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Subject: COVID-19 BREAKING NEWS: The CARES Act and More Regulations Released! Telehealth and More... 03-31-2020
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E-Reimbursement Newsletter

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Last week, the President signed the [Coronavirus Aid, Relief, and Economic Security Act \(the “CARES Act”\)](#) which will be the **third coronavirus relief package**. It has many implications for healthcare providers. The biggest ones for Oncology practices and clinics is the lifting of the Sequester from 5/1/2020-12/31/2020. **[But, there is loan relief and, COA distributed a document that shows all of the small business relief spelled out in the law.](#)** I am not an expert in Small Business loans, so I am distributing this information, which is not outlined below.

As we went to press, CMS also released a whole humongous load of regulations, some of which answer your questions regarding telehealth and others pose even more quandaries during this health emergency. Check it out!!!

Stay well and shelter in place, everybody!! I want to see all of you back!

Da' Mistress

PS--Thank the Lord for Bo Gamble for helping me preserve what little is left of my sanity!

The CARES Act: Help Is On The Way

Last Friday, the President signed the huge [the Coronavirus Aid, Relief, and Economic Security Act \(the “CARES Act”\)](#) which will be the **third coronavirus relief package**. The first relief package was \$8 billion in emergency spending aimed at stopping the spread of the virus at the local, state, national, and international levels. This included provisions to allow Medicare beneficiaries to access telehealth programs as many of you know and have implemented. .The second coronavirus package provided paid sick and family leave for workers impacted by the illness, expanded unemployment assistance, nutrition assistance, and increased resources for testing for the coronavirus.

There are several sections of the CARES Act that will impact healthcare facilities and providers. **This article highlights how the CARES Act impacts reimbursement, healthcare facilities, healthcare finance, patient access---and, I kid you not, tampons.** There are other parts of the CARES Act which healthcare organizations may be eligible for that may help meet capital needs of the organization. Again, we have the [small business implications from COA](#), which are not included in this article.

Testing /Preventive Services

- Covers testing for COVID-19 **must be covered by commercial insurance plans with no cost to patients, including those tests without an Emergency Use Authorization (EUA) by the FDA.** It requires insurers to pay either the rate specified in a contract between the provider and the insurer or if

requires insurers to pay either the rate specified in a contract between the provider and the insurer or if there is no contract, a cash price posted by the provider.

- Medicare Part B beneficiaries can receive a COVID-19 vaccine at no cost. ...but, we all know there isn't one.
- Ensures that **uninsured individuals can receive a COVID-19 test** and related service at no cost in any state Medicaid program that decides to offer such enrollment option.

Insurance, Health Saving Accounts ("HSAs"), and Flex Spending Accounts

- **Allows a high-deductible health plan (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible.**
- Allows patients to **use funds in HSAs and Flexible Spending Accounts for the purchase of over-the-counter medical products**, including those needed in quarantine and social distancing, without a prescription from a physician.

Medicare Reimbursement

- **Best news: Lifts the Medicare sequestration rate, which reduced payments to providers by 2% of the Medicare 80% payment, from May 1 through December 31, 2020. The bad news: to make up for the money lost during this temporary suspension, sequestration is now extended through 2030.**
- **Increases the payment to a hospital for treating an inpatient admitted with COVID-19 by increasing the DRG weight by 20%** during the COVID-19 emergency period. Attention hospital coders--this will be paid in response to diagnosis codes, condition codes, and/or the combination!!!
- **Changes time frame and grants acute care hospitals the flexibility to transfer patients out of their facilities and into alternative care settings to prioritize resources to treat COVID-19 cases during the COVID-19 emergency period.** This waives the Inpatient Rehabilitation Facility (IRF) 3-hour rule and allows a Long Term Care Hospital (LTCH) to maintain its designation even if more than 50% of its cases are less intensive. It would also temporarily pause the current LTCH site-neutral payment methodology.
- Prevents scheduled reductions in **Medicare payments for durable medical equipment** through the length of COVID-19 emergency period.
- **Stalls parity with commercial rate reductions in Medicare payments for clinical diagnostic laboratory tests furnished in 2021 and delays by one year the upcoming PAMA reporting period** during which laboratories are required to report private payer data.
- **Expands an existing Medicare accelerated payment program for qualified hospitals for the duration of the COVID-19 emergency period.** Qualified hospitals would be able to request up to a six-month advanced lump sum or periodic payments based on net reimbursements represented by unbilled discharges or unpaid bills. Qualified hospitals could elect to receive up to 100% of the prior period payments, with Critical Access Hospitals able to receive up to 125%. A qualifying hospital would not be required to start paying down the loan for four months and would also have at least 12 months to complete repayment without a requirement to pay interest.
- **While there was a Press Release that stated physicians were entitled to this, the CARES regulations only outline the Acceleration policy for hospitals.** Physicians, however, when there is a Disaster qualify for Advance Payments. **To qualify for accelerated or advance payments, providers and suppliers must have billed Medicare for claims within 180 days immediately prior to any request. Providers in bankruptcy are not eligible for accelerated payments, nor are providers under active medical review or program integrity investigation.** See the [Palmetto website](#) for more information.
- **Preserves "The GPCI Floor"**, which now sets a Work Geographical Adjustment Index of 1.00, was due to expire in May. This GPCI Floor then increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average until **December 1, 2020 (why not 12/31???)**.
- **Medicare Part D plans will provide a 90-day supply of a prescription medication** if requested by a beneficiary during the COVID-19 emergency period. However, safety edits still apply
- Additionally, from March 6, 2020, to the end of the emergency period, the CARES Act **averts price reductions to durable medical equipment** by suspending revisions to the Medicare durable medical equipment payment methodology for areas other than those that are rural and noncontiguous.

