hfma
healthcare financial management association

HFMA Executive Summary
Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency
March 31, 2020

On Monday, March 30, CMS issued an interim final rule that, for the duration of the COVID-19 public health emergency (PHE)[1], offers providers flexibility by reinterpreting regulations related to telehealth, physician supervision, site of service and other regulatory requirements. CMS believes that providing additional flexibilities to Medicare and Medicaid regulations will help providers combat the COVID-19 pandemic. The following is a summary of provisions included in the interim final rule.

- **Telehealth Payment**: On an interim basis, CMS is adding additional services to the list of eligible Medicare telehealth services, eliminating frequency limitations and other requirements associated with particular services furnished via telehealth, and clarifying several payment rules that apply to other services that are furnished using telecommunications.

  CMS believes that, as more telehealth services are furnished to patients wherever they are located rather than in statutory originating sites, it is appropriate to assume the relative resource costs of services furnished through telehealth should be reflected in the payment to the furnishing physician or practitioner as if they furnished the services in person, and to assign the payment rate that ordinarily would have been paid under the physician fee schedule (PFS) were the services furnished in-person.

  To implement this change on an interim basis, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the point-of-service (POS) code that would have been reported had the service been furnished in person. This will allow CMS's 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.

  Because CMS currently uses the POS code on the claim to identify Medicare telehealth services, 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 notes it is 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.

[1] The definition identifies the PHE determined to exist nationwide by the Secretary of Health and Human services under section 319 of the Public Health Service Act on January 31, 2020, as a result of confirmed cases of COVID-19, including any subsequent renewals.

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- **Telehealth – Additional Covered Services**: CMS is adding approximately **80 telehealth services** (listed in Appendix I) to the list of Medicare-covered telehealth services. Coverage begins for services provided on or after March 1, 2020, and will run through the end of the declared PHE.

  CMS notes that with other services on the Medicare telehealth list, it may not be clinically appropriate or possible to use telecommunications technology to furnish these particular services to every person or in every circumstance.

  The rule also states that the CPT codes describing evaluation and management (E/M) services reflect an assumption that the nature of the work involved in E/M visits varies, in part, based on the setting of care and the patient's status. Consequently, there are separate sets of E/M codes for different settings of care, such as office/outpatient codes, nursing facility codes or emergency department codes.

  CMS expects physicians and other practitioners to use the E/M code that best describes the nature of the care they are providing, regardless of the physical location or status of the patient. Under ordinary circumstances, CMS would expect the kind of E/M code reported to generally align with the physical location or status of the patient.

  Related to therapy services, the rule notes 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.

- **Telehealth Visit Frequency for Inpatient and Nursing Facility Visits:** On an interim basis, CMS is removing the frequency restrictions for some codes related to services subsequent to inpatient visits and to subsequent nursing facility (NF) visits furnished via Medicare telehealth for the duration of the PHE for the COVID-19 pandemic. Additionally, CMS is removing the restriction that critical care consultation codes may only be furnished to a Medicare beneficiary once per day.

  Additionally, CMS is relaxing the requirement that the required clinical examination of the vascular access site for end stage renal disease (ESRD) patients be furnished "hands-on." The rule permits the required clinical examination to be furnished as a Medicare telehealth service during the PHE for the COVID-19 pandemic.

  The codes impacted by the changes in the rule can be found in Appendix II.

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- **Telehealth Modalities**: For the duration of the PHE, *interactive telecommunications system* means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. In addition, the HHS Office for Civil Rights (OCR) is exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the PHE for the COVID-19 pandemic.

- **Telehealth Cost Sharing**: The Office of Inspector General (OIG) issued a Policy Statement 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 services furnished consistent with the then-applicable coverage and payment rules.

  OIG's Policy Statement applies to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management and monthly remote patient monitoring. The Policy Statement applies to a physician or other practitioner billing for services provided remotely through information or communication technology or a hospital or other eligible individual or entity billing on behalf of the physician or practitioner for such services when the physician or other practitioner has reassigned his or her right to receive payments to such individual or entity.

