Society of Gynecologic Oncology

# Federal Regulatory Changes for the COVID-19 Public Health Emergency

The Administration either using its authority under the emergency declaration or under waivers provided by Congress as part of the CARES Act is issuing an unprecedented array of temporary regulatory waivers and new rules to provide physicians with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Most of these changes apply as of either March 1 or March 6, 2020, and are temporary for the duration of the Public Health Emergency (PHE) Declaration.

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**Expansion of Telehealth Services Due to 1135 Waiver:**

- Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020.
- A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients.
- Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in person visits.
- List of services payable under the Medicare Physician Fee Schedule when furnished via telehealth. **cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes**
- Common telehealth CPT and HCPCS codes include: 99201-99215: Office or other outpatient visits, or G0425-G0427: Telehealth consultations, emergency department or initial inpatient.

**Provision of Telehealth Services:**

- The provider must use an interactive audio and video telecommunications system that permits real time communication between the distant site and the patient at home.
- Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.
- To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

**Place of Service:**

To implement this change on an interim basis, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the Place of Service (POS) code that would have been reported had the service been furnished in person. Because CMS currently uses the POS code on the claim to identify Medicare telehealth services, **CMS is finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth.**

**Selection of E/M Level of Telehealth Visit:**

On an interim basis, CMS is revising their policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on Medical Decision Making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record.

This policy is like the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule.

It remains CMS' expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care. To reduce the potential for confusion, CMS is maintaining the current definition of MDM. Note that currently there are typical times associated with the office/outpatient E/Ms, and CMS is finalizing

those times as what should be met for purposes of level selection. This policy only applies to office/outpatient visits furnished via Medicare telehealth, and only during the Public Health Emergency (PHE) for the COVID-19 pandemic.

**Site of Service Differential for Medicare Telehealth Services:**

Under the waiver authority, Medicare telehealth services can be provided to patients wherever they are located, including in the patient's home. The agency recognizes that as physicians' practices transition a significant portion of their services from in-person to telehealth services, the relative cost of providing services may not be significantly different than if these services were provided in-person (i.e. physicians' offices will continue to employ nursing staff just as they would have when providing in-person services).
Therefore, the agency will assign the payment rate that would have been paid under the Physician Fee Schedule (PFS) as if the services were furnished in-person. To implement this change on an interim basis, when billing for telehealth services, physicians and practitioners should report the point-of-service (POS) that would have been reported had the service been performed in-person.

**Hospice Certification via Telehealth:**

Hospice certification will be allowed to use telehealth to conduct the face-to-face encounter prior to recertification of eligibility for hospice care during the public health emergency period.

**Removal of Frequency Limitations on Medicare Telehealth:**

To better serve the patient population that would otherwise not have access to clinically appropriate in-person treatment, the following services no longer have limitations on the number of times they can be provided by Medicare telehealth:

- A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
- A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
- Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

**Virtual Check-In Visits:**

Medicare pays for these "virtual check-ins" (or brief communication technology-based service) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office. In general, these virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would generally apply to these services.

Doctors and certain practitioners may bill for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012). The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal. Standard Part B cost sharing applies to both. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (HCPCS code G2010).

- Virtual check-in services normally can only be reported when the billing practice has an established relationship with the patient. Under the Public Health Emergency (PHE) they can be billed for new patients, as well using the existing G codes.
- 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 an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an 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.
- Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.

**Virtual E-Visits:**

E-Visit services can only be reported when the billing practice has an established relationship with the patient. For these E-Visits, the patient must generate the initial inquiry and communications can occur over a 7-day period.

The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.

Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:

- 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

- G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
- G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
- G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time

**Patient Privacy—Health Insurance Portability and Accountability Act (HIPAA):**
Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. For more information: **hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html**

**Telephone Call Services:**

In the context of the goal of reducing exposure risks associated with the Public Health Emergency (PHE) for the COVID-19 pandemic, especially in the case that two-way, audio and video technology required to furnish a Medicare telehealth service might not be available, CMS is finalizing, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443. For these codes, CMS is finalizing on an interim basis for the duration of the Public Health Emergency for the COVID-19 pandemic, the following work RVUs:

- 0.25 for CPT code 98966;
- 0.50 work RVUs for CPT code 98967; and
- 0.75 for CPT code 98968.
- 0.25 for CPT code 99441;
- 0.50 for CPT code 99442; and
- 0.75 for CPT code 99443.

CMS is finalizing the Health Care Professionals Advisory Clinic (HCPAC) and RVS Update Committee (RUC)-recommended direct practice expense inputs which consist of 3 minutes of post-service RN/LPN/MTA clinical labor time for each code.

