Wynne Health Group

Memorandum

April 30, 2020

IN FOLLOW UP TO FIRST SET, CMS ANNOUNCES ADDITIONAL WIDE-REACHING FLEXIBILITIES FOR PROVIDERS TO AID THE COVID-19 RESPONSE

In follow-up to its March 31st interim final rule with comment period (IFC) (WHG summary here), the Centers for Medicare & Medicaid Services (CMS) **announced a second set of wide-reaching changes in response to the COVID-19 pandemic**.

- **What it is.** CMS is effectuating these changes through a combination of its IFC rulemaking authority and its application of 1135 blanket waiver authority, the latter of which having been broadened by the recently passed CARES Act.

- **Why it is important for you.** Broadly, these changes feature several augmentations of previously instituted reforms (e.g., clarifying or modifying billing rules for new temporary services) as well as brand new policies in response to continued stakeholder feedback. Of note, CMS is instituting changes aimed at improving diagnostic testing, including flexibilities around ordering COVID-19 tests for beneficiaries and covering certain serology tests. CMS is also instituting new policies to support its *CMS Hospitals Without Walls* initiative – including allowing payment for outpatient hospital services in temporary expansion locations (e.g., parking lot tents). To support providers responding to the pandemic, CMS is making certain health care workforce modifications and is also eliminating several administrative requirements that could delay care.

  Of critical note, CMS is also making even more expansive changes to current telehealth regulations to support this modality during the public health emergency. For example, CMS is expanding the list of eligible providers that can furnish telehealth services, as well as broadening the list of services that providers can furnish via audio-only technologies (i.e., telephones). CMS is also planning to expedite the process by which it adds new services to the approved Medicare telehealth list through using a subregulatory process that bypasses the standard notice and comment procedures.

- **Potential next steps.** Comments on this IFC are due within 60 days of when it is published in the *Federal Register*, likely to occur in the next few days. However, the provisions contained in the rule will be effective immediately upon publication. Applicability dates for each provision are retroactive back to either March 1, 2020, January 27, 2020, or otherwise, as detailed in the table on p. 4 of the preview copy. Please note that **comments for the March 31st IFC are separate** and still due according to that timeline (i.e., June 1, 2020).

  The new 1135 blanket waiver authorities are applicable beginning on March 1, 2020.

Details on these blanket waivers and the IFC provisions follow and are also attached.

CMS has added several new blanket waivers to its running list, previously updated on April 21, 2020. These new flexibilities are indicated in red in the CMS document and are outlined in the table below.

Table: Blanket Waivers Updated on April 30, 2020 (full text here)

Waiver Category	Waiver Description
Telehealth (*p. 1*)	CMS is allowing: • An **expanded list of providers** to furnish telehealth services under Medicare, including physical therapists, occupational therapists, speech language pathologists, and others. • Providers to furnish certain telehealth services to patients using **audio-only technologies** (i.e., telephones) for evaluation and management services, and behavioral health counseling and educational services.
Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (*p. 9)*	• CMS is waiving in part the regulation that requires a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish care at least 50 percent of the RHC operation time. CMS intends this to address potential staffing shortages.
Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs) (*p. 16*)	CMS is: • Modifying certain quality assurance and performance improvement (QAPI) requirements to narrow the scope of the QAPI program to focus on adverse events and quality control. • Postponing the deadline for completing the nurse aide training requirements that require nursing assistants to receive at least 12 hours of in-service training annually. CMS is postponing the deadline until the end of the first full quarter after the public health emergency concludes. • Allowing facilities to expedite discharge and movement of residents across care settings by waiving the regulation requiring LTC facilities to support residents' selection of a post-acute care provider using several data inputs. • Waiving the regulation requiring LTC facilities to provide a copy of their records to residents within two working days following a resident's request. CMS is now temporarily requiring that facilities provide a copy of requested records **within ten working days.**
Home Health Agencies (HHAs) & Hospice (*p. 17-18*)	CMS is: • Waiving several changes pertaining to HHAs, including 12-hour annual in-service training requirements for home health aides, and requirements to provide detailed information currently required for discharge planning. • Extending the deadline for when an HHA must provide a patient with a copy of any requested medical records from four business days to ten business days. • Postponing the deadline for completing onsite assessments that registered nurses or other professionals must make for each aide that provides services on behalf of the agency. Assessments must now be completed no later than 60 days following the conclusion of the public health emergency. • As with SNFs, CMS is modifying HHA QAPI requirements such that they must now concentrate only on infection control issues.

Hospice (*p. 19*)	• CMS is postponing the deadline for hospices to conduct annual assessments of providers' skills and competence until the end of the first full quarter of the public health emergency's conclusion.
Physical Environment for Multiple Providers/Suppliers (*p. 23*)	• CMS is permitting facilities to adjust scheduled inspections, testing and maintenance (ITM) frequencies and activities for facility and medical equipment. Specifically waived requirements are further detailed on p. 23.
Ambulatory Surgical Centers (*p. 25*)	• CMS is waiving the requirement that medical staff privileges must periodically be reappraised, and that the scope of procedures performed must be periodically reviewed.
Community Mental Health Centers (CMHCs) (*p. 25*)	CMS is: • Requiring CMHC QAPI efforts to focus only on the challenges and opportunities for improvement during the public health emergency. • Allowing CMHCs to provide partial hospitalization services and other CMHC services in an individual's home. Accompanying billing information is contained in the corresponding interim final. • Waiving the requirement that CMHCs provide at least 40 percent of its items and services to individuals not eligible for Medicare.

In addition to these new blanket waiver authorities, please find **below a summary of the provisions contained in the IFC** (full text here).

- **Reporting Under the Home Health Value-Based Purchasing Model for CY 2020 During the COVID-19 Public Health Emergency** – The interim final rule aligns Home Health Value-Based Purchasing (HHVBP) Model data submission requirements for home health agencies (HHAs) with any exceptions or extensions allowed for the Home Health Quality Reporting Program (HHQRP) during the Public Health Emergency (PHE) for COVID-19. In addition, the interim final rule allows CMS to grant exceptions to New Measure reporting requirements (for the April 2020 and July 2020 submission periods) for HHAs participating in the HHVBP Model during the PHE for COVID-19. See pp. 15-19 more details, including a discussion of policy considerations for future rulemaking.

- **Scope of Practice** – On pp. 19-27, the interim final rule makes several policy changes intended to expand the number of health care professionals able to furnish COVID-19 related tests and services.

    - **Diagnostic Tests** – The interim final rule allows a nurse practitioner, clinical nurse specialist, physician assistant, or a certified nurse-midwife to order, furnish directly, and supervise the performance of COVID-19 related diagnostic tests, subject to applicable scope of practice state laws, during the PHE. In addition, the interim final rule requires the physician or qualified NPP order the diagnostic test to document medical necessity in the beneficiary's medical record.

    - **Therapy** – The interim final rule allows an occupational therapy assistant (OTA) or physical therapy assistant (OTA) to furnish "maintenance therapy" services during the PHE.

- **Student Documentation** – The interim final rule allows qualified clinicians to review and verify, rather than re-document, notes in the medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team during the PHE.

- **Pharmacists** – The interim final rule allows pharmacists to work with a physician or other qualified non-physician practitioner (NPP) to provide assessment and special collection services, under the supervision of the billing physician or NPP, if the service is not reimbursed under the Medicare Part D benefit during the PHE.

To better understand the scope of impact of these changes, CMS is seeking public feedback on the number of states where these changes would be implemented.

- **Modified Requirements for Ordering COVID-19 Diagnostic Laboratory Tests** – The interim final rule temporarily eliminates the requirement that the treating physician or NPP order a covered diagnostic laboratory test for COVID-19 or for influenza virus or a similar respiratory condition. During the PHE, any healthcare professional authorized under state law to do so can order such tests, and they will be covered by Medicare. CMS will publish a list of covered diagnostic laboratory tests for which ordering requirements are modified. See pp. 27-31 for more details.

- **Opioid Treatment Programs (OTPs) – Furnishing Periodic Assessments via Communication Technology** – During the PHE, the interim final rule allows OTPs to furnish periodic assessment via two-way interactive audio-visual communication technology or audio-only telephone calls, if the beneficiary lacks access to audio-video community technology, during the PHE. See pp. 32-33 for a list of COVID-19 related resources from the Substance Abuse and Mental Health Services (SAMHSA).

- **Treatment of Certain Relocating Provider-Based Departments During the COVID-19 PHE** – The interim final rule temporarily expands the "extraordinary circumstances relocation policy" to include on-campus provider-based departments that relocate off-campus during the PHE in order to address the COVID-19 pandemic. Specifically, on-campus departments that relocate on or after March 1, 2020 through then end of the PHE may bill at the OPPS rate, provided the relocation is consistent with the state's emergency preparedness or pandemic plan. See pp. 33-43 for more details.

- **Furnishing Hospital Outpatient Services in Temporary Expansion Locations of a Hospital or a Community Mental Health Center (including the Patient's Home)** – Beginning on p. 46, the interim final rule clarifies the following:

    - Hospital and Community Mental Health Center (CMHC) staff can furnish certain outpatient therapy, counseling, and educational services to a beneficiary in their home or other temporary expansion location using telecommunications technology if the beneficiary is registered as a hospital outpatient;
    - Hospitals can furnish clinical services (e.g., drug administration) in the patient's home and bill and be paid for these service if the patient is registered as an outpatient;
    - A hospital may bill the originating site facility fee for the delivery of a professional service via telehealth to a patient registered as an outpatient.

- **Medical Education** – For the purposes of calculating the indirect medical education (IME) adjustment, the interim final rule allows a hospital's available bed count to be the same as it was on the day before the PHE was declared. Similarly, the teaching status adjustment payment for inpatient rehabilitation facilities and inpatient psychiatric facilities will remain the same as it was on the day before the PHE was declared. In addition, the interim final rule allows a hospital that sends its residents to train at another hospital to claim those FTE residents on its Medicare cost report if it meets certain conditions listed on p. 67.

- **Rural Health Clinics (RHCs)** – The interim final rule changes the period of time used to determine the number of beds in a hospital for purposes of determining which provide-based RHCs are subject to the national per-visit payment limit. CMS will use the number of beds from the cost reporting period prior to the start of the PHE as official hospital bed count.

- **Durable Medical Equipment (DME) Interim Pricing in the CARES Act** – Beginning on p. 69, CMS details that section 3712 of the CARES Act revises the fee schedule amounts for certain DME and enteral nutrients, supplies, and equipment furnished in non-competitive bidding areas (CBAs), other than former CBAs, through the duration of the COVID-19 PHE. CMS notes that this provision of the law was written in a way that is ambiguous and mandates two different and conflicting effective dates for the increase in fee schedule amounts in non-rural and contiguous non-CBAs. Therefore, to aid suppliers in furnishing items, CMS is implementing the earlier effective date of March 6, 2020 and revising regulations to implement the higher fee schedule amounts required under the CARES Act.

- **Care Planning for Medicare Home Health Services** – Pursuant to the CARES Act, the rule allows for nurse practitioners (NPs), certified nurse specialists (CNSs), physician assistants (PAs) to practice to the top of their state licensure to order and certify patient eligibility for Medicare home health services, as well as establish and periodically review the requisite home health plan of care – tasks previously only allowable by a physician. Such items and services prescribed by an NP, CNS, or PA will be payable under the home health prospective payment system (HH PPS) effective upon publication of the IFC and will be retroactively applicable to March 1, 2020. CMS states this "is imperative during the PHE for the COVID-19 pandemic as more beneficiaries may be considered "homebound." See p. 77-79 for more detail.

- **Care Planning for Medicaid Home Health Services** – Beginning on p. 145, CMS implements the CARES Act home health provisions, which allows NPs, CNSs, and PAs to order home health services for Medicaid beneficiaries. Through the IFC, CMS is also amending current home health regulation to remove the requirement that advanced practitioners have to communicate the clinical finding of the face-to-face encounter to the ordering physician. These revisions to the Medicaid home health program will remain permanently in effect.

  CMS also notes that the Medicaid program is to implement these changes "in the same manner and to the same extent as such requirements apply" under Medicare. To better align the Medicare and Medicaid programs, CMS is amending Medicaid home health regulations to allow other licensed practitioners (NPs, CNSs, and PAs) to order medical equipment, supplies, and appliances in addition to physicians, when practicing in accordance with state laws.

- **CARES Act Waiver of the "3-Hour Rule" –** Beginning on p. 80, CMS makes a technical change to rescind provisions of the previous IFC published on March 31, 2020 because provisions of the CARES Act that were implemented later supersede the previous guidance. The

agency clarifies further that the "3-Hour Rule" waiver afforded under the CARES Act (and outlined further on p. 10 here) is not limited to particular inpatient rehabilitation facilities (IRFs) or patients, and therefore, is available during the emergency period regardless of whether a patient was admitted for standard IRF care or to relieve acute care hospital capacity.