- **Communication Based Technology Services – New Patients**: During the PHE for the COVID-19 pandemic, CMS is finalizing that certain services (G2010 and G2012), which may only be reported if they do not result in a visit (or are not triggered by a related E/M service that was provided in the last seven days by the same physician or other qualified health care worker), including a telehealth visit, can be furnished to both new and established patients. These communication technology-based services (CTBS) include, for example, certain kinds of remote patient monitoring (either as separate services or as parts of bundled services), and interpretations of diagnostic tests when furnished remotely.

  Consent to receive these services can be documented by auxiliary staff under general supervision. While CMS continues to believe that beneficiary consent is necessary so that the beneficiary is notified of any applicable cost sharing, CMS does not believe that the timing or manner in which beneficiary consent is acquired should interfere with the provision of one of these services.

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- **Revising Direct Supervision Requirements**: CMS revises the definition of direct supervision to allow, for the duration of the PHE for the COVID-19 pandemic, direct supervision to be provided using real-time interactive audio and video technology. This change is limited to only the manner in which the supervision requirement can be met, and does not change the underlying payment or coverage policies related to the scope of Medicare benefits, including Part B drugs.

  This change applies to the supervision of diagnostic services furnished directly or under arrangement in the hospital or in an on-campus or off-campus outpatient department of the hospital.

- **Incorporating Telehealth into Home Health Care**: For the purposes of Medicare payment, the rule amends the plan-of-care requirements, to state that the plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system, and that these services cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment. The plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care. Home health agencies (HHAs) can report the costs of telecommunications technology as allowable administrative and general costs on an interim basis by identifying the costs using a subscript between line 5.01 through line 5.19.

- **Incorporating Telehealth into Hospice**: The rule amends the hospice regulations on an interim basis to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for management of a patient's terminal illness and related conditions without jeopardizing the patient's health or the health of those who are providing such services during the PHE for the COVID-19 pandemic. To appropriately recognize the role of technology in furnishing services under the hospice benefit, the use of such technology must be included in the plan of care. The inclusion of technology in the plan of care must continue to meet the requirements, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the measurable outcomes that the hospice anticipates will occur as a result of implementing the plan of care.

  Hospices are paid a per diem payment amount based on the level of care for each day that a patient is under a hospice election. There is no payment beyond the per diem amount for the use of technology in providing services under the hospice benefit. For the purposes of the hospice claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim. However, hospices can report the costs of telecommunications

technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as "other patient care services" using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as "PHE for COVID-19."

- **Telehealth for Hospice Recertifications**: CMS amends the hospice regulations on an interim basis to allow the use of telecommunications technology by the hospice physician or nurse practitioner (NP) for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services during the PHE for the COVID-19 pandemic. By telecommunications technology, CMS means the use of multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient (from home, or any other site permissible for receiving services under the hospice benefit) and distant-site hospice physician or hospice NP. Such encounters solely for the purpose of recertification would not be a separately billed service, but rather considered an administrative expense.

- **Inpatient Rehabilitation Facility (IRF) Physician Face-to-Face Visit Requirement**: CMS believes it is essential to temporarily allow the required physician face-to-face visits to be conducted via telehealth to safeguard the health and safety of Medicare beneficiaries and the rehabilitation physicians treating them. CMS is temporarily revising the IRF regs to state that physician supervision by a rehabilitation physician is required, except that during the PHE, such visits may be conducted using telehealth services
  The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

- **IRF Post-Admission Physician Evaluation Requirement during PHE and 3-Hour Rule Clarification**: CMS amends the IRF regulations to note that the post-admission physician evaluation is not required during the PHE for the COVID-19 pandemic. This does not preclude an IRF patient from being evaluated by a rehabilitation physician within the first 24 hours of admission if the IRF believes that the patient's condition warrants such an evaluation.

  CMS also recognizes that IRFs may have difficulties in meeting the 3-hour therapy requirements because normal staffing shifts may be disrupted as staff who would conduct the therapy program

may have COVID-19, be self-isolated or be unavailable for other reasons related to the PHE. While the 3-hour requirements remain in place, CMS clarifies that in cases where an IRF's intensive rehabilitation therapy program is impacted by the PHE, the IRF should not feel obligated to meet the industry standards referenced in regulations, but should instead make a note to this effect in the medical record.

