

MEDICARE INTERM FINAL RULE MARCH 30, 2020 REVIEW

(re Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency)

Key Links:

- [The full rule](#)
- [The summary](#)
- [Updated CPT Appendix P \(modifier -95 codes\)](#)

Abbreviations:

- RTAV - Real time audio-video (CMS refers to this as “telehealth”)
- NPP (non-physician practitioner, i.e. NP, PA, CNS)

Disclaimer:

This is a brief summary and not legal advice. Please review the rule in its entirety. Pages of the posted rule are provided for ease of use. The [CMS summary](#) outlines major changes. This review provides practical details related to the RI community, especially professional providers. The rule is effective March 30, 2020, but is retroactive to March 1. The expanded codes are effective March 1, 2020.

Of special interest to PCPs:

- The rule about criteria for selecting an [E/M level](#) (page 135)
- The rule about the coverage of [telephone calls](#) (page 122).

A helpful resource is the American Medical Association [telemedicine quick guide](#).

Summary of changes – indented text is directly quoted from the final rule:

PAGE 11 A. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

As previously implemented, Medicare is covering RTAV services and waiving the site of service restrictions and the HIPAA compliant communication systems. This rule adds several services to the Medicare telehealth list.

When furnished under the telehealth rules, many of these specified Medicare telehealth services are still 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.

PAGE 13 A.1. Site of Service Differential for Medicare Telehealth Services

CMS traditionally pays telehealth at a “facility” rate which is lower than the non- facility (NF) rate. They will pay at a NF rate if the claims are coded with the routine place of service code (where the service would have been done if in-person) and modifier -95.

To implement this change on an interim basis, we are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment 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. Given the potential importance of using telehealth services as means of minimizing exposure risks for patients, practitioners, and the community at large, we believe this interim change will maintain overall relativity under the PFS for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth. Because we currently use the POS code on the claim to identify Medicare telehealth services, we are 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. We note that we are maintaining the facility payment rate for services billed using the general telehealth POS code 02, should practitioners choose, for whatever reason, to maintain their current billing practices for Medicare telehealth during the PHE for the COVID-19 pandemic.

PAGE 34 A. 16. Therapy Services

Therapy services have been added to the approved list but may not be reported by therapists due to statutory restrictions. These may be reported by others who are allowed to report these services and are allowed to report as a telehealth practitioner.

We have received a number of requests, most recently for CY 2018 PFS rulemaking, that we add therapy services to the Medicare telehealth list. In the CY 2018 PFS final rule, we noted that section 1834(m)(4)(E) of the Act specifies the types of practitioners who may furnish and bill for Medicare telehealth services as those practitioners under section 1842(b)(18)(C) of the Act. Physical therapists, occupational therapists and speech-language pathologists are not among the practitioners identified in section 1842(b)(18)(C) of the Act.... In light of the PHE for the COVID-19 pandemic, we believe that the risks associated with confusion are outweighed by the potential benefits for circumstances when these services might be furnished via telehealth by eligible distant site practitioners. We believe this is sufficient clinical evidence to support the addition of therapy services to the Medicare telehealth list on a category 2 basis. However, we note that the statutory definition of distant site practitioners under section 1834(m) of the Act does not include physical therapists, occupational therapists, or speech-language pathologists, meaning that it does not provide for payment for these services as Medicare telehealth services when furnished by physical therapists, occupational therapists, or speech-language pathologists.

PAGE 41 B. Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations and Required “Hands-on” Visits for ESRD Monthly Capitation Payments

Frequency limitations and in person requirements are being modified. Frequency limits are removed for follow-up inpatient and follow-up nursing facilities. Some ESRD services are eligible for payment if the in-person requirement is met with real time audio-video and not just in-person. Mandatory SNF/NF visits are no longer required to be in-person and may be RTAV.

