

04/07/2020

## Dear Clinician:

As you are aware, the United States is currently experiencing an unprecedented outbreak of the respiratory illness 2019 caused by the Novel Coronavirus (COVID-19). Given the potential effect this virus may have on our healthcare system, the Centers for Medicare & Medicaid Services (CMS) is working to ensure maximum flexibility to reduce unnecessary barriers to allow you to focus on your patients. It is important for you to know that the Centers for Disease Control and Prevention (CDC) is publishing reliable [clinical guidance daily](#). CMS also has up to date information for beneficiaries and about its programs and response to COVID-19 on the [Current Emergencies](#) page. While we have more work ahead of us, we sincerely thank you for all that you have done and all that you will do on behalf of patients across the United States.

## Accelerated and Advanced Payments:

In response to the COVID-19 pandemic, CMS will provide accelerated payments to requesting providers and advance payments to requesting suppliers, including physicians and non-physician practitioners, who submit a request to the appropriate Medicare Administrative Contractor (MAC) and meet the following criteria:

1. Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form,
2. Is not in bankruptcy,
3. Not be under active medical review or program integrity investigation, and
4. Does not have any outstanding delinquent Medicare overpayments.

CMS intends to provide assistance first to those providers and suppliers that experience increased demand and surge in patients. MACs responsible for processing accelerated/advance payment requests for different states, will prioritize those states that were hit the hardest (currently, these states are reported to be California, New York, and Washington). Most Providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period. However, Inpatient acute care hospitals, children's hospitals, and certain cancer hospitals are able to request up to 100% of the Medicare payment amount for a six-month period. Critical access hospitals (CAH) can request up to 125% of their payment amount for a six-month period. Based on this formula, qualified providers/suppliers will be asked to request a specific amount using an Accelerated/Advanced Payment Request Document provided on each MAC's website.

For complete details on the process, please review the following [fact sheet](#).

## Testing and Claims Reporting for COVID-19:

As of March 13, CDC recommends collecting a single upper respiratory nasopharyngeal swab. CPT code 87635 or HCPCS code U0002 can be reported for the non-CDC diagnostic lab test, depending on the method used. HCPCS code U0001 can be reported for the CDC diagnostic lab test. Labs, physician offices, hospitals and other settings can bill for tests ordered that they perform.

There are no co-payments for testing. Patients without insurance may be tested through State labs.

CMS has also provided additional flexibilities for patients receiving Medicare home health services by permitting a home health nurse, during an otherwise covered visit, to obtain a sample to send to the laboratory for COVID-19 diagnostic testing.

Effective with services on and after April 1, 2020, a confirmed diagnosis of COVID-19 (2019 novel coronavirus disease) should be reported with diagnosis code U07.1, COVID-19. Assignment of this code is applicable to positive COVID-19 test results and presumptive positive COVID-19 test results.

While this list is not comprehensive, here are some additional ICD-10-CM codes that may be helpful for reporting encounters related to possible COVID-19 exposure as described in the ICD-10-CM Official Coding and Reporting Guidelines at:

- Z03.818: (Encounter for observation for suspected exposure to other biological agents ruled out)
- Z20.828: (Contact with and (suspected) exposure to other viral communicable diseases)
- Z11.59 (Encounter for screening for other viral diseases)

Effective with services **prior** to April 1, 2020, the interim coding guidance for coding encounters related to COVID-19 should be followed, which can be found at [CDC.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Guidance-Interim-Advice-coronavirus-feb-20-2020.pdf](https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Guidance-Interim-Advice-coronavirus-feb-20-2020.pdf). This guidance instructs that the applicable respiratory diagnosis code should be reported followed by diagnosis code B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for patients with a confirmed diagnosis of COVID-19.

**Coverage and payment for COVID-19 testing and care:** [Medicare Coverage and Payment Related to COVID-19 \(PDF\)](#), [COVID-19: New ICD-10-CM Code and Interim Coding Guidance](#)

## **Medicare Telehealth Visits:**

Effective for services starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency (PHE), Medicare will make payments for Medicare telehealth services furnished to patients in broadened circumstances. During the PHE, clinicians can use popular applications that allow for video chat such as Apple FaceTime and Skype, thanks in part to enforcement discretion by the HHS Office of Civil Rights. Clinicians who seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that offer HIPAA business associate agreements (BAAs) with their video communication products. In addition, clinicians may utilize telephone without video for other communication technology-based services.