CMS believes it is important during the PHE to extend these services to both new and established patients. While some of the code descriptors refer to “established patient,” during the PHE CMS is exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors.

**Physician Supervision Requirements:**

Medicare Physician Supervision requirements: For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology. Medicare Physician Supervision and Auxiliary Personnel: The physician can enter into a contractual arrangement that meets the definition of auxiliary personnel at 42 CFR 410.26, including with staff of another provider/supplier type, such as a home health agency (defined under § 1861(o) of the Act) or a qualified home infusion therapy supplier (defined under § 1861(iii)(3)(D)), or entities that furnish ambulance services, that can provide the staff and technology necessary to provide care that would ordinarily be provided incident to a physicians’ service (including services that are allowed to be performed via telehealth). In such instances, the provider/supplier would seek payment for any services provided by auxiliary personnel from the billing practitioner and would not submit claims to Medicare for such services.

- Medicare Physician Supervision requirements: Direct physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.

- Physician Services: CMS is waiving 482.12(c) (1-2) and (4), which requires that Medicare patients in the hospital be under the care of a physician. This allows hospitals to use other practitioners, such as physician's assistants and nurse practitioners, to the fullest extent possible. This waiver should be implemented in accordance with a state's emergency preparedness or pandemic plan.

**Medical Licensure Waivers:**

Temporarily waive Medicare and Medicaid's requirements that physicians and non-physician practitioners be licensed in the state where they are providing services. State requirements will still apply.

CMS waives the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met:

1. must be enrolled as such in the Medicare program,
2. must possess a valid license to practice in the State which relates to his or her Medicare enrollment,
3. is furnishing services – whether in person or via telehealth—in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and
4. is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.

A physician or non-physician practitioner may seek an 1135-based licensure waiver from CMS by contacting the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area. This waiver does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirements.

Please contact your state board of medicine or department of health for up-to-the minute information. The Federation of State Medical Boards (FSMB) is tracking executive orders related to licensure. Stay up to date by referencing the FSMB website at **fsmb.org**. You can also find additional information on the CMS website at **cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf.**

**"Stark Law"—Physician Self-Referral Waivers:**

The physician self-referral law (also known as the "Stark Law") prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service.
CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. They include:

- Hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians (or vice versa). For example, a physician practice may be willing to rent or sell needed equipment to a hospital at a price that is below what the practice could charge another party. Or, a hospital may provide space on hospital grounds at no charge to a physician who is willing to treat patients who seek care at the hospital but are not appropriate for emergency department or inpatient care.
- Health care providers can support each other financially to ensure continuity of health care operations For example, a physician owner of a hospital may make a personal loan to the hospital without charging interest at a fair market rate so that the hospital can make payroll or pay its vendors.
- Hospitals can provide benefits to their medical staffs, such as multiple daily meals, laundry service to launder soiled personal clothing, or child-care services while the physicians are at the hospital and

engaging in activities that benefit the hospital and its patients.

- Allowing the provision of certain items and services that are solely related to COVID-19 Purposes (as defined in the waivers), even when the provision of the items or services would exceed the annual non monetary compensation cap.
- Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms, even though such expansion would otherwise be prohibited under the Stark Law.
- Group practices can furnish medically necessary MRIs, CT scans or clinical laboratory services from locations like mobile vans in parking lots that the group practice rents on a part-time basis.

**Changes to the Quality Payment Program—Merit-based Incentive Payment System (MIPS):**

CMS is making two updates to the Merit-based Incentive Payment System (MIPS) in the Quality Payment Program.

- Modifying the MIPS Extreme and Uncontrollable Circumstances policy to allow 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 submit their MIPS data during the current submission period, to request reweighting and potentially receive a neutral MIPS payment adjustment for the 2021 payment year.

- CMS is adding one new Improvement Activity for the CY 2020 performance year that, if selected, would provide high-weighted credit for clinicians within the MIPS Improvement Activities performance category.

Clinicians will receive credit for this Improvement Activity by participating in a clinical trial utilizing a drug or biological product to treat a patient with COVID-19 and then reporting their findings to a clinical data repository or clinical data registry. This would help contribute to a clinician's overall MIPS final score, while providing important data to help treat patients and address the current COVID-19 pandemic.

**Medicare Payment Changes:**

- Adjustment of the Medicare Sequestration
  - Medicare sequester, which reduces payments to providers by 2 percent, will be lifted from May 1 through December 31, 2020, boosting payments for hospitals, physicians, nursing homes, home health, and other care.

- Extension of the work geographic index floor under the Medicare program
  - This provision increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average through December 1, 2020.

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