Medicaid Reimbursement

- Ensures that states are able to receive the **Medicaid 6.2% Federal Medical Assistance Percentage (FMAP) increase.**
- Allows state Medicaid programs to **pay for direct support professionals, caregivers trained to help with activities of daily living, to assist disabled individuals in the hospital to expedite discharge.**
- **Suspends scheduled DSH reductions.** Like the GPCI floor, however, Congress has revised and delayed those reductions in subsequent legislation. DSH reductions have been delayed DSH reductions through May 22, 2020. The CARES Act further delays the cuts **until December 1, 2020.** The program is now set to be reduced by \$4 billion starting in fiscal year 2021 and \$8 billion in each of fiscal years 2022 through 2025.

Telehealth

- **Reauthorizes the Health Resources and Services Administration (HRSA) grant programs** promoting the use of telehealth technologies for health care delivery, education, and health information services.
- Eliminates the requirement in Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (Public Law 116-123) **limiting the Medicare telehealth expansion authority during the COVID-19 emergency period to situations where the physician or other professional has treated the patient in the past three years, i.e. Established patients.**
- During the COVID-19 emergency period, **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) can serve as a distant site for telehealth consultations.** Medicare would reimburse for these telehealth services based on the Medicare Physician Fee Schedule, and costs associated with these services would be excluded from both the FQHC prospective payment system and the RHC all-inclusive rate calculation.
- **Hospice face-to-face recertification requirements can be performed using telehealth during the COVID-19 emergency period.**
- Requires the Department of Health and Human Services (HHS) to issue **clarifying guidance encouraging the use of telecommunications systems, including remote patient monitoring, to furnish home health services consistent with the beneficiary care plan during the COVID-19 emergency period.**
- **Allows physician assistants, nurse practitioners, and other professionals to order home health services for beneficiaries,** reducing delays and increasing beneficiary access to care in the safety of their home. Be sure to check your state Scope of Services to ensure they can do this in your state

HIPAA

- Requires the Department of Health and Human Services (HHS) to **issue guidance on what patient health information is allowed to be shared during the public health emergency** related to COVID-19.

Other

- **Addresses drug shortages.** The Federal Food, Drug, and Cosmetic Act requires prescription drug manufacturers to notify the US Food and Drug Administration (FDA) if they anticipate a permanent discontinuance or temporary interruption in the supply of a life-supporting or life-sustaining drug. The CARES Act builds on this statute by requiring **FDA to expedite and prioritize review of drugs that manufacturers have identified for possible shortages.**
- **The Act also requires manufacturers to submit additional information to FDA when there is an interruption in the supply chain for pharmaceuticals or medical equipment.** Manufacturers must submit a contingency plan to ensure back-up supplies of life-saving and life-preserving products, and information about drug volume. In cases where the interruption is caused by missing or diminished active ingredient supply, manufacturers must share information about these ingredients with FDA.