- **Patients may be either a new or established patient.**
- **These visits are the same services as would be provided during in-person visit and are paid at the same rate as in-person visits.**
- **The patient may be located in any geographic location (not just those designated as rural), in any healthcare facility, or in their home.**
- **The Medicare coinsurance and deductible would generally apply to these services; however, the HHS Office of the Inspector General is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.**
  - Common telehealth CPT and HCPCS codes include:
    - 99201-99215: Office or other outpatient visits
    - G0425-G0427: Telehealth consultations, emergency department or initial inpatient
    - G0406-G0408: Follow up inpatient telehealth consultations furnished to beneficiaries in hospitals or skilled nursing facility (SNF)

**Please note:** In a case where two-way audio and video technology required to furnish a Medicare telehealth service might not be available, there are circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate yet not fully replace a face-to-face visit.

For the duration of the PHE for the COVID-19 pandemic, Medicare will make separate payment for audio-only visits described by CPT codes 98966-98968 and CPT codes 99441-99443 as outlined on page 125 in the [Interim Final Rule with Comment](#).

## **Virtual Check-ins:**

New or established Medicare patients may have a brief communication service with practitioners from wherever they are located, including in their home, via a number of communication technology modalities including synchronous or real-time discussion over a telephone or exchange of information through video or image. We expect 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. Medicare pays for these “virtual check-ins.”

- **This is NOT limited to only rural settings or certain locations, during the PHE or otherwise.**
- **Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.**
  - HCPCS code 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 a new or 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.
  - HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by a new or established patient (e.g., store and forward), including interpretation with 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.

## **E-visits:**

These visits use an online patient portal. In all types of locations including the patient’s home, and in all areas (not just rural), new or established Medicare patients may have non-face-to-face patient-initiated communications with their doctors or other practitioners. These services are not a substitute for an in-person visit, but are exchanges with a practitioner online through a patient portal.

- **This is not limited to only rural settings. There are no geographic or location restrictions for these visits.**
- **Patients communicate with their doctors without going to the doctor’s office by using online patient portals.**
- **Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.**
  - Common telehealth CPT and HCPCS codes include:
    - CPT codes 99421-99423
    - HCPCS codes G2061-G2063.

## **Expanded Options for Telehealth Services:**

Through the recent [rulemaking](#), CMS added many new services that can be provided as telehealth services during the PHE in order to continue lowering exposure risk for clinicians and patients. The following have been added to the Medicare telehealth list:

- Emergency Department Visits, Levels 1-5
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients, All levels
- Home Visits, New and Established Patient, All levels
- Care Planning for Patients with Cognitive Impairment
- Psychological and Neuropsychological Testing
- Therapy Services, Physical and Occupational Therapy, All levels

Several other important changes were made to expand telehealth services including:

- Clarifying the types of technology that can be used for Medicare telehealth services to allow telephones and other devices that offer interactive audio-video telecommunications
- Allowing home health agencies to provide more services to beneficiaries using telecommunications technology, so long as it is part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care
- Allowing hospices to provide services via a telecommunications system and permitting face-to-face encounters for purposes of patient recertification for the Medicare hospice benefit to be conducted via telehealth

For a full list of telehealth services, we encourage you to visit the [Medicare Telehealth](#) page.

## **Workforce Flexibilities:**

CMS had made several updates to overall workforce requirements to allow non-physician practitioners expand their scope of practice. These include:

- Easing requirements so that only general supervision is required for the entirety of non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals
- Waiving certain requirements that Medicare patients in the hospital be under the care of a physician to allow hospitals to use other practitioners, such as physician assistants and nurse practitioners, to the fullest extent possible
- Temporarily waiving Medicare and Medicaid's requirements that physicians and non-physician practitioners be licensed in the state where they are providing services in order to contribute relief efforts

Additional flexibilities are outlined in the [Physician and Other Practitioner COVID-19 Worksheet](#).

## **CMS Quality Payment Program:**

The 2019 Merit-based Incentive Payment System (MIPS) data submission deadline will be extended by 30 days to **April 30, 2020**. In general, if you have already submitted MIPS data or if you submit MIPS data by April 30, 2020, you will be scored and receive a MIPS payment adjustment based on the data you submit. Many MIPS eligible clinicians have performed very well in the MIPS program in previous years. If you need to revise any data that has already been submitted you can still make changes by logging into [qpp.cms.gov](http://qpp.cms.gov) by the new deadline.

### ***2019 MIPS Extreme and Uncontrollable Circumstances Policy Update***

MIPS eligible clinicians who have not submitted any MIPS data by April 30, 2020 do not need to take any additional action to qualify for the automatic extreme and uncontrollable circumstances policy. In addition, CMS has modified the application-based extreme and uncontrollable circumstances policy to allow MIPS eligible clinicians who have been adversely affected by the COVID-19 public health emergency to submit an application and request reweighting of the MIPS performance categories for the 2019 performance year. This is an important change that allows clinicians who have been impacted by the COVID-19 outbreak and may be unable to complete their submission of MIPS data during the current submission period, to request reweighting and potentially receive a neutral MIPS payment adjustment for the 2021 MIPS payment year.