- **Virtual Communication Services Furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs):** To facilitate the ability of RHCs and FQHCs to communicate with patients virtually when appropriate, CMS is expanding the services that can be included in the payment for HCPCS code G0071, and updating the payment rate to reflect the addition of these services on an interim basis. Specifically, CMS adds the following three CPT codes:

    - 99421 (Online digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes)
    - 99422 (Online digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes)
    - 99423 (Online digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes)

    During the PHE for the COVID-19 pandemic, CMS finalizes that all virtual communication services that are billable using HCPCS code G0071 will also be available to new patients who have not been seen in the RHC or FQHC within the previous 12 months. Also, in situations where obtaining prior beneficiary consent would interfere with the timely provision of these services, or the timely provision of the monthly care management services, consent can obtained when the services are furnished instead of prior to the service being furnished, but must be obtained before the services are billed.

    CMS is also allowing patient consent to be acquired by staff under the general supervision of the RHC or FQHC practitioner for the virtual communication and monthly care management codes during the PHE for the COVID-19 pandemic.

- **Clarification of Homebound Status under the Medicare Home Health Benefit**: The definition of "confined to the home" (that is, "homebound") allows patients to be considered homebound if it is medically contraindicated for the patient to leave the home. As an example for the PHE for COVID-19 pandemic, this would apply for those patients: (1) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or (2) where a physician has determined that it is

medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19. A patient who is exercising "self-quarantine" for their own safety would not be considered "confined to the home" unless a physician certifies that it is medically contraindicated for the patient to leave the home.

- **Revision of Home Health Agency Shortage Area Requirements for Furnishing Visiting Nurse Services**: For the duration of the PHE for the COVID-19 pandemic, any area typically served by the RHC, and any area that is included in the FQHC's service area plan, is determined to have a shortage of HHAs, and no request for this determination is required.

  RHCs and FQHCs should check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care. If a patient is under a home health plan of care, the HHA must provide optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing and rehabilitative needs. Therefore, RHC/FQHC visiting nurse services would not be covered by Medicare if such services are found to overlap with a 30-day period of home health care.

  Finally, the definition of "homebound" is modified to conform with the changes made in the home health regulations described above.

- **Payment for Specimen Collection Related to COVID-19**: CMS will provide for Medicare payment of a nominal specimen collection fee and associated travel allowance to independent laboratories for collection of specimens related to COVID-19 clinical diagnostic laboratory testing for homebound and nonhospital inpatients. The definition of "homebound" is modified to conform with the changes made in the home health regulations described above.

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

  Medicare-enrolled independent laboratories can bill Medicare for the specimen collection fee using one of two new HCPCS codes for specimen collection for COVID-19 testing and bill for the travel allowance with the current HCPCS codes

  To identify specimen collection for COVID-19 testing, CMS established two new level

II HCPCS codes. Independent laboratories must use one of these HCPCS codes when billing Medicare for the nominal specimen collection fee for COVID-19 testing for the duration of the PHE for the COVID-19 pandemic. These new HCPCS codes are:

- G2023, specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source.
- G2024, specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source.

- **Revisions to Teaching Physician Regulations during a PHE for the COVID-19 Pandemic:** For the duration of the PHE for the COVID-19 pandemic, CMS amends the teaching physician regulations to allow that as a general rule, the requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology, as described earlier in this summary. 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. Specifically, CMS believes that when use of such real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means, their ability to furnish assistance and direction could be met without requiring the teaching physician's physical presence for the key portion of the service.

  The rule provides the following examples of when virtual supervision will support the physician supervision requirements to allow resident billing:

  - E/M service provided in primary care centers may be provided under direct supervision of the teaching physician by interactive telecommunications technology. CMS believes use of real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means, and thus would meet the requirement for teaching physician presence for office/outpatient E/M services furnished in primary care centers.
  - The interpretation of diagnostic radiology and other diagnostic tests may be billed when the interpretation is performed by a resident under direct supervision of the teaching physician by interactive telecommunications technology. The teaching physician must still review the resident's interpretation.
  - The requirement for the presence of the teaching physician during the psychiatric service in which a resident is involved may be met by the teaching physician's direct supervision by interactive telecommunications technology.

The PHE for the COVID-19 pandemic exceptions previously described will not apply in the case of surgical, high risk, interventional or other complex procedures, services performed through an endoscope and anesthesia services.

- **Application of the Expansion of Telehealth Services to Teaching Physician Services:** The use of real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means while the resident is furnishing services via telecommunications technology, and thus, in the circumstances of the PHE, would meet the requirement for teaching physician presence for office/outpatient E/M services furnished in primary care centers. Consequently, for the duration of the PHE for the COVID-19 pandemic, CMS is revising its regulations to specify that Medicare may make payment under the PFS for teaching physician services when a resident furnishes telehealth services to beneficiaries under direct supervision of the teaching physician, which is provided by interactive telecommunications technology. Additionally, on an interim basis, for the duration of the PHE for the COVID-19 pandemic, Medicare may make payment under the PFS for services billed under the primary care exception by the teaching physician when a resident furnishes telehealth services to beneficiaries under the direct supervision of the teaching physician by interactive telecommunications technology.

- **Payment under the PFS for Teaching Physician Services when Resident under Quarantine:** For the duration of the PHE for the COVID-19 pandemic, Medicare may also make payment under the PFS for teaching physician services when the resident is furnishing these services while in quarantine under direct supervision of the teaching physician by interactive telecommunications technology.

- **Revisions to Moonlighting Regulations during a PHE for the COVID-19 Pandemic:** For the duration of the PHE for the COVID-19 pandemic, CMS amends its regulations to state that the services of residents that are not related to their approved graduate medical education (GME) programs and are performed in the inpatient setting of a hospital in which they have their training program are separately billable physicians' services for which payment can be made under the PFS, provided that the services are identifiable physicians' services and meet the conditions of payment for physicians' services to beneficiaries in providers, the resident is fully licensed to practice medicine, osteopathy, dentistry or podiatry by the state in which the services are performed, and the services are not performed as part of the approved GME program.

- **Medicare Diabetes Prevention Program:** The rule amends the Medicare Diabetes Prevention Program (MDPP) expanded model to modify certain MDPP policies during the PHE. Specifically, it

will permit certain beneficiaries to obtain the set of MDPP services more than once per lifetime, increase the number of virtual make-up sessions and allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis.

Under these temporary flexibilities, the requirement for in-person attendance at the first core session will remain in effect. As a result, if beneficiaries are prohibited from attending the first core session in person, suppliers will be unable to start any new cohorts with MDPP beneficiaries.

- **Comprehensive Care for Joint Replacement (CJR)**: CMS/Center for Medicare & Medicaid Innovation is broadening the extreme and uncontrollable circumstances policy by applying certain financial safeguards to participant hospitals that have a CMS Certification Number (CCN) primary address that is located in an emergency area for episodes that overlap with the emergency period. Accordingly, all participant hospitals are located in the emergency area and qualify for applicable financial safeguards during the emergency period.

  Specifically, CMS states that for a fracture or nonfracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before the date that the emergency period begins, or that occurs through the termination of the emergency period, actual episode payments are capped at the target price determined for that episode.

  CMS is also implementing a 3-month extension to CJR performance year (PY) 5 such that the model will now end on March 31, 2021, rather than ending on December 31, 2020.

- **Alternative Payment Model (APM) Treatment under the Quality Payment Program (QPP):** CMS notes that aspects of APM policies under the QPP are designed to follow on from the specific designs, policies and operations of individual APMs. It recognizes current regulations may be insufficient for purposes of adequately responding to the still-emerging COVID-19 national emergency and that additional action may be necessary and appropriate to prevent APM participants from facing undue burden in, or negative consequences through, the QPP. CMS will consider undertaking additional rulemaking, including possibly another interim final rule, to amend or suspend APM QPP policies as necessary to ensure accurate and appropriate application of QPP policies in light of the PHE due to COVID-19.

- **Remote Physiologic Monitoring (RPM) – New Patients:** In response to the PHE for the COVID-19 pandemic, CMS is finalizing on an interim basis, that RPM services can be furnished to new patients, as well as to established patients. Consent to receive RPM services can be obtained once annually, including at the time services are furnished, during the duration of the PHE for the

COVID-19 pandemic. However, to enhance beneficiary protection, for both new and established patients, CMS suggests that the physician or other health care practitioner review consent information with a beneficiary, obtain the beneficiary's verbal consent and document in the medical record that consent was obtained. Finally, CMS clarifies that RPM codes can be used for physiologic monitoring of patients with acute and/or chronic conditions. The typical patient needing RPM services may have a chronic condition (for example, high blood pressure, diabetes, chronic obstructive pulmonary disease). However, RPM can be used for other conditions. For example, RPM services allow a patient with an acute respiratory virus to monitor pulse and oxygen saturation levels using pulse oximetry.

- **Telephone E/M Services**: The rule finalizes that for the duration of the PHE for the COVID-19 pandemic, separate Medicare payment for CPT codes 98966-98968 and CPT codes 99441-99443. Previously, these codes had been noncovered services.

  During the PHE, these services extend to both new and existing patients. While some of the code descriptors refer to "established patient," during the PHE CMS is exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. CMS will not conduct review to consider whether those services were furnished to established patients.

  CPT codes 98966-98968 described assessment and management services performed by practitioners who cannot separately bill for E/Ms. CMS notes that these services may be furnished by, among others, licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech-language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners.

- **Physician Supervision Flexibility for Outpatient Hospitals - Outpatient Hospital Therapeutic Services Assigned to the Nonsurgical Extended Duration Therapeutic Services (NSEDTS)**
  Level of Supervision: CMS is assigning, on an interim basis, all outpatient hospital therapeutic services that are considered nonsurgical extended duration therapeutic services, a minimum level of general supervision to be consistent with the minimum default level of general supervision that applies for most outpatient hospital therapeutic services. General supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure.

- **Application of Certain National Coverage Determination (NCD) and Local Coverage Determination (LCD) Requirements During the PHE for the COVID-19 Pandemic**:

- *Face-to-Face Encounters*: On an interim basis, CMS finalizes that to the extent an NCD or LCD would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements would not apply during the PHE for the COVID-19 pandemic. CMS notes that some face-to-face encounter requirements for Durable Medical Equipment Prosthetics, Orthotics and Supplies Power Mobility Devices (PMDs) are mandated by statute for program integrity purposes. The Interim Final Rule does not apply to those statutory requirements.

- *Clinical Indications for Certain Respiratory, Home Anticoagulation Management and Infusion Pump Policies*: On an interim basis CMS will not enforce the clinical indications for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs, allowing for maximum flexibility for practitioners to care for their patients. These policies include, but are not limited to the NCDs and LCDs identified in Appendix III.

- *Requirements for Consultations or Services Furnished by or with the Supervision of a Particular Medical Practitioner or Specialist*: To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish a service, procedure or any portion thereof, CMS finalizes on an interim basis the chief medical officer or equivalent of the facility can authorize another physician specialty or other practitioner type to meet those requirements during the PHE for the COVID-19 pandemic. Additionally, to the extent NCDs and LCDs require a physician or physician specialty to supervise other practitioners, professionals or qualified personnel, the chief medical officer of the facility can authorize that such supervision requirements do not apply during the PHE for the COVID-19 pandemic.

- **Change to Medicare Shared Savings Program (MSSP) Extreme and Uncontrollable Circumstances Policy:** CMS is revising the MSSP regulations to remove the restriction which prevents the application of the Shared Savings Program extreme and uncontrollable circumstances policy for disasters that occur during the quality reporting period if the reporting period is extended, to 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. CMS is considering whether the current policy, which assigns an ACO the higher of the mean quality score across all ACOs and the ACO's own quality score, in the event the ACO is determined to be impacted by an extreme and uncontrollable circumstances, will continue to be appropriate for PY20 and beyond. Any change to that current policy would be made through future notice and comment rulemaking.

CMS notes that because the PHE for the COVID-19 pandemic was declared during the reporting period for those performance years, the provisions that allow for an adjustment to the amount of shared losses for ACOs found to be affected by an extreme and uncontrollable circumstance during a performance year would not apply for performance years starting in 2019.

However, for PY20 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. At this time, the PHE for the COVID-19 pandemic applies to all counties in the country; therefore, 100% of assigned beneficiaries for all Shared Savings Program ACOs reside in an affected area and the total months affected by an extreme and uncontrollable circumstance will begin with March and continue through the end of the current PHE.