Consequently, on an interim basis, we are removing the frequency restrictions for each of the following listed codes for subsequent inpatient visits and subsequent NF visits furnished via Medicare telehealth for the duration of the PHE for the COVID-19 pandemic.... For this reason, we are also removing the restriction that critical care consultation codes may only be furnished to a Medicare beneficiary once per day....(Page 45) we added ESRD related services to the Medicare telehealth list; however, we specified that the required clinical examination of the vascular access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA) (69 FR 66278). On an interim basis in light of the PHE for the COVID-19 pandemic, we are instead permitting the required clinical examination to be furnished as a Medicare telehealth service during the PHE for the COVID-19 pandemic. ... The Bipartisan Budget Act of 2018 (Pub. L. 115-123, enacted on February 9, 2018) (BBA of 2018) amended section 1881(b)(3)(B) of the Act to require that such an individual must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months. Due to the conditions presented by the PHE, we are also exercising enforcement discretion on an interim basis to relax enforcement in connection with the requirements under section 1881(b)(3)(B) of the Act that certain visits be furnished without the use of telehealth for services furnished during the PHE. Specifically, CMS will not conduct review to consider whether those visits were conducted face-to-face, without the use of telehealth.

PAGE 48 C. Telehealth Modalities and Cost-sharing 2. Beneficiary Cost-sharing

CMS allows cost sharing to be waived i.e. the provider **does not** get paid the cost sharing, if waived.

The Office of Inspector General (OIG) issued a Policy Statement⁵ to notify physicians and other practitioners that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth.

PAGE 51 New vs Established patients with telemedicine and digital on-line services and increased provider types allowed to report services.

Telephone services and digital on-line services may be provided to new patients, even if the guidelines or code language presently states a limitation to established patients. CMS will also allow provider types such as MSW to use the virtual check in codes, the CPT telephone codes and the CMS on-line digital G codes.

PAGE 52 Consent

Consent may be obtained by staff or the practitioner at any time, verbally and at least annually.

While we continue to believe that beneficiary consent is necessary so that the beneficiary is notified of any applicable cost sharing, we do not believe that the timing or manner in which beneficiary consent is acquired should interfere with the provision of one of these services. Therefore, we are finalizing on an interim basis during the PHE for the COVID-19 pandemic that, while consent to receive these services must be obtained annually, it may be obtained at the same time that a service is furnished. We are also re-emphasizing that this consent may be obtained by auxiliary staff under general supervision, as well as by the billing practitioner.

PAGE 55 E. Direct Supervision by Interactive Telecommunications Technology

Some services (e.g. an injection) require direct supervision (in the suite). CMS now allows RTAV availability to meet the direct supervision requirements. Availability means just that, not that the service is viewed real-time.

PAGE 60 F. Clarification of Homebound Status under the Medicare Home Health Benefit

If a patient is quarantined or advised to self-isolate or would otherwise be at risk to leave the home because of COVID, they meet the definition of “homebound” for home health services. The required “face-to-face” visit may be RTAV.

PAGES 64-77 Issues related to Hospice and Home Health Payment Rules of In Person Services

Pages listed to alert these provider types.

PAGE 82 L. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

FQHCs may now also report on-line digital evaluation services using G0071 and the new rate for G0071 reflects more than the virtual check in and is therefore higher. These services are also available to new patients. Consent may be obtained by staff at any point and may be verbal but is required annually.

PAGE 92 M. Medicare Clinical Laboratory Fee Schedule: Payment for Specimen Collection for Purposes of COVID-19 Testing

Independent labs may bill a COVID specific specimen acquisition and processing fee. (This information is added in this summary so that practices are aware that there is a G code intended for labs only. This may be an opportunity for others to be paid by private carriers when an E/M service is already provided as Medicare uses 99211 for specimen collection by physicians and NPPs.) Medicare did not attempt to separate out overlap between higher E/M and specimen collection, even though there are codes for services like injections, which likely use less staff and supply than COVID specimen collections.

- G2023, specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source.

