Practitioners CMS has:

- Established toll-free hotlines to enroll and receive temporary Medicare billing privileges
- Waived the following screening requirements:
    - Criminal background checks associated with fingerprint-based criminal background checks (FCBC)
    - Site visits - 42 C.F.R 424.517
    - Postpone all revalidation actions

The hotlines can also be used for physicians and non-physician practitioners to report a change in practice location. Physicians and non-physician practitioners shall only contact the hotline for the MAC that services their geographic area.

CGS Administrators, LLC (CGS)
The toll-free number: 1-855-769-9920
Hours of Operation: 7:00 am – 4:00 pm CT

First Coast Service Options Inc. (FCSO)
The toll-free number: 1-855-247-8428
Hours of Operation: 8:30 AM – 4:00 PM EST

National Government Services (NGS)
The toll-free number: 1-888-802-3898
Hours of Operation: 8:00 am – 4:00 pm CT

National Supplier Clearinghouse (NSC)
The toll-free number: 1-866-238-9652
Hours of Operation: 9:00 AM – 5:00 PM ET

Novitas Solutions, Inc.
The toll-free number: 1-855-247-8428
Hours of Operation: 8:30 AM – 4:00 PM EST

Noridian Healthcare Solutions
The toll-free number: 1-866-575-4067
Hours of Operation: 8:00 am – 6:00 pm CT

Palmetto GBA
The toll-free number: 1-833-820-6138
Hours of Operation: 8:30 am – 5:00 pm ET

Wisconsin Physician Services (WPS)
The toll-free number: 1-844-209-2567
Hours of Operation: 7:00 am – 4:00 pm CT