Finally, the factors used to update 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.

- **Level Selection for Office/Outpatient E/M Visits When Furnished Via Medicare Telehealth:** 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 Master Data Management (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY20 PFS final rule.

  It remains CMS's expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care. To reduce the potential for confusion, CMS maintains the current definition of MDM. The rule notes that currently there are typical times associated with the office/outpatient E/Ms, and CMS is finalizing those times as what should be met for purposes of level selection. The typical times associated with the office/outpatient E/M services are available as a public use file at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.

- **Counting of Resident Time During the PHE for the COVID-19 Pandemic**: If a resident is training in a hospital, that hospital claims the resident for indirect medical education (IME) and direct graduate medical education (DGME), and if a resident is training in a nonprovider site such as a doctor's office or clinic, the hospital or hospitals that pays the resident's salaries and fringe benefits claims the resident for IME and DGME.

Currently, there is no provision in the regulations for a hospital to claim a resident for IME or DGME if the resident is performing patient care activities within the scope of their approved program in their own home, or in a patient's home. For the duration of this emergency situation, CMS permits the hospital that is paying the resident's salary and fringe benefits for the time that the resident is at home or in the home of a patient who is already a patient of the physician or hospital, but performing patient care duties within the scope of the approved residency program, to claim that resident for IME and DGME purposes.

- **Changes to Expand Workforce Capacity for Ordering Medicaid Home Health Nursing and Aide Services, Medical Equipment, Supplies and Appliances and Physical Therapy, Occupational Therapy or Speech Pathology and Audiology Services**: CMS recognizes that increased demand on the direct care services provided by physicians during the PHE for the COVID-19 pandemic could cause a delay in the availability of physicians to order home health services in the normal timeframe.

  In recognition of the critical need to expand workforce capacity, CMS is amending the regulations to allow licensed practitioners practicing within their scope of practice, such as, but not limited to, NPs and physician assistants, to order Medicaid home health services during the PHE for the COVID-19 pandemic. This change applies to who can order Medicaid home health nursing and aide services, medical supplies, equipment and appliances and physical therapy, occupational therapy or speech pathology and audiology services. This change does not expand the benefit categories where these items can be covered.

- **Origin and Destination Requirements Under the Ambulance Fee Schedule:** On an interim basis, CMS will expand the list of destinations that Medicare covers ambulance transportation to include all destinations, from any point of origin, that are equipped to treat the condition of the patient consistent with Emergency Medical Services (EMS) protocols established by state and/or local laws where the services will be furnished. Based on these protocols, a patient suspected of having COVID-19 who requires a medically necessary transport may be transported to a testing facility to get tested for COVID-19 instead of a hospital in an effort to prevent possible exposure to other patients and medical staff. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, critical access hospital (CAH) or skilled nursing facility (SNF), community mental health centers, FQHCs, RHCs, physicians' offices, urgent care facilities, ambulatory surgery centers (ASCs), any location furnishing dialysis services outside of an ESRD facility when an ESRD facility is not available, and the beneficiary's home. This expanded list of destinations will apply to medically necessary emergency and nonemergency ground ambulance transports of beneficiaries during the PHE for the COVID-19 pandemic.

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- **Merit-based Incentive Payment System (MIPS) Updates:**

  - *Additional Improvement Activity*: CMS is adding one new improvement activity to the Improvement Activities Inventory for the CY20 performance period in response to this PHE. This improvement activity promotes clinician participation in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection. To receive credit for this clinical improvement, clinicians must report their findings through an open source clinical data repository or clinical data registry.

  - *MIPS Applications for Reweighting Based on Extreme and Uncontrollable Circumstances*: To provide additional relief to individual clinicians, groups and virtual groups for whom sufficient MIPS measures and activities may not be available for the 2019 MIPS performance period due to the PHE for the COVID-19 pandemic, CMS extends 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 from December 31, 2019 to April 30, 2020, or a later date that CMS may specify. This extended deadline of April 30, 2020 mirrors the MIPS data submission deadline extension. The extended deadline is available only for applications that demonstrate the clinician has been adversely affected by the PHE for the COVID-19 pandemic.

