

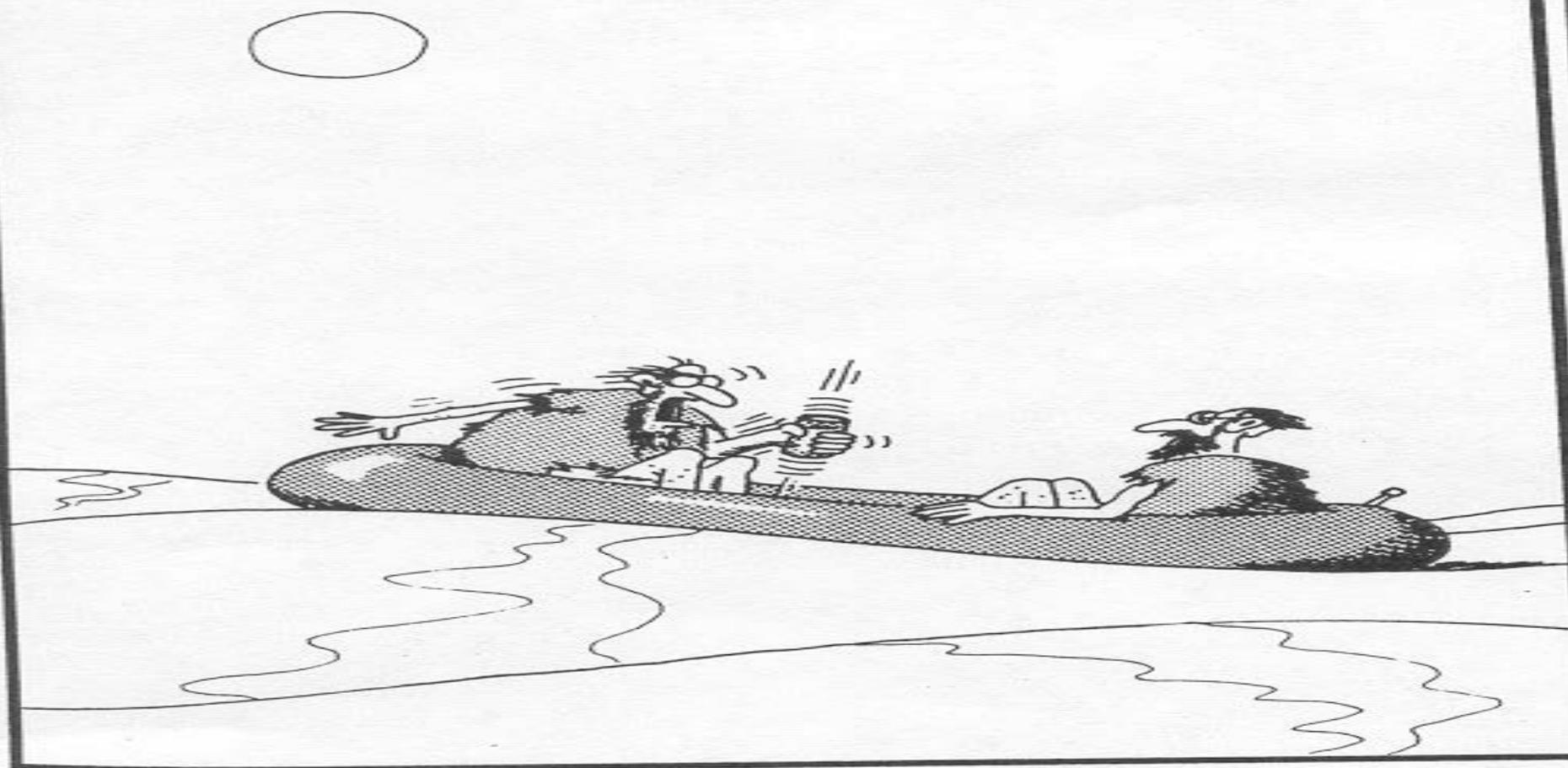
COVID-19 Interim Final Rule: The Sequel

Presented by:

David Glaser & Katie Ilten

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Fredrikson
& BYRON, P.A.



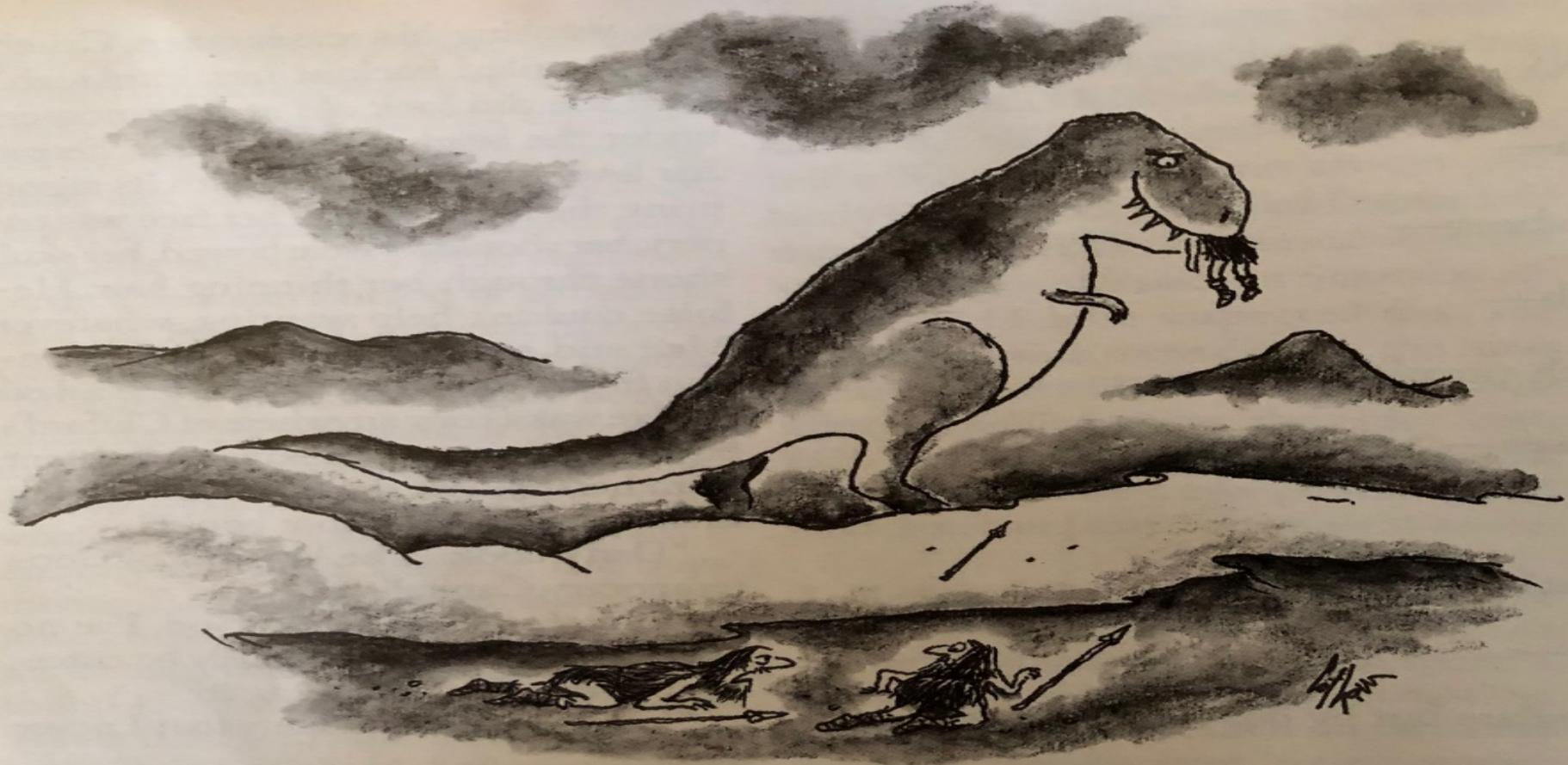
**“OK, crybaby! You want the last soda?
Well, let me get it ready for you!”**

How Did We Get Here?

- Public Health Emergency (PHE) January 31, 2020.
- Coronavirus Preparedness and Response Supplemental Appropriations Act Pub. L. 116-123, March 6, 2020.
- March 13, 2020 Presidential National Emergency Declaration.

How Did We Get Here?

- Families First Coronavirus Response Act
Pub. L. 116-127, March 18, 2020.
- Coronavirus Aid, Relief, and Economic Security Act (CARES Act) Pub. L.116-136,
March 27, 2020.
- First IFC. March 30/April 6, 2020 85 FR
19230.



“He thought the creature seemed more conciliatory of late.”

General Thoughts

- Most changes apply only during the emergency (and many retroactively). In this rule March is the default.
- Note there are rules, waivers and press releases.
- Things remain influx.
- Heed the wisdom of CMS: “our non-specificity provides the flexibility.”

Acronyms

- PHE = Public Health Emergency.
- NPP = Non-physician Practitioner.
- PA = Physician Assistant.
- NP = Nurse Practitioner.
- CNM = Certified Nurse Midwife.
- CNS = Clinical Nurse Specialist.

Acronyms

- PBD = Provider-based Department.
- IFC = Interim Final Rule April 30, 2020.
- IPF = Inpatient Psychiatric Facility.
- IRF = Inpatient Rehab Facility.
- CCN = CMS Certification Number.
- PHP = Partial Hospitalization Program.

Stark

- Newest waiver info:

<https://www.cms.gov/files/document/explanatory-guidance-march-30-2020-blanket-waivers-section-1877g-social-security-act.pdf>

Don't Ask Me, Why?

- “Some parties inquired whether a physician could repay a loan in kind through the provision of professional or other services to the entity making the loan, or whether an entity could repay a loan in kind through the provision of office space, items, or services to the physician lender.”
- “Nothing in either of the exceptions identified in the inquiries requires cash payments to satisfy a borrower’s debt to a lender.”

Home Health Value Based Purchasing

- A mandatory program for all Home Health Agencies (HHAs) in AZ, FL, IA, NE, NC, TN, MD, MA and WA.
- IFC aligns reporting for the value-based program with the traditional HHA Quality Reporting Program (QRP).
- Any exceptions and extensions granted for the QRP (or granted in the future during the PHE) are also granted for the HHAs in the value-based purchasing program.
- Also granting exceptions to New Measure reporting for HHAs in the value-based purchasing program during the PHE (April July 2020 submission periods). See 42 CFR 484.315(b).

Scope of Practice

- CMS continues to loosen restrictions for Medicare purposes.
- Note state law.

Supervision of Diagnostic Tests

- “Of course” follow 42 CFR § 410.75.
- Pre-PHE, NPs, CNSs, PAs, and CNMs could order, but not supervise, diagnostic tests. Only physicians could supervise.
- During the PHE, NPs, CNSs, PAs, and CNMs may supervise diagnostic tests, if state law allows it.

Ordering of Diagnostic Tests

- Pre-PHE, diagnostic tests could only be ordered by the treating physician or the treating non-physician practitioner (NPP).
- During the PHE, COVID-19 and certain other* diagnostic tests will be covered when ordered by any health care professional who is authorized by state law.

Ordering of Diagnostic Tests

*CMS will publish a list of tests that may be ordered by non-physician practitioners (NPPs). It will include tests for influenza and respiratory syncytial virus, when furnished in conjunction with a COVID-19 test.

Opioid Treatment Programs (OTPs)

- In the first IFC, CMS allowed therapy and counseling portions of the weekly bundle of services by OTPs, and add-on codes for additional counseling or therapy, to be furnished by audio-only telephones (i.e., no need for A/V technology) during the PHE.
- In the 4-30-2020 IFC, CMS is additionally permitting OTPs to do the “periodic assessment” services (G2077) to be provided by telehealth, or audio-only if no access to audio-visual technology and it is clinically appropriate.

Therapy Student Documentation

- 2020 PFS “allowed” PAs, NPs, CNSs, CNMs and CRNAs to review and verify rather than redocument information.
- During the PHE any individual who has “a separately enumerated benefit under Medicare” may review and sign rather than redocument.
- “We note that although there are currently no statutory or regulatory documentation requirements that would impact payment for therapists when documentation is added to the medical record by persons other than the therapist, we are discussing this issue in response to stakeholder concerns about burden and in consideration of the current COVID-19 PHE.” P. 26.

Physical Therapy Assistants

- Historically, maintenance therapy could not be billed by a PT or OT if it is provided by a PTA or OTA.
- During PHE if PT or OT establishes a maintenance program, PTAs or OTAs may provide maintenance therapy.

PT/OT/SLP and Telehealth

- Not in the rule, but now allowed.
- Incident to always worked.*
- Now explicit hospitals can bill it.

“Incident to” Changes

- Pharmacists can provide services incident to.
- COVID testing can be done using 99211 even for new patients.

Relocating PBDs

- “PBD” = Provider-based Department
- Background: Services provided at off-campus provider-based departments established on or after November 2, 2015, are paid at Physician Fee Schedule rate. On-campus and “excepted” off-campus PBDs are paid under the OPPS.

Temporary “Extraordinary Circumstances” Relocation Policy

- During the PHE, on-campus PBDs (or “excepted” off-campus PBDs) that temporarily relocate off-campus during the PHE for purposes of addressing COVID-19 will still be “excepted” – i.e., paid under the OPPS – if the relocation is not inconsistent with the state pandemic plan.

Process for Temporary Relocation

- No enrollment update required (if PBD services are billed under the main hospital);
- May begin furnishing and billing under the OPPS in the new location prior to notifying the Regional Office (RO);
- Use modifier “PO” for OPPS claims; and
- Notify the RO by email of the relocation.

Notification to Regional Office

- Email notification should include (i) hospital CCN; (ii) addresses of current and relocated PBD; (iii) start date of services at relocated PBD; (iv) brief justification for relocation and role of relocation in hospital's response to COVID-19; (v) why the location is appropriate for outpatient services; and (vi) attestation the relocation is not inconsistent with state emergency/pandemic plan.

Relocation of PBD to Patient's Home

- During the PHE, a hospital may relocate to an off-campus PBD that is otherwise the patient's home: i.e., it may register and treat outpatients at their homes (for some services).
- Hospitals need not submit a relocation request for each outpatient treated at home. A hospital need only submit one such unique relocation request.

Dividing a PBD into Multiple Locations

- Can relocate the *entire* PBD to multiple off-campus locations; and
- Can relocate *part* of the PBD to one or more new locations while maintaining original location.
- Heed the wisdom of CMS: “our non-specificity provides the flexibility.”

But then again...

- “[W]e anticipate most multi-relocations or partial relocations would be to a *limited number* of locations as needed to respond to the COVID-19 PHE...with the exception being multiple relocations to accommodate care in patient’s homes.

- [cont.] We also expect hospitals exercising this flexibility to be able to support that the excepted PBD is still the same PBD, just split into more than one location. For example, if the excepted PBD was an oncology clinic, we would expect that the relocated PBD(s) during the COVID-19 PHE would still be providing oncologic services, including in the patient's home to the extent such location is made provider based to the hospital.”

What's this about the patient's home?

- Three categories of outpatient services may be provided with the PBD as the patient's home:
- (1) hospital outpatient therapy, education, and training services, including PHP services, that can be furnished remotely; (2) hospital outpatient clinical staff services furnished in-person to the beneficiary; and (3) hospital services associated with a professional service delivered by telehealth.

(1) Remote Outpatient Therapy, Training, and Education

- Certain PHP services: Individual psychotherapy, patient education, and group psychotherapy.
- CMS will publish a list of permitted services.

(2) In-Person Services at a Temporary Location

- E.g., wound care, chemotherapy and drug administration.
- Waiving direct supervision requirement.
- HHA may not provide services in a hospital. Must be temporal demarcation between outpatient hospital services and home health.
- Hospital may not furnish services that may be furnished by an HHA.

(3) Payment for Facility Fee for Telehealth

- Typically, a hospital bills separately to be paid for the clinical labor, equipment, overhead, and capital to support the delivery of the professional service.
- During the PHE, when a patient's home is considered a PBD, it may be an originating site for the telehealth service and paid a facility fee.

Residency Programs/Medical Education

- Indirect Medical Expense (IME) based on resident-to-bed ratio.
- Bed count fixed at 1/30/20.
- IRF or IPF status adjustment is so fixed to that date.

Resident Time at Other Hospitals

- Time at another hospital is counted at the approved site/base hospital if:
 - Resident was sent due to COVID-19.
 - The activities would count if done at the approved training site.
 - Time by the resident immediately prior to and post PHE is included in base hospital's count.

Rural Health Clinics (RHCs)

- RHCs that are integral and subordinate part of a CAH are exempt from the All-Inclusive Rate (AIR). If bed count increases above 50 due to COVID, the RHC may remain exempt.

RHC and FQHC Staffing

- Currently an NP, PA or CNW must be available 50% of the time an RHC operates. That requirement is being waived.
- A physician, NP, PA, CNW, CSW or psychologist must be available at all times.

Care Planning for Medical Home Health Services

- CARES Act allows NPs, CNSs, and PAs to order and certify patients for the Medicare home health benefit and to establish and review the home health plan of care.
- This IFC makes these permanent changes effective March 1, 2020.

Teaching Physician Issues

- Expanding codes for the primary care exception. Codes 99441-99443, 99495-96, 99241-99243, 99452, G2012, G2010.
- May be based on MDM or time.
- Only applies to primary care exception. Claims of relaxed supervision for other teaching services are mistaken.

FLY
SUX



Audio Only Telephone Evaluations

- Increasing reimbursement for Codes 99441 (5-10 minutes), 99442 (11-20 minutes) and 99443 (21-30 minutes).
- Cross walk to 99212, 99213 and 99214.
- Retro to 3/1. Must you resubmit?

Medicaid Lab Services

- Families First Act added a new mandatory Medicaid benefit for Medicaid coverage of COVID-19 lab (disease or antibody) and x-ray tests.
- IFC removes the requirements that the COVID-19 test be performed in the office and also permits coverage for self-collected lab test systems.
- Flexibility applies during the PHE and any period of “active surveillance.”

Medicaid Home Health Services

- CARES syncs who may order HH for Medicare and Medicaid.
- Not limited to PHE.
- Permit NPPs to order “DME.” (Really “supplies”.)
- Remove obligation on NPP to report to physician.

NCD/LCD

- “Articles are often published alongside LCDs and containing coding or other guidelines that complement an LCD. NCDs and LCDs contain critical conditions a patient must meet to qualify for coverage of the item or service.” P. 157. That statement is mistaken. (See next slide.)
- Concern the first IFC was misinterpreted as waiving all medical necessity requirements.

AseraCare: Role of LCDs

- “The district court correctly stated in its instructions to the jury that LCDs are ‘eligibility guidelines’ that are not binding and should not be considered “the exact criteria used for determining” terminal illness.”
 - *United States v. Aseracare, Inc., et al.*, 938 F.3d 1278, 1288 (11th Circ. 2019)

Delay in Reporting Requirements for IRF, LTCH, HHAs and SNFs

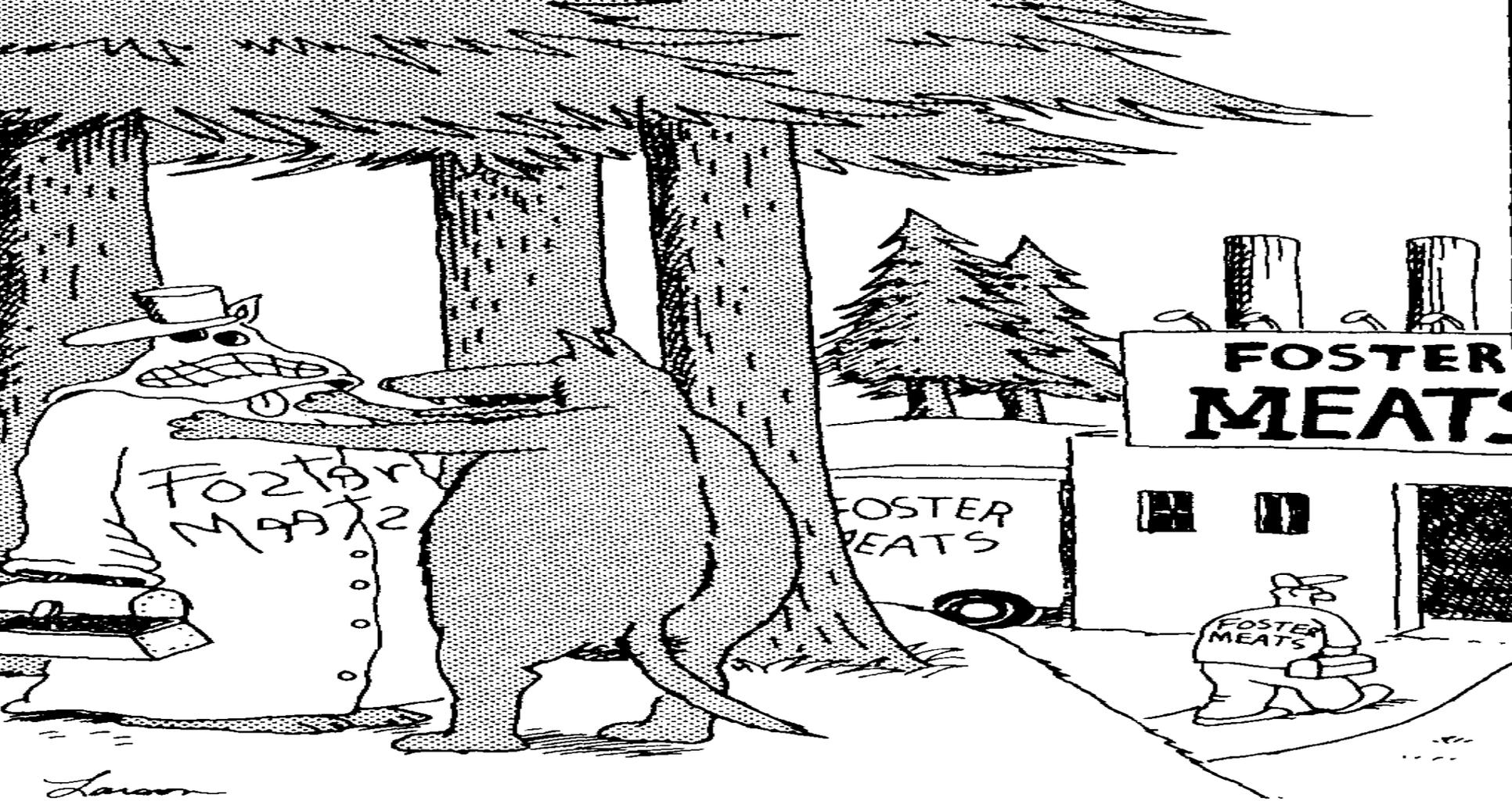
- IRFs to use IRF-PAI V4.0 and LTCHs to use LTCH CARE Data Set V5.0, collect data on the SPADEs for admissions and discharges (except for the hearing, vision, race, and ethnicity SPADEs) second October 1st following PHE.
- HHAs will be required to use OASIS-E second January 1 post PHE.

Serology Testing

- During the PHE, Medicare will cover FDA-authorized COVID-19 serology (antibody) tests that are reasonable and necessary.
- There won't be an NCD for this.
- 42 CFR 410.32 is amended to reflect this.

SNF Required to Report Resident and Staff Infection

- Both confirmed or suspected cases.
- By 5 PM the next calendar day for either:
 - Single confirmed infection or
 - Three or more residents/staff with new onset respiratory services occurring within 72 hours.
- Report may not include personally identifiable information.



“OK, let’s take a look at you.”

Time for Choosing E/M

- Use the CPT typical times.
- This varies from typical times in the public use file.
- Note this applies to clinic/outpatient only, not inpatient hospital E&M.

Updated Telehealth List

- CMS.gov will list services.
- That list is illustrative, not exhaustive.

Remote Physiologic Monitoring (RPM)

- 99091, 99453-4 and 99457-8 historically cannot be reported for <16/30 days.
- If patient has confirmed or suspected COVID, will pay with at least 2 days.

Modifications to SNF QAPI Program, 483.75(b)-(d)

- CMS modifying Quality Assurance and Performance Improvement (QAPI) regulations to narrow QAPI program requirements to focus on adverse events and infection control.

In-Service Training

- 483.95(g)(1) requires SNFs and NFs, to give nursing assistant 12 hours of in-service training. Postponed until first full quarter after the declaration of the PHE concludes.

Discharge Planning for LTCs

- 483.21(c)(1)(viii), which requires facilities to assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use.
- All other requirements remain.

HHAs

- 12-hour annual service training for Home Health Aides postponed until the end of first full quarter post-PHE.
- Waiving § 484.58(a) requiring a detailed discharge plan.
- Allowing 10 days, rather than 4, to provide copies of medical records.

HHA/Hospice

- Annual on-site visit (§ 418.76(h)(2)/ § 484.80(h)(1)(iii)) waived until 60 days post-PHE.
- Quality assurance and performance improvement changes.
- Annual assessment (§ 418.100(g)(3)) waived until first full quarter post-PHE.

ASCs

- Need not reappraise medical staff annually during PHE. Medical staff members whose privileges expired may continue to practice during PHE.

Community Mental Health Centers

- New flexibility for CMHCs to focus on PHE-related matters in the QAPI program.
- CMHCs may provide PHP and other services in a patient's home during the PHE.
- Waiver of requirement that CMHC provide at least 40 percent of items and services to patients who are not eligible for Medicare benefits.



Questions for the Presenters:



David Glaser
612.492.7143
dglaser@fredlaw.com



Katherine Ilten
612.492.7428
kilten@fredlaw.com

