

## **CMS Issues Policy Changes in Response to COVID-19**

### **Interim Final Rule Summary**

On March 30, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency*, which included adoption of several ASTRO COVID-19 requests. The final rule (with comment period) includes key policy changes designed to give physicians and other health care providers needed flexibilities so they may continue to provide care while also addressing COVID-19. ASTRO has been actively working with the Administration to address member requests for flexibility, particularly involving on-treatment visits and supervision. ASTRO is pleased that the rule addresses these issues, as well as others of key importance to radiation oncology, including:

- Extended telehealth flexibilities for on-treatment visits (OTVs), as part of CPT code 77427 Radiation Treatment Management;
- Relaxed supervision requirements in all sites of service;
- Flexibilities for Alternative Payment Models (APMs) and the Merit Based Incentive Payment System (MIPS);
- Reimbursement for telephone E/M codes (99441-99443);
- Modified Guidance on use of POS Indicator for Telehealth Services;
- Guidance on the selection of E/M level;
- Expansion of Virtual Check-Ins and E-Visit to New Patients;
- Teacher-Physician Supervision Guidance; and
- Prior Authorization and Medicare Appeals Policies.

### **Medicare Telehealth Expansion for On-Treatment Visits (OTVs)**

In the final Rule, CMS broadens telehealth flexibilities to include in-person, face-to-face interactions associated with radiation oncology on-treatment visits (OTVs) under CPT Code 77427 – *Radiation Treatment Management, 5 treatments*. CMS agreed with [ASTRO](#) that: “the weekly face-to-face visit component of this service could be conducted via telehealth when the billing practitioner weighs the exposure risks against the value of in-person assessment on a case-by-case basis.”

The delivery of the OTV via telehealth is not ideal. The telehealth option to utilize virtual two-way communication in the office should be used judiciously and only during this emergency when the radiation oncologist deems that a regular face-to-face interaction would put the patient or physician at risk for COVID-19 infection.

ASTRO urged the Agency to apply telehealth flexibilities to CPT code 77427 and applauds the decision.

### **Supervision for Hospital and Freestanding Facilities**

In the final rule, CMS relaxed the current supervision requirements for both the hospital and freestanding settings. Currently, radiation oncology services paid under the Physician Fee Schedule in the freestanding setting are required to adhere to direct supervision requirements. “Direct supervision” requires that the physician be immediately available to provide assistance throughout the duration of the procedure.

Given the circumstances of the COVID-19 public health emergency, CMS recognizes that in some cases, the physical proximity of the physician might present an additional exposure risk. To address this, the Agency is revising the definition of direct supervision, for the duration of the COVID-19 public health epidemic, to allow direct supervision to be provided using real-time interactive audio and video technology. The Agency seeks comments on whether there should be safeguards put in place to reduce risk that this revised policy may introduce.

Additionally, CMS is adopting similar changes to diagnostic services provided in hospital outpatient settings. Effective January 1, 2020, hospitals were under general supervision for many therapeutic services; however, this change did not impact radiation therapy image guidance services, which are designated as diagnostic services in the hospital outpatient setting. CMS states that given the circumstances of the COVID-19 public health emergency, it is critical that hospitals have the most flexibility possible to provide the services Medicare beneficiaries need during this challenging time and will allow for the application of general supervision associated with diagnostics during the COVID-19 public health emergency.

ASTRO [urged](#) the Agency to allow for flexibilities to existing supervision requirements during the COVID-19 public health emergency and applauds the Agency for temporarily relaxing the existing requirements. This action will ensure the continuity of life-saving radiation treatments for cancer patients during the pandemic.

### **Flexibilities for Alternative Payment Models (APMs) and the Merit Based Incentive Payment System (MIPS)**

In the final rule, CMS recognizes that practices participating in the Quality Payment Program may experience undue burden related to their participation in either Alternative Payment Models (APMs) or the Merit Based Incentive Payment System (MIPS). While CMS does not explicitly state that it will delay the implementation of the alternative payment model for Radiation Oncology (RO Model), the Agency does state that possible changes may be necessary to address issues for APM participants in light of the pandemic. CMS will pursue additional rulemaking to amend or suspend APM policies as necessary.

ASTRO [urged](#) the Agency to delay the implementation of the RO Model from July 1, 2020 to January 1, 2021. A July 1, 2020 implementation date would be particularly burdensome for

practices, as they also manage disruptions to patient care due to COVID-19. ASTRO is pleased that the Agency recognizes the additional challenges that APM participants face during the COVID-19 public health emergency and will continue to monitor Agency efforts related to the RO Model.