- **Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital During the PHE for the COVID-19 Pandemic**: CMS is changing its under arrangements policy during the PHE for the COVID-19 pandemic so that hospitals are allowed broader flexibilities to furnish inpatient services, including routine services outside the hospital. Effective for services provided for discharges for patients admitted to the hospital during the PHE for COVID-19 beginning March 1, 2020, if routine services are provided under arrangements outside the hospital to its inpatients, these services are considered as being provided by the hospital. CMS emphasizes that it is not changing its policy that a hospital needs to exercise sufficient control and responsibility over the use of hospital resources in treating patients. Hospitals need to continue to exercise sufficient control and responsibility over the use of hospital resources in treating patients regardless of whether that treatment occurs in the hospital or outside the hospital under arrangements. If a hospital cannot exercise sufficient control and responsibility over the use of hospital resources in treating patients outside the hospital under arrangements, the hospital should not provide those services outside the hospital under arrangements.

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- **Advance Payments to Suppliers Furnishing Items and Services under Part B**: In an effort to be more responsive to situations in which Part B suppliers could request advance payments from CMS makes several technical modifications to existing advance payments rules. The definition is revised to state that a contractor (not carrier as is currently written) will make the conditional partial payment. CMS adds language to specifically address emergency situations in which it will be able to make advance payments.

  Additionally, existing rules limit CMS to no more than 80% of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid to the supplier. Under exceptional circumstances, CMS is increasing this limit to 100% of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid to the supplier. CMS also adds criterion to § 421.214 that suppliers in bankruptcy would not be eligible to receive advance payments to ensure that, with such expanded authority, CMS is able to appropriately pay and recover advance payments made to Part B suppliers.

Appendix I: Additional Telehealth Services Covered During PHE

Service Type	CPT Code	Description
Emergency Department Visit	99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.)
Emergency Department Visit	99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

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Service Type	CPT Code	Description
Emergency Department Visit	99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.)
Emergency Department Visit	99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
Emergency Department Visit	99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
Initial and Subsequent Observation, and Observation Discharge Day Management	99217	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])

Service Type	CPT Code	Description
Initial and Subsequent Observation, and Observation Discharge Day Management	99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial and Subsequent Observation, and Observation Discharge Day Management	99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial and Subsequent Observation, and Observation Discharge Day Management	99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial and Subsequent Observation, and Observation Discharge Day Management	99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

Service Type	CPT Code	Description
Initial and Subsequent Observation, and Observation Discharge Day Management	99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial and Subsequent Observation, and Observation Discharge Day Management	99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial and Subsequent Observation, and Observation Discharge Day Management	99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial and Subsequent Observation, and Observation Discharge Day Management	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

Service Type	CPT Code	Description
Initial and Subsequent Observation, and Observation Discharge Day Management	99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial hospital care and hospital discharge day management	99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial hospital care and hospital discharge day management	99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial hospital care and hospital discharge day management	99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
Initial hospital care and hospital	99238	Hospital discharge day management; 30 minutes or less

Service Type	CPT Code	Description
discharge day management		
Initial hospital care and hospital discharge day management	99239	Hospital discharge day management; more than 30 minutes
Initial nursing facility visits and nursing facility discharge day management	99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
Initial nursing facility visits and nursing facility discharge day management	99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
Initial nursing facility visits and nursing facility discharge day management	99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
Initial nursing facility visits and nursing facility discharge day management	99315	Nursing facility discharge day management; 30 minutes or less

Service Type	CPT Code	Description
Initial nursing facility visits and nursing facility discharge day management	99316	Nursing facility discharge day management; more than 30 minutes
Critical Care Services	99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
Critical Care Services	99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
Domiciliary, Rest Home, or Custodial Care services	99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.
Domiciliary, Rest Home, or Custodial Care services	99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.
Domiciliary, Rest Home, or Custodial Care services	99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.

Service Type	CPT Code	Description
Domiciliary, Rest Home, or Custodial Care services	99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.
Domiciliary, Rest Home, or Custodial Care services	99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.
Domiciliary, Rest Home, or Custodial Care services	99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.
Home Visits	99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

Service Type	CPT Code	Description
Home Visits	99342	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Home Visits	99343	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
Home Visits	99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Home Visits	99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.