If no MIPS eligible clinicians in an APM Entity submit data for the Promoting Interoperability (PI) or Quality performance categories due to extreme and uncontrollable circumstances, this would result in a neutral MIPS payment adjustment for MIPS eligible clinicians in the APM Entity.

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## **Emergency Waivers: What does this mean to me in the care of my patients?**

CMS is extending many flexibilities authorized by the Secretary under section 1135 of the Social Security Act or other waiver authority to make it easier for clinicians and facilities to provide care.

This is not an exhaustive list, so we encourage you to view all waivers and provisions on the [CMS Coronavirus Waivers & Flexibilities](#) page.

- If you're in a Skilled Nursing Facility:
  - CMS is waiving the 3-day prior hospitalization requirement for coverage of a skilled nursing facility stay, which provides temporary coverage of SNF services without a qualifying hospital stay for those who experience dislocations or are otherwise affected by the emergency.
- If you're in a critical access hospital:
  - CMS is waiving requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours.
- If you're in an acute care hospital:
  - CMS is waiving many requirements such that providers and facilities have more flexibility to care for patients in alternative settings.
- If you're in a Long-term Care Acute Hospital (LTCH):
  - CMS is allowing a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, allowing these facilities to be paid as LTCHs.
- If you're in a Home Health Agency:
  - CMS is providing relief to Home Health Agencies on the timeframes related to OASIS Transmission.
- License Waivers:
  - CMS is temporarily waiving Medicare and Medicaid requirement that a physician or non-physician practitioner must be licensed in the State in which they are practicing when four conditions are met:
    - Enrolled as such in the Medicare program
    - The physician or non-physician practitioner must possess a valid license to practice in the State which relates to his or her Medicare enrollment
    - Furnishing services in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and
    - Is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.
  - This does not apply to state licensing laws, but rather only to federal requirements.



## **Caring for Your Patients: [Frequently Asked Questions to Assist Medicare Providers \(PDF\)](#)**

The following recommendations are for your consideration. We also encourage you to review the Frequently Asked Questions to Assist Providers listed above.

- Encourage patients who are not ill, or have minimal symptoms to remain at home and use social-distancing (avoid crowds, stay 6 feet away from others) as well as appropriate hand hygiene.
- Protect the Vulnerable. Consider reaching out to your highest risk patients (those over 60 with chronic underlying conditions) to inform them of safe practices such as avoiding crowds and non-essential travel (such as cruises). Instruct patients to remain at home as much as possible. You may wish to consider providing additional refills of chronic medications so patients have appropriate supplies.
- Develop plans within your office for a positive or potential positive patient such as a separate exam room, or screening patient temperature. Maintain appropriate cleaning and disinfection of your office – most usual anti-bacterial agents will kill the virus but be sure to check manufacturer’s specifications. Stay aware of the influenza activity in your community as it is potentially treatable. Continue reviewing the Occupational Safety and Health Administration’s (OSHA) [preparedness guidelines](#).
- Consider alternative means of seeing your patients.
- Discuss with your healthcare facility/system any plans to delay elective procedures or visits ([CMS Elective Surgeries and Procedures Recommendations](#)) in order to prevent unnecessary patient and staff exposure, and to expand healthcare system capacity and conserve supplies such as PPE.

## **Clinical and Technical Guidance Resources**

- [Guidance for Use of Certain Industrial Respirators by Health Care Personnel](#) (3/10/20)
- [Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 \(COVID-19\) in Home Health Agencies](#) (3/10/20)
- [Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 \(COVID-19\) in Dialysis Facilities](#) (3/10/2020)
- [Emergency Medical Treatment and Labor Act \(EMTALA\) Requirements and Implications Related to Coronavirus Disease 2019 \(COVID-19\)](#) (3/9/20)
- [Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 \(COVID-19\) by Hospice Agencies](#) (3/9/20)
- [Guidance for Infection Control and Prevention of Coronavirus Disease 2019 \(COVID-19\) in Nursing Homes-REVISED](#) (3/9/20)
- [Guidance for Infection Control and Prevention Concerning Coronavirus Disease \(COVID-19\): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge](#) (3/4/20)
- [Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness \(2019-nCoV\)](#) (2/6/20)
- [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare settings](#)
- [Updated Guidance on Evaluating and Testing Persons for Coronavirus Disease 2019 \(COVID-19\)](#)
- [Regulatory Memos and Updates from CMS](#)
- [CDC Updates](#)
- [CMS.gov](#)