Funniest

- This totally cracked me up, but many of you will really appreciate it. Among the items in the \$2 trillion-plus coronavirus stimulus law is a tax break for menstrual products, a provision worth more than **\$8 billion** (Gold-plated maxi pads?) that “menstrual equity” people (how can this be equitable? With men?) **hope will decrease the price of these supplies by making them deductible for tax purposes as “medical expenses”.** Additionally, under the law, tampons, pads, liners, cups, sponges and other products “used with respect to menstruation” (what else would you use them for? Easter Bonnet?) would be added to the **list of products covered by Health Savings Accounts and Medical Spending Accounts.** If this was retroactive, someone would owe me some VERY major bucks.

To see the law, [please click here](#).

More COVID-19 Changes from CMS

The Trump Administration yesterday issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the COVID-19. These temporary, emergency changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. Here is a summary of the waivers that apply to cancer clinics and offices.

Medicare Telehealth

Clinicians can now provide more services to beneficiaries via telehealth so that clinicians can take care of their patients while mitigating the risk of the spread of the virus. **Under the public health emergency, all beneficiaries across the country can receive Medicare telehealth and other communications technology**

beneficiaries across the country can receive Medicare telehealth and other communications technology-based services wherever they are located. Clinicians can provide these services to *new or established patients*. In addition, providers can waive Medicare copayments for these telehealth services for beneficiaries in Original Medicare.

CMS also stated in their Press Release that "Providers also can evaluate beneficiaries who have audio phones only." We do not think this means that the video requirement is totally waived, but other publications do.

To enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation & Observation Discharge Day Management (CPT 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327-99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347-99350)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468- 99473;CPT codes 99475- 99476)
- Initial and Continuing Intensive Care Services (CPT code 99477- 994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- **Radiation Treatment Management Services (CPT codes 77427)**
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.
- **Billing for telehealth:** the [Press Release](#) states that "Providers can bill for telehealth visits at the same rate as in-person visits." Some are interpreting this to mean that the Non-Facility rate will be paid rather than Facility rate. That's not what it means to me, but we shall see.

A complete list of all other Medicare telehealth services can be found [here](#):

Virtual Check-Ins & E-Visits

- Additionally, **clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients**. Virtual check-in services were previously limited to established patients.
- Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).
- A broad range of clinicians, including physicians, **can now provide certain services by telephone to their patients (CPT codes 98966-98968; 99441-99443, Telephone calls). Check with your MAC to see when they will pay for these. Prior to 3/30/2020, these were not payable by Medicare, but they do have RVUs.**

Remote Patient Monitoring

- **Clinicians can provide remote patient monitoring services to both new and established patients**. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494)

Removal of Frequency Limitations on Medicare Telehealth

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).

Other Medicare Telehealth and Remote Patient Care

- To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) **would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.**
- **HEADS UP: Beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.**
- Physician visits: CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners **to perform in-person visits for nursing home residents** and allow visits to be conducted, as appropriate, via telehealth options.

Workforce

- 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. By the way, 'incident to' requires direct supervision.**
- **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 physician's 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.
- 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 assistant and nurse practitioners, to the fullest extent possible. This waiver should be implemented in accordance with a state's emergency preparedness or pandemic plan.
- National coverage determinations (NCDs) and Local Coverage Determinations (LCDs): **To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service, during this public health emergency, the Chief Medical Officer or equivalent of a hospital or facility will have the authority to make those staffing decisions.**
- Practitioner Locations: **Temporarily waives 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
- **Provider Enrollment: CMS has established toll-free hotlines for physicians, non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges.** CMS is providing many flexibilities for provider enrollment so more physicians are in the workforce.

Patients Over Paperwork

- "Stark Law" Waivers: **There are conditions to this waiver. [See the original document for more information.](#)**
- **Signature Requirements: CMS is waiving signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures.** Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.
- **Changes to MIPS:** There are two updates to the Merit-based Incentive Payment System (MIPS) in the Quality Payment Program.
 - Modify 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.

- **Additionally, we are 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.

Accelerated/Advance Payments: See the [Medicare Fact Sheet](#).

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor(QICs) in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), 42 CFR 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 **to allow extensions to file an appeal;**
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and the Part C and Part D IRE's **to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a non-contract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest** 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1);
- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs **to process an appeal even with incomplete Appointment of Representation forms 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary;**
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs **to process requests for appeal that don't meet the required elements** using information that is available 42 CFR § 422.562, 42 CFR § 423.562. CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562 **to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.**

Additional Guidance

ALL Provider waivers can be found [here](#)

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