In the final rule, the Agency is proposing two updates to the MIPS program. CMS is modifying the MIPS Extreme and Uncontrollable Circumstances policy to allow clinicians adversely impacted by the COVID-19 public health emergency to submit an application requesting a reweighting of the MIPS performance categories for the 2019 performance year.

CMS is also adding a new Improvement Activity for the 2020 performance year that will provide high-weighted credit for clinicians who participate in a clinical trial utilizing a drug or biological product to treat patients with COVID-19 and then report their findings to a clinical data repository or clinical data registry.

#### **Telephone Evaluation and Management (E/M) Services (99441-99443)**

In the final rule, CMS establishes payment for CPT codes 99441-99443 *Telephone Evaluation and Management Services*. CMS states that temporary approval for the codes is based on the goal of reducing exposure risks during the COVID-19 public health emergency and recognizes that prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate. The Agency will pay for the services based on RUC-recommended values established in 2008.

- **99441** - Telephone evaluation and management service provided by a physician 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, 0.25 RVU
- **99442** - Telephone evaluation and management service provided by a physician 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, 0.50 RVU
- **99443** - Telephone evaluation and management service provided by a physician 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, 0.75 RVU

ASTRO joined the AMA and other medical specialties in seeking payment for the telephone E/M services and applauds the Agency's decision.

### **Place of Service (POS) Indicator for Telehealth Services**

For Medicare telehealth services, CMS had previously instructed medical group practices billing Medicare for telehealth services to use the place of service code “02” indicator for services furnished via telemedicine from a distant site. In the final rule, CMS establishes that, on an interim basis, the use of the CPT telehealth modifier (modifier 95) should be applied to claim lines that describe services furnished via telehealth. CMS is instructing practices to bill based on the location in which they would have normally provided the service and then append the 95 modifier to indicate that the service was delivered during the COVID-19 public health emergency.

### **Selection of E/M Levels**

On an interim basis, CMS is revising their policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on medical decision making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. Additionally, CMS removed any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the revised policy that will apply to all office/outpatient E/M codes scheduled to go into effect January 1, 2021 under policies finalized in the CY 2020 PFS final rule.

It remains CMS’ expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care. To reduce the potential for confusion, CMS is maintaining the current definition of MDM. Note that currently there are typical times associated with the office/outpatient E/M codes and CMS is finalizing those times as what should be met for purposes of level selection. This policy only applies to office/outpatient visits furnished via Medicare telehealth, and only during the COVID-19 public health emergency.

### **Virtual Check-Ins and E-Visits**

In the final rule, CMS will allow physicians to provide virtual check-in services (HCPCS codes G2010, G2012) and E-Visits (CPT codes 99421-99423) to both new and established patients. Virtual check-ins and E-Visits were previously limited to established patients. The existing code descriptors refer to “established patient,” however during the COVID-19 public health emergency the Agency is exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. Additionally, CMS will not conduct reviews to consider whether these services were furnished to established patients.

### **Teaching Physician Regulations**

In the final rule, CMS is temporarily amending the teaching physician regulations to allow for interactive telecommunications technology to be utilized to meet the direct supervision requirement for the presence of a teaching physician. The teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service. 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.

Additionally, CMS will allow Physician Fee Schedule payment to be made for the interpretation of diagnostic radiology and other diagnostic tests 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.

### **Prior Authorization and Medicare Claims Appeals Policies**

CMS also announced that it is [pausing](#) its standard medical review policies, including prior authorization. The final rule did not provide much detail regarding this provision. ASTRO has asked [CMS](#) and all payers to suspend prior authorization during the outbreak and will report back to members with more information once it becomes available.

CMS is allowing Medicare Administrative Contractors (MACs) and Medicare Advantage plans to utilize all flexibilities available associated with the appeals process during the COVID-19 public health emergency. This includes allowances for extensions on filing appeals. Additionally, MACs may waive the timeliness requirements associated with adjudicating appeals. Medicare Advantage plans may extend the adjudication and reconsideration period by up to 14 days.

### **National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)**

In the final rule, CMS is also applying flexibilities to NCDs and LCD that require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services. CMS said these requirements would not apply during the public health emergency for the COVID-19 pandemic.

These same flexibilities will also be applied to NCDs and LCDs that require a specific practitioner type or physician specialty to furnish a service, procedure or any portion thereof. According to the final rule, the chief medical officer or equivalent of the facility can authorize another physician specialty or other practitioner type to meet those requirements during the COVID-19 public health emergency.

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 suspension of supervision requirements during the COVID-19 public health emergency.

**Additional information about the COVID-19 Interim Final Rule can be found at the following links:**

The Interim Final Rule and waivers can be found at:

<https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current->

[emergencies/coronavirus-waivers](#)

CMS Fact Sheet:

<https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient>

Physician-specific Fact Sheet:

<https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at:

<https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting>