ENDOCRINE SOCIETY
Hormone Science to Health

Summary of Key Provisions of the COVID-19 Public Health Emergency Interim Final Rule Relevant to Endocrinology

CMS issued an interim final rule on March 30, 2020 that extends temporary regulatory waivers to health care providers to facilitate safe and effective care for the duration of the public health emergency. The regulations aim to increase hospital capacity, expand the health care workforce, improve access to telehealth services, and reduce the regulatory burden on providers. A link to the rule can be found here. The regulations are retroactively applicable beginning March 1, 2020.
Please note that these changes are for the Medicare program. Private insurers may not adopt the same policies. We have summarized the key provisions that are relevant 2020for Endocrine Society members below. These include:

1. Expansion of Covered Telehealth Services
2. Reducing or Waiving Beneficiary Cost Sharing for Telehealth and Certain Other Services
3. Coverage of Remote Monitoring Services for New Patients
4. Coverage of Telephone E/M Services
5. Waiving Requirement for the Face-to-Face Visit for Patients with Insulin Pumps: The Endocrine Society advocated that this change be made.
6. Simplifying the Documentation Requirements for E/M Services Delivered by Telehealth
7. Providing Additional Flexibilities to Deliver Medicare Diabetes Prevention Program Services

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

Since March 17, CMS has expanded access to telehealth services on a temporary and emergency basis pursuant to waiver authority granted in the Coronavirus Preparedness and Response Supplemental Appropriations Act. In the new rule, the agency is adding 80 services to the list of eligible telehealth services, eliminating frequency limitations and other requirements associated with particular telehealth services, and clarifying payment rules that apply to other services furnished through telecommunication technologies that can reduce exposure risk to COVID-19.

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Site of Service Differential for Medicare Telehealth Services
Under the waiver authority, Medicare telehealth services can be provided to patients wherever they are located, including in the patient's home. The agency recognizes that as physicians practices transition a significant portion of their services from in-person to telehealth services, the relative cost of providing services may not be significantly different than if these services were provided in-person (i.e. physicians' offices will continue to employ nursing staff just as they would have when providing in-person services). Therefore, the agency will assign the payment rate that would have been paid under the Physician Fee Schedule (PFS) as if the services were furnished in-person.
To implement this change on an interim basis, when billing for telehealth services, physicians and practitioners should report the point-of-service (POS) that would have been reported had the service been performed in-person. CMS also 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 by telehealth.

Adding Services to the List of Medicare Telehealth Services
CMS has an established process for adding or deleting services to the list of Medicare telehealth services covered under Sec. 1834(m)(4)(F)(ii). Services can fall into one of the following categories:

- Category 1: services that are similar to professional consultations, office visits and office psychiatry visits that are currently on the list of telehealth services.
- Category 2: services that are not similar to those on the current list of telehealth services but that demonstrate a clinical benefit to the patient.

CMS is adding over 80 services to the list of telehealth services for the duration of the Public Health Emergency, for telehealth services with dates of service beginning on March 1, 2020. The following services are being added on an interim basis to category 2 (a full description of the CPT codes is in Appendix A):

- Emergency Department Visits:
    - CPT Codes 99281-99285
- Initial and Subsequent Observations, and Observation Discharge Day Management:
    - CPT Codes 99217-99220, 99224-99226, 99234-99236
- Initial Hospital Care and Hospital Discharge Day Management:
    - CPT Codes 99221-99223; 99238-99239
- Initial Nursing Facility Visits and Nursing Facility Discharge Day Management:

- CPT Codes 99304-99306, 99315-99316
- Critical Care Services:
  - CPT Codes 99291-99292
- Domiciliary, Rest Home, or Custodial Care Services:
  - CPT Codes 99327-99328, 99334-99337
- Home Visits:
  - CPT Codes 99341-99345, 99347-99350
- Inpatient Neonatal and Pediatric Critical Care:
  - CPT Codes 99468-99469, 99471-99473, 99475-99476
- Initial and Continuing Intensive Care Services:
  - CPT Codes 99477-99480
- Care Planning for Patients with Cognitive Impairment:
  - CPT Code 99483
- Group Psychotherapy:
  - CPT Code 90853
- ESRD Services:
  - CPT Codes 90952-90953, 90959, 90962
- Psychological and Neuropsychological Testing:
  - CPT Codes 96130-96133, 96136-96139
- Therapy Services:
  - CPT Codes 97161-97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507
- Radiation Treatment Management Services:
  - CPT Code 77427

A full list of services , including the additions made in the IFC, can be located on the CMS website at: https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/index.html.

2. **Telehealth Modalities and Cost-sharing (pg. 48)**

Clarifying Telehealth Technology Requirements
CMS is revising the regulatory definition of interactive telecommunication systems at Sec. 410.78(a)(3) to add an exception for the duration of the PHE, by adding the following language:

> "Exception. For the duration of the public health emergency as defined in § 400.200 of this chapter, 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."

The agency also reiterates that the Office of Civil Rights (OCR) is exercising enforcement 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 more information, see https://www.hhs.gov/hipaa/forprofessionals/special-topics/emergency-preparedness/index.html.

Beneficiary Cost-sharing

On March 17, the Office of Inspector General (OIG) issued a policy statement that notified physicians and other practitioners that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations that Medicare beneficiaries may owe for telehealth services furnished consistent with the then applicable coverage and payment rules. This policy applies to a number 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.

3. **Remote Physiologic Monitoring (pg. 119)**

CMS has seven CPT codes for remote physiologic monitoring (RPM) services:

- CPT code 99091 (Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation requiring a minimum of 30 minutes of time)
- CPT code 99453 (Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment)
- CPT code 99454 (Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days)
- CPT code 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes))
- CPT code 99458 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring

interactive communication with the patient/caregiver during the month; each additional 20 minutes)

- CPT code 99473 (Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration)
- CPT code 99474 (Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient)

The typical patient receiving RPM services are patients with chronic conditions, such as **diabetes**, high blood pressure, and COPD. In this rule, CMS clarifies that the RPM codes listed above can be used for physiologic monitoring of patients with acute and/or chronic conditions.

RPM services are considered to be communication technology-based services (CTBS) and historically, these services are billable for only established patients, however during the COVID-19 public health emergency, CMS is allowing these services to be delivered to new patients as well. Practitioners must receive verbal consent from Medicare beneficiaries to provide CTBS and RPM services. This requirement will prevent scenarios where beneficiaries are unexpectedly surprised by copays for services that do not involve the typical in-person, face-to-face service that a patient receives during an office visit. During the COVID-19 emergency, CMS is finalizing that consent to receive RPM services can be obtained once annually, including at the time services are furnished. CMS suggests that the practitioner review consent information with the beneficiary, obtain verbal consent, and then document that verbal consent was obtained.

4. **<u>Telephone Evaluation and Management (E/M) Services (pg. 122)</u>**

During CY 2008 rulemaking, the CPT Editorial Panel created the following CPT codes to describe E/M services furnished by a physician or a qualified healthcare professional via telephone or online:

- CPT code 98966 (Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)

- CPT code 98967 (Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion)
- CPT code 98968 (Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and CMS-1744-IFC 123 management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion)
- CPT code 99441 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)
- CPT code 99442 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion)
- CPT code 99443 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion)

CMS had assigned a status indicator of “N” to indicate that they are “noncovered” services, however CMS will cover these services in light of the COVID-19 public health emergency. CMS recognizes that these services do not describe full E/M services; they are similar to the virtual check-in services.

In the effort of reducing exposure risks in association with the COVID-19 public health emergency, CMS believes there are certain circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate.

CMS believes that the existing telephone E/M codes listed above are the best way to recognize the relative resources to furnish these services. Therefore, CMS is finalizing payment for CPT codes 98966-98968 and CPT codes 99441-99443.
CMS is finalizing the following work RVUs which were included in the CY 2008 PFS final rule (72 CFR 66371):

CPT Code	Work RVUs
98966	0.25
98967	0.50
98968	0.75
99441	0.25
99442	0.50
99443	0.75

These services can be billed for new and established patients during the COVID-19 public health emergency and therefore, CMS will not conduct review to determine whether these services were provided to established patients.
CPT codes 98966-98968 describe assessment and management services performed by practitioners who cannot bill separately for E/M services. CMS notes that these services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners.

5. **Application of Certain National Coverage Determination and Local Coverage Determination Requirements During the PHE for the COVID-19 Pandemic (pg. 127)**

Some National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) include clinical conditions that must be met for coverage of an item or services, including face-to-face evaluations and re-evaluations for continued coverage. On an interim basis, CMS is waiving the requirements for these face-to-face and in-person encounters included in NCDs and LCDs for continued coverage. *This does not change any of the clinical indications for coverage in a NCD or LCD unless specifically addressed in this rule and outlined below. At the conclusion of the Public Health Emergency, CMS will return to enforcement of these clinical indications.*
Also, the chief medical officer of a facility can authorize that supervision requirements in NCDs and LCDs do not apply during the Public Health Emergency.

6. **Level Selection for Office/Outpatient E/M Visits When Furnished Via Medicare Telehealth (pg. 135)**

For office/outpatient visits delivered via telehealth during the PHE, CMS is revising its policy to allow providers to select the level of a visit based on MDM or time with time defined as all of the time associated with the E/M on the day of encounter. Providers will also not be required to document history and/or physical exam in the medical record. This policy is similar to the E/M documentation policy scheduled to be implemented on January 1, 2021. Despite the similarity, the agency is maintaining the current definition of MDM and using the times available in the public use file.

7. **Innovation Center Models (pg.114)**

Medicare Diabetes Prevention Program (MDPP) expanded model Emergency Policy
In response to the COVID-19 emergency, this rule amends the MDPP to allow 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. The COVID-19 emergency interrupted the expanded model services delivered by MDPP suppliers and has therefore prevented MDPP beneficiaries from attending live in-person sessions. Changes in this rule are only applicable to MDPP suppliers that are enrolled in MDPP as of March 1, 2020, and MDPP beneficiaries who were receiving MDPP services as of March 1, 2020.
Through this interim rule, CMS plans to implement provisions that allow for temporary flexibilities for the continuation of services for MDPP suppliers and MDPP beneficiaries. First, the requirement for beneficiaries to attend the first core-session in-person remains in effect. If beneficiaries are prohibited from attending the first core session in person, suppliers will be unable to start any new cohorts with MDPP beneficiaries until the conclusion of the COVID-19 PHE.
The Centers for Disease Control and Prevention (CDC) issued guidance to all MDPP suppliers providing alternative delivery options during the COVID-19 national emergency. CMS plans to conform with CDC guidance to minimize disruption of services for MDPP suppliers and MDPP beneficiaries and is amending the MDPP regulations to allow MDPP suppliers to either deliver MDPP services virtually or suspend in-person services and resume services at a later date. Furthermore, the limit to the number of virtual make-up sessions is waived for MDPP suppliers with existing capabilities to provide services virtually. MDPP suppliers may only furnish to the MDPP beneficiary a maximum of one session on the same day as a regularly scheduled session and a maximum of one virtual

make-up session per week. Virtual make-up sessions may only be furnished to achieve attendance goals and may not be furnished to achieve weight-loss goals.
Under these changes, CMS also permits beneficiaries to obtain a set of MDPP services more than once per lifetime so that MDPP beneficiaries can maintain eligibility for MDPP services "despite a break in service, attendance, or weight loss achievement."

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