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## **Medicare and Medicaid Policy and Regulatory Revisions Interim Final Rule AMGA Executive Summary**

The Centers for Medicare & Medicaid Services (CMS) on March 30 issued an [interim final rule](#) that changes Medicare payment rules and policies during the Public Health Emergency (PHE) for the 2019 novel coronavirus (COVID-19).

The rule details changes to Medicare telehealth policy, efforts to support the healthcare workforce, and other policy changes intended to reduce burdens on providers so they can focus on caring for patients during the PHE. The following summarizes some of the key provisions of the interim final rule.

Comments on the rule are due by June 1 at 5:00 p.m. EST.

### **Telehealth Technology Requirements**

- The rule clarifies that phones that are capable of both audio and visual communication will qualify as an acceptable telecommunications system for the duration of the PHE.
- In addition, the rule notes that the Department of Health and Human Services (HHS) Office of Civil Rights is exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communication technologies, such as FaceTime or Skype, during the PHE for the COVID-19 pandemic.

### **Telephone Evaluation and Management (E/M) Services**

- CMS will use existing telephone E/M codes to recognize the relative resource costs of these kinds of services. CMS is finalizing separate payment for CPT codes 98966-98968 and CPT codes 99441-99443 on an interim basis for the duration of the PHE for the COVID-19 pandemic. CMS will exercise its enforcement discretion and will not conduct reviews to determine if these services were provided for “established patients” as would be required outside of the PHE.

### **Telehealth and E/M Level Selection**

- Under the PHE waivers, telehealth office/outpatient E/M services may be provided to any patient in their home regardless of their diagnosis or medical condition.
- On an interim basis, CMS is revising its 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 or time. Time is defined as, “all of the time associated with the E/M on the day of the encounter.”
- CMS also is removing any requirements regarding documentation of history and/or physical exams in the medical record.

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

- CMS will assign the Physician Fee Schedule (PFS) payment rate that would have been paid had the services been provided in-person.
- Physicians and practitioners who bill for Medicare telehealth services are instructed to report the place of service (POS) code that would have been reported had the service been furnished in person. Including the POS code will allow CMS' system to make appropriate payments for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person.
- 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.
- CMS also is maintaining the facility payment rate for services billed using the general telehealth POS code 02, should practitioners choose to maintain their current billing practices for Medicare telehealth during the PHE for the COVID-19 pandemic.

### **Communication Technology-Based Services (CTBS)**

- On an interim basis, during the PHE for the COVID-19 pandemic, CMS is broadening the availability of HCPCS codes G2010 and G2012, which describe remote evaluation of patient images/video and virtual check-ins.
- The codes can be furnished to new and established patients
- Consent to receive these services can be documented by auxiliary staff under general supervision.
- The agency recognizes that in the context of the PHE for the COVID-19 pandemic, practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists might also utilize virtual check-ins and remote evaluations instead of other, in-person services within the relevant Medicare benefit to facilitate the best available, appropriate care while mitigating exposure risks.
- CMS is requesting comment on other kinds of practitioners who might be furnishing these kinds of services as part of the Medicare services they furnish in the context of the PHE for the COVID-19 pandemic.

### **Temporary Code Additions on a Category 2 Basis**

- CMS is adding the following services to the Medicare telehealth list on a Category 2 basis for the duration of the PHE for COVID-19.
- Providers may bill these codes for dates of services beginning March 1, 2020.
  - Emergency Department Visits: 99281, 99282, 99284, 99285
  - Initial and Subsequent Observation, and Observation Discharge Day Management: 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236
  - Initial hospital care and hospital discharge day management: 99221, 99222, 99223, 99238, 99239
  - Initial nursing facility visits and nursing facility discharge day management: 99304, 99305, 99306
  - Critical Care Services: 99291, 99292
  - Domiciliary, Rest Home, or Custodial Care services: 99327, 99328, 99334, 99335, 99336, 99337
  - Home Visits: 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Inpatient Neonatal and Pediatric Critical Care: 99468, 99469, 99471, 99472, 99473, 99475, 99476
- Initial and Continuing Intensive Care Services: 99477, 99478, 99479, 99480
- Care Planning for Patients with Cognitive Impairment: 99483
- Group Psychotherapy: 90853
- End-Stage Renal Disease (ESRD) Services: 90952, 90953, 90959, 90962
- Psychological and Neuropsychological Testing: 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139
- Therapy Services (does not include services provided by physical therapists, occupational therapists, or speech-language pathologists): 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521, 92522, 92523, 92524, 92507
- Radiation Treatment Management Services: 77427

### **Innovation Center Models**

The interim final rules also includes provisions on Center for Medicare and Medicaid Innovation models.

#### **Comprehensive Care for Joint Replacement (CJR):**

- The rule will cap actual episode expenditures at the target amount for episodes initiated within 30 days prior to the declared state of emergency or during the state of emergency.
- Expands the extreme and uncontrollable policy on account of the COVID-19 pandemic.
- Extends performance year five of CJR so that it concludes on March 31, 2021.

#### **Medicare Diabetes Prevention Program (MDPP) expanded model:**

- Permit beneficiaries to obtain the set of MDPP services more than once per lifetime.
- Increase the number of virtual make-up sessions.
- Allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis .

### **Change to Medicare Shared Savings Program Extreme and Uncontrollable Circumstances Policy**

- CMS is revising the regulation at § 425.502(f) to remove the restriction which prevents the application of the Shared Savings Program's extreme and uncontrollable circumstances policy for disasters that occur during the quality reporting period if the reporting period is extended. This will offer relief under the Shared Savings Program to all ACOs that may be unable to completely and accurately report quality data for 2019 due to the PHE for the COVID-19 pandemic.
- Financial reconciliation: CMS will reduce the amount of an ACO's shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance, and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.
- ACO benchmarks: The factors used to update an ACOs' benchmarks will reflect the national and regional trends related to spending and utilization changes during 2020, including any changes arising from the PHE for the COVID-19 pandemic.

### **Addressing the Impact of COVID-19 on Part C and Part D Quality Rating Systems**

- CMS is eliminating the HEDIS 2020 submission requirement that covers the 2019 measurement year and requesting that Medicare health plans, including MA and section 1876 organizations, curtail HEDIS data collection work immediately.
- CMS proposes to eliminate requirements for collection of HEDIS and CAHPS data that would otherwise occur in 2020.
- This IFC amends the calculations for the 2021 and 2022 Part C and D Star Ratings to incorporate changes to address the expected impact of the PHE for the COVID-19 pandemic on data collection and performance.

#### **Merit-Based Incentive Payment System (MIPS) Updates**

- CMS is extending the deadline to submit an application for reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances and the Promoting Interoperability performance category based on extreme and uncontrollable circumstances to April 30, 2020, or a later date that we may specify.
- CMS is also modifying an existing policy where if the MIPS eligible clinician, group, or virtual group submits an application for reweighting based on the COVID-19 PHE by the new deadline, then MIPS data they have already submitted or will submit will not void their application for reweighting (applies to performance year 2019/payment year 2021).