Under this policy, the nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally will be \$23.46 and for individuals in a SNF or individuals whose samples will be collected by laboratory on behalf of an HHA will be \$25.46.

PAGE 101 O. Application of Teaching Physician and Moonlighting Regulations During the PHE for the COVID-19 Pandemic

There are many points in this section. Some relate to hospital funding formulae and are not of interest except to hospitals and program directors. The key points are the “direct” supervision can be RTAV in case the trainee or attending teaching physician is at home; the primary care exception now includes level 4 and 5 codes; and procedures still require physical presence.

To increase the capacity of teaching settings to respond to the PHE for the COVID-19 pandemic as more practitioners are increasingly being asked to assist with the COVID-19 response, on an

interim basis, for the duration of the PHE for the COVID-19 pandemic, we are amending the teaching physician regulations to allow that as a general rule under § 415.172, the requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology, as described in section II.E. of this IFC. In other words, the teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service....

Consequently, on an interim basis, for the duration of the PHE for the COVID-19 pandemic, we are amending § 415.174 to allow that all levels of an office/outpatient E/M service provided in primary care centers may be provided under direct supervision of the teaching physician by interactive telecommunications technology....

The regulations describing PFS payment for teaching physician services do have additional exceptions for specific policies. For example, as described in § 415.172, in the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing. As described in § 415.178 for anesthesia services, the teaching anesthesiologist must be present during all critical or key portions of the anesthesia service or procedure involved and the teaching anesthesiologist must be immediately available to furnish anesthesia services during the entire procedure. Given the complex nature of these procedures and the potential danger to the patient, even in the context of the PHE for the COVID-19 pandemic and the inherent exposure risks for patients and physicians, we believe that the requirements for physical presence for either the entire procedure or the key portions of the service, whichever are applicable, are necessary for patient safety.

PAGE 119 R. Remote Physiologic Monitoring

CMS clarifies that remote physiological monitoring services may be for new or established patients and for acute or chronic conditions. Verbal consent is required. This may include pulse oximetry monitoring in a COVID patient.

PAGE 122 S. Telephone Evaluation and Management (E/M) Services

CMS covers telephone services codes in addition to the virtual check in telephone code G2012. These are 99441-99443 and 98966-98968. They use the current RUC recommended valuations. Pay attention to the values and note that if 30 minutes in one day is spent on non-face to face activities, 99358 Prolonged Services without Direct Patient Contact may be reported. The time is not just the telephone time in 99358, but is telephone time for the others.

CODE	PAYMENT \$ (National NF rate rounded)
G2012 (5-10 min)	15
99441 (5-10 min)	14
99442 (11-20 min)	28
99443 (21-30 min)	41
99358 (30+ min)	114

PAGE 128 U. Application of Certain National Coverage Determination and Local Coverage Determination Requirements During the PHE for the COVID-19 Pandemic

Requirements that some evaluations/certifications be performed in person are waived (or in some cases met via RTAV).

PAGE 135 W. Level Selection for Office/Outpatient E/M Visits When Furnished Via Medicare Telehealth

Code level should be selected by total time on the date of the encounter or medical decision-making. This is the 2021 concept for level selection for office visits. Counseling and coordination of care need not dominate, but total time must be obtained from the CMS table. CMS is using time as they will in 2021, but using MDM with the current MDM rules in the 2020 CPT references, (not the 2021 ones posted on the AMA website). Do not use the typical time in CPT, see the table below for office visits. Time is only that of the reporting clinician and not staff time. This policy only applies to the Office Visit services.

CODE	TOTAL TIME (CMS TIME FILES)
99201	17
99202	26
99203	29
99204	45
99205	67
99211	Neither time minimum nor MDM applies
99212	16
99213	23
99214	40
99215	55

PAGE 173 DD. Advance Payments to Suppliers Furnishing Items and Services under Part B

Providers may be eligible for advance payments when claims are pending, and processing is delayed.