- **Modification of IRF Coverage and Classification Requirements for Freestanding IRF Hospitals for the PHE During the COVID-19 Pandemic –** Also on p. 80, CMS addresses amendments to certain regulatory requirements made in order to waive the requirement to complete a post-admission physician evaluation during the COVID-19 PHE for care furnished to patients admitted to freestanding IRF hospitals (identified as those facilities with the last 4 digits of their Medicare provider numbers between 3025 through 3099). The agency makes this change in recognition of billing difficulties encountered by IRFs not connected to a broader IPPS hospital, to relieve acute care hospital capacity during the COVID-19 PHE. CMS adds that the flexibilities in this IFC are available for freestanding IRF hospitals admitting patients in support of acute care hospitals when the state is in phase 1 or prior to entering phase 1, but are no longer available to the freestanding IRF hospital when the state is in phase 2 or phase 3 of the Administration's the Guidelines for Opening Up America Again (details). See pg. 82 for additional details and instructions.

- **Medicare Shared Savings Program –** Due to the lack of predictability for Accountable Care Organizations (ACOs) regarding the impact of COVID-19 on future expenditures and revenue, CMS is modifying Shared Savings Program policies to:

    - Allow ACOs whose current agreement periods expire on December 31, 2020, the option to extend their existing agreement period by one year;
    - Allow ACOs in the BASIC track's glide path the option to elect to maintain their current level of participation for PY 2021;
    - Clarify the applicability of the program's extreme and uncontrollable circumstances policy to mitigate shared losses for the period of the COVID19 PHE (see p. 93);
    - Adjust program calculations to mitigate the impact of COVID-19 on ACOs; and
    - Expand the definition of primary care services for purposes of determining beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication.

  Additionally, beginning on p. 127, CMS addresses how these adjustments to program policies will apply to ACOs participating in the now discontinued Track 1+ Model. As of January 1, 2020, CMS notes there are 20 Track 1+ Model ACOs participating in performance year 3 of a 3-year agreement under the model. See p. 129 for additional detail.

- **Additional Flexibility under the Teaching Physician Regulations** – Starting on p. 130, CMS expands on flexibilities that were offered to teaching physicians and residents in the March 31, 2020 IFC, to allow that, on an interim basis for the duration of the PHE for the COVID-19 pandemic, a teaching physician may not only direct the care furnished by residents remotely, but also review the services provided with the resident, during or immediately after the visit, remotely through virtual means via audio/video real time communications technology. Additionally, the rule adds additional services to the primary care exception so that Medicare may make PFS payment to the teaching physician for such services when furnished by a resident. See p. 135 for a full list of the relevant CPT codes.

- **Payment for Audio-Only Telephone Evaluation and Management Services –** In the March 31 IFC, CMS established separate payment for audio-only telephone evaluation and management (E/M) services (CPT Codes 99441, 99442, 99443). Since that time, CMS says it has learned that use of audio-only services is more prevalent than it had previously considered and is serving as a substitute for office/outpatient Medicare telehealth visits for beneficiaries not using video-enabled telecommunications technology. Therefore, in this new IFC, CMS establishes new relative value units (RVUs) (i.e. higher reimbursement rates) for the telephone E/M services based on crosswalks to the most analogous office/outpatient E/M codes. See the discussion at the bottom of pg. 139 for the revised RVUs.

- **Flexibility for Medicaid Laboratory Services** – Section 6004(a) of the Families First Coronavirus Response Act (FFCRA), as amended by the CARES Act, added a new mandatory benefit in the Medicaid statute that, for any portion of the COVID-19 emergency period, Medicaid coverage must include in vitro diagnostic products and serological antibody tests. The IFC amends certain regulations relating to limitations and conditions on Medicaid coverage of laboratory tests and X-rays in order to permit flexibility for coverage of COVID-19 tests. Specifically, the rule addresses barriers to coverage for tests administered in non-office settings (e.g. such as parking lots or other temporary outdoor locations), and coverage for laboratory processing of self-collected COVID-19 tests that are FDA-authorized for self-collection. CMS states that this flexibility will apply not only during the current COVID-19 PHE, but also during any subsequent periods of active COVID-19 surveillance, as part of strategies to detect recurrence of the virus and further spread of the disease. Furthermore, the change is not limited to the COVID-19 PHE and subsequent period of surveillance, but would apply to future PHEs resulting from outbreaks of other communicable diseases. See p. 141.

- **Basic Health Program Blueprint Revisions** – Beginning on p. 150, CMS notes that states may need to revise certain provisions or add certain provision to their basic health program (BHP) Blueprint to ensure enrollees have access to necessary services without delay during the COVID-19 pandemic. CMS details that this process typically needs certification from the HHS Secretary before the changes can be implemented. To accommodate these revisions, CMS is allowing states to submit a revised Blueprint that makes temporary changes to the BHP to respond to the PHE for COVID-19, with the option for states to make such changes retroactive to the start of the PHE. CMS stipulates that states submit a cover letter to the agency that lists each change for which it is seeking certification and how the change is related to COVID-19.

- **Merit-based Incentive Payment System (MIPS) Qualified Clinical Data Registry (QCDR) Measure Approval Criteria** – Beginning on p. 151, CMS notes that QCDRs are anticipating being unable to complete QCDR measure testing or collect data on QCDR measures for the 2021 MIPS performance period. Therefore, CMS is the delaying the implementation of the completion of the QCDR measure testing policy and the collection of data on QCDR measures for 1 year. Beginning with the 2022 performance year, CMS will require all QCDR measures to be fully developed and tested prior to submitting the measure and QCDRs are required to collect data on a QCDR measure prior to submitting the measure for CMS consideration during the self-nomination period.

- **Application of Certain National Coverage Determination and Local Coverage Determination Requirements during the PHE for the COVID-19 Pandemic** – Beginning on p. 157, CMS details that they previously finalized, on an interim basis, that the face-to-face or in-person

encounter requirements would not apply during the PHE for the COVID-19 pandemic. In this IFC, CMS clarifies that the agency did not waive the medical necessity requirements and reminds physicians, practitioners, and suppliers that most items and services must be reasonable and necessary for the diagnosis and treatment of an illness, or injury, or to improve the functioning of a malformed body member to be paid under Part A and Part B of Medicare.

- **Delay in the Compliance Date of Certain Reporting Requirements Adopted for IRFs, LTCHs, HHAs and SNFs** – Beginning on p. 159, CMS outlines the numerous new quality measures that IRFs, LTCHs, HHAs, and SNFs are required to begin collecting with discharges on or after October 1, 2020. Due to the COVID-19 PHE, CMS is delaying the collection of data on these measures beginning with discharges on October 1 of the year that is at least 1 full fiscal year after the end of the COVID-19 PHE.

- **Update to the Hospital Value-Based Purchasing (VBP) Program Extraordinary Circumstance Exception (ECE) Policy** – Beginning on p. 164, CMS details that in 2014, the agency finalized an ECE policy for the Hospital VBP Program to mitigate any adverse impact on quality performance as a direct result of unforeseen circumstances outside of the hospital's control and the resulting impact on their value-based incentive payment amounts. Due to the overwhelming and widespread nature of the COVID-19 PHE, CMS is updating the ECE policy to include the ability to grant exceptions to hospitals located in entire regions without a request, rather than individual hospitals submitting requests. CMS notes that the agency will communicate the decision to hospitals when the determination to grant an exception to all hospitals in a region has been made.

- **COVID-19 Serology Testing** – Beginning on p. 168, CMS finalizes, on an interim basis, that FDA-authorized COVID-19 serology tests fall under the Medicare benefit category of diagnostic laboratory test and are eligible to be covered by the Medicare program. CMS explains that serology tests may potentially aid in identifying patients who have had an immune response to COVID-19 infection and are therefore immune and do not pose a risk to the community.

- **Modification to Medicare Provider Enrollment Provision Concerning Certification of Home Health Services** – Beginning on p. 170, CMS codifies Section 3708 of the CARES Act, which authorizes nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) to certify the need for home health services. CMS notes they are implementing these statutory changes in the IFC, rather than the notice-and-comment making rulemaking, to provide the necessary flexibility during the PHE.

- **Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges: Separate Billing and Segregation of Funds for Abortion Services** – Beginning on p. 172, HHS is delaying the implementation of the separate billing policy for qualified health plans (QHPs) for 60 days from the effective date included in the "Patient Protection and Affordable Care Act; Exchange Program Integrity" final rule. This pushes the QHP separate billing compliance date to August 26, 2020.

  Additionally, HHS details that under the separate billing policy finalized in the 2019 Program Integrity Rule, issuers of individual market QHPs are required to begin separately billing policy holders for the portion of the policy holder's premium attributable to non-Hyde abortion services on June 27, 2020. However, in light of the COVID-19 PHE, HHS is delaying the implementation of the separate billing policy for 60 days. The new compliance date is August 26, 2020.

HHS notes that it will continue to monitor QHP ability to comply with the new deadlines and will consider exercising discretion if a QHP fails to timely comply with the separate billing policies.

- **Requirement for Facilities to Report Nursing Home Residents and Staff Infections, Potential Infections, and Deaths Related to COVID-19** – Beginning on p. 178, CMS establishes explicit reporting requirements for confirmed or suspected cases of COVID-19 in long term care facilities to support surveillance efforts. The report, that is to be submitted to the Centers for Disease Control and Prevention (CDC), should include the following information:

    - Suspected and confirmed COVID-19 infections among residents and staff; including residents previously treated for COVID-19;
    - Total deaths and COVID-19 deaths among residents and staff;
    - Personal protective equipment and hygiene supplies in the facility;
    - Ventilator capacity and supplies available in the facility;
    - Resident beds and census;
    - Access to COVID-19 testing while the resident is in the facility;
    - Staffing shortages; and
    - Other information specified by the HHS Secretary.

    CMS notes that facilities will be required to provide the information at a frequency specified by the HHS Secretary, but no less than weekly. Additionally, the agency notes that the information will be shared CMS and the information will be publicly reported.

    CMS will also require facilities to inform residents, their representatives, and families of those residing the in facilities of confirmed or suspected COVID-19 cases in the facility among residents and staffs. CMS explains that this requirement ensures that all residents are informed participants in the care that they receive.

- **Time Used for Level Selection for Office/Outpatient Evaluation and Management CMS-5531-IFC 10 Services Furnished Via Medicare Telehealth** – In its previous March 31st IFC, CMS revised its policy to specify that office/outpatient E/M level selection for telehealth services can be based on MDM or time, with time defined as all the time associated with the E/M on the day of the encounter. In the IFC, CMS further clarifies that the times to use for level selection are those listed in the CPT code descriptor. The typical times associated with the office/outpatient E/M visits are available as a public use file here. See p. 182 for more.

- **Updating the Medicare Telehealth List** – CMS states that, for the duration of the public health emergency, it will now use a subregulatory process to modify the services included on the Medicare telehealth list. CMS states it is doing so to expedite the addition of approved services, as the current mechanism for adding new services currently employs the standard notice and comment rulemaking process. Though CMS does not codify the exact subregulatory process it will use to update the telehealth list, it states it may notify providers when it has added new services by posting such information to the web listing of telehealth services. CMS clarifies these services would remain on the list only during the COVID-19 public health emergency. See the discussion beginning at the bottom of p. 182.

- **Payment for COVID-19 Specimen Collection to Physicians, Nonphysician Practitioners and Hospitals** – In the March 31st IFC, CMS established a nominal specimen collection fee and associated travel allowance for independent laboratories that collect specimens for COVID-19 clinical diagnostic laboratory testing. CMS did so for homebound and non-hospital inpatients.

These services are described by CPT code 88211.

In the IFC, CMS further establishes that, for the duration of the COVID-19 public health emergency, providers may furnish such services for both new and established patients. This amends the current billing rules that require providers to have an established relationship wit ha patient before clinical staff can furnish such services.

In addition, CMS is also creating a new E/M code to support COVID-19 testing for hospital outpatient departments (HOPDs) during the public health emergency. The new code is:

> *HCPCS code C9803 (Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]). any specimen source.)*

CMS clarifies that it expects to retire the new code once the public health emergency concludes. See more beginning on p. 184.

- **Payment for Remote Physiologic Monitoring (RPM) Services Furnished During the COVID-19 Public Health Emergency** – CMS is implementing a policy that will now allow RPM monitoring services to be reported to Medicare for periods of time fewer than 16 days of 30 days, (but no less than 2 days). This is in response to several stakeholders reporting that many patients with COVID-19 do not require monitoring for as many as 16 days, states CMS. This flexibility only applies for monitoring of patients with suspected or confirmed cases of COVID-19. CMS further states it is not proposing to alter the payment for associated CPT codes (99454, 99453, 99091, 99457, and 99458). See p. 192 for more.