Service Type	CPT Code	Description
Home Visits	99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
Home Visits	99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
Home Visits	99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Home Visits	99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Inpatient Neonatal and Pediatric Critical Care	99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger.

Service Type	CPT Code	Description
Inpatient Neonatal and Pediatric Critical Care	99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger.
Inpatient Neonatal and Pediatric Critical Care	99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age.
Inpatient Neonatal and Pediatric Critical Care	99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age.
Inpatient Neonatal and Pediatric Critical Care	99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration.
Inpatient Neonatal and Pediatric Critical Care	99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age.
Inpatient Neonatal and Pediatric Critical Care	99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age.
Initial and Continuing Intensive Care Services	99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services.
Initial and Continuing Intensive Care Services	99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams).
Initial and Continuing Intensive Care Services	99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams).
Initial and Continuing Intensive Care Services	99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams).

Service Type	CPT Code	Description
Care Planning for Patients with Cognitive Impairment	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.)
Group Psychotherapy	90853	Group psychotherapy (other than of a multiple-family group.
End-Stage Renal Disease (ESRD) Services	90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
End-Stage Renal Disease (ESRD) Services	90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.
End-Stage Renal Disease (ESRD) Services	90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.

Service Type	CPT Code	Description
End-Stage Renal Disease (ESRD) Services	90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month.
Psychological and Neuropsychological Testing	96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
Psychological and Neuropsychological Testing	96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).
Psychological and Neuropsychological Testing	96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
Psychological and Neuropsychological Testing	96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).
Psychological and Neuropsychological Testing	96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes.
Psychological and Neuropsychological Testing	96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure).
Psychological and Neuropsychological Testing	96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes.
Psychological and Neuropsychological Testing	96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure).

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Service Type	CPT Code	Description
Therapy Services	97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
Therapy Services	97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Therapy Services	97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
Therapy Services	97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.

Service Type	CPT Code	Description
Therapy Services	97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Therapy Services	97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
Therapy Services	97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of

Service Type	CPT Code	Description
		tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Therapy Services	97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Therapy Services	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
Therapy Services	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
Therapy Services	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing).
Therapy Services	97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.
Therapy Services	97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.
Therapy Services	97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes.
Therapy Services	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes).
Therapy Services	97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes.
Therapy Services	92521	Evaluation of speech fluency (e.g., stuttering, cluttering).
Therapy Services	92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).

Service Type	CPT Code	Description
Therapy Services	92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language).
Therapy Services	92524	Behavioral and qualitative analysis of voice and resonance.
Therapy Services	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.
Radiation Therapy Management Services	77427	Radiation treatment management, 5 treatments.

Appendix II: Services with Telehealth Visit Frequency for Inpatient and Nursing Facility Visits Removed

Service Type	CPT Code	Description
Inpatient Visits	99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
Inpatient Visits	99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

Service Type	CPT Code	Description
Inpatient Visits	99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
Subsequent SNF Visits	99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
Subsequent SNF Visits	99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
Subsequent SNF Visits	99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

Service Type	CPT Code	Description
Subsequent SNF Visits	99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
Critical Care Consultation	G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth.
Critical Care Consultation	G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth.
ESRD	90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.
ESRD	90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
ESRD	90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.
ESRD	90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.
ESRD	90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.

Service Type	CPT Code	Description
ESRD	90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.
ESRD	90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
ESRD	90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.
ESRD	90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.
ESRD	90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
ESRD	90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month.
ESRD	90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
ESRD	90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
ESRD	90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
ESRD	90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older.
ESRD	90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age.

Service Type	CPT Code	Description
ESRD	90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age.
ESRD	90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age.
ESRD	90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older.

Appendix III: NCD/LCDs Related to Clinical Indications for Certain Respiratory, Home Anticoagulation Management and Infusion Pump Policies

NCD/LCD
NCD 240.2 Home Oxygen
NCD 240.4 Continuous Positive Airway Pressure for Obstructive Sleep Apnea.
LCD L33800 Respiratory Assist Devices (ventilators for home use).
NCD 240.5 Intrapulmonary Percussive Ventilator
LCD L33797 Oxygen and Oxygen Equipment (for home use).
NCD 190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR)
NCD 280.14 Infusion Pumps.
LCD L33794 External Infusion Pumps.