Summary: CMS' Interim Final Rule on CARES Act
Compiled March 31, 2020

The American College of Physicians has compiled a high-level summary of CMS' Interim Final Rule on the CARES Act which is retroactive to March 1st. and which portions are most relevant to internal medicine physicians and their practices.

Telephone Calls

CMS will provide reimbursement for CPT codes 99441 – 99443, which are telephone evaluation and management services 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. It is available to new and established patients, and CMS will not audit to determine whether a prior relationship existed.

99441 (Telephone evaluation and management service by a physician or other qualified health care professional 5-10 minutes	wRVU – 0.25	$14.44
99442 (Telephone evaluation and management service by a physician or other qualified health care professional 11-20 minutes	wRVU – 0.50	$28.15
99443 (Telephone evaluation and management service by a physician or other qualified health care professional 21-30 minutes	wRVU – 0.75	$41.14

Telehealth

CMS is not changing their definition of what they consider to be telehealth (interactive telecommunications systems). They are making a temporary exception:

This carves out space for FaceTime, Skype, and others during the public health emergency (PHE). Additional guidance is provided by the HHS OIG.

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Level Selection for Office/Outpatient E/M Visits When Furnished via Medicare Telehealth

The office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter. CMS is also temporarily removing any requirements regarding documentation of history and/or physical exam in the medical record. The agency is maintaining the current definition of MDM.

Patient Check-ins

CMS is making G-codes G2010 & G2012 available to new and established patients. These codes may be report

furnished, during the duration of the PHE for the COVID-19 pandemic. Additionally, RPM codes can be used for acute and chronic conditions.

CMS provides payment for seven CPT codes in the Remote Physiologic Monitoring (RPM) code family.
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 codes 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)a1rg0 1.024 Tf1 0 0 1 72.024 43q0.00000912 0M

Qualified providers/suppliers can request a specific amount using an Accelerated or Advance Payment Request form provided on each MAC's webs ers and suppliers will be able to request up to 100% of the Medicare payment a -month period. Each MAC will work to review and issue payments within 7 cale eiving the request.

When Will I Have to Repay CMS?

Repayment of these accelerated/advance payments is expected s after the dat of issuance of the payment. The repayment timeline is broken out e below:

Inpatient acute care hospitals, children's hospitals, certain can nd C Access Hospitals (CAH) have up to one year from the date the ac made to repay the balance.

All other Part A providers and Part B suppliers will have 210 days fro accelerated or advance payment was made to repay the balance. The p recovered according to the process described below.

Recoupment and Reconciliation:

The provider/supplier can continue to submit claims as usual a e of accelerated or advance payment. Providers/suppliers will re nts for t claims during the delay period. At the end of the delay per ment proces will begin and every claim submitted by the provider/su set from the new claims to repay the accelerated/advanced payme of receiving payment for newly submitted claims, the provider tanding accelerated/advance payment balance is reduced yment amount. This process will be automatic. All other Part A prov bove and Part B suppliers will have up to 210 days for the rec ss to begin.

For the small subset of Part A providers wh Interim Payment (PIP), the accelerated payment reconciliation process will happen at the final cost report process (180 days after the fiscal year closes). A step by step application guide can be found below. More information on this process will also be available on your MAC's website.

Step-by-Step Guide on How to Request Accelerated or Advance Payment

Complete an Accelerated/Advance Payment Request form and submit it to your servicing MAC via mail or email. These forms vary by contractor and can be found on each indi

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Correspondence Address;
National Provider Identifier (NPI); and
Other information as required by the MAC.

B. Amount requested based on your need:
Most providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period.

C. Reason for request:
Please check box 2 ("Delay in provider/supplier billing process of an isolated temporary nature beyond the provider's/supplier's normal billing cycle and not attributable to other third party payers or private patients."); and
State that the request is for an accelerated/advance payment due to the COVID-19 pandemic.

The form must be signed by an authorized representative of the provider/supplier.

Quality Payment Program (QPP) Updates

Merit-Based Incentive Payment System (MIPS)

CMS modified its extreme and uncontrollable circumstances policy. First, it extended the deadline from Dec. 31, 2019 to April 30, 2020 (or a later date as specified by CMS) for COVID-19-related hardships only.

reduce the amount of an ACO's shared losses by the percentage of total months of the performance year affected by an extreme and uncontrollable circumstance (March through the end of the COVID-19 PHE). CMS notes that it will update ACO benchmarks using national and regional trends that include any changes arising from the COVID-19 pandemic and clarifies that for MIPS APMs, the ACO, or APM Entity will be scored unless all assigned clinicians and groups either do not submit any data, or submit hardship exception applications for the Promoting Interoperability and Quality Categories.

For the Medicare Diabetes Prevention Program (MDPP), CMS will permit certain beneficiaries to obtain the set of MDPP services more than once per lifetime to allow beneficiaries to remain eligible for MDPP services despite a temporary break in service, attendance, or weight loss achievement. CMS will also waive the limit to the number of virtual make