High-Priority Flexibilities for Hospitals During the COVID-19 Crisis

Last Updated: November 6, 2020

Red text indicates material that has been updated since the previous version of this deck (published on September 29, 2020). *Given the fluid nature of the COVID-19 response, please consult the latest Federal, State and City guidance as needed for the most up-to-date information.*

Agenda

- **Context & Scope**
- **Operational Implications of Federal & State Flexibilities**
  - COVID-19 Testing & Reporting
  - Hospital Workforce
  - Telehealth & Alternative Sites of Care
  - Administrative Activities
- **Revenue Cycle Implications & Billing Guidance**

Context & Scope

To support hospitals and other providers during the COVID-19 crisis, federal and state governments have authorized *emergency funding* and *regulatory relief*.

Goal for this presentation:	**Highlight COVID-related flexibilities that have significant implications for hospitals' clinical operations and revenue cycle.**

Sources for Flexibilities Addressed

- The CARES Act
- Section 1135 waivers
- CMS's interim final rules (March 31, May 8, September 2, and November 2, 2020)
- HHS and CMS Guidance (e.g., HIPAA flexibility, Medicare coverage)
- New York State Executive Orders (EOs) and Department of Health (DOH) guidance (focusing on changes that support implementation of federal flexibilities)

See the Appendix for links to these authorities, as well as Manatt summaries and analysis

Note: The flexibilities discussed in this presentation are ***temporary***. Without legislative or regulatory action, these flexibilities will expire when the emergency period ends.

Flexibilities Addressed in this Presentation

This presentation highlights the operational flexibilities most relevant for New York City hospitals.

	Focus Area(s)	Not Addressed in this Presentation
Provider Type	Hospitals (including psychiatric and rehab. units)	Critical access hospitals Non-hospital providers (*e.g., nursing homes, home health agencies*)
Source of Emergency Flexibilities	Federal legislative and executive action State action that supports implementation	Comprehensive review of additional state flexibilities (*e.g., licensure laws, Medicaid policy*)
Payers of Interest	Medicare and Medicaid	Commercial plans
Type of Emergency Relief	Regulatory relief	Supplemental funding that is not connected to reimbursement for particular services (*e.g., funds from CARES Act pools, Medicare advance payments*)

Operational Implications of Federal & State Flexibilities

Overview of Flexibilities

Federal and state flexibilities allow hospitals to rapidly increase access to care.

COVID-19 Testing & Reporting

Expand testing capacity through flexibilities on scope of practice and coverage

Comply with state and federal mandates on testing, reporting, and price transparency

Workforce Flexibilities

Maximize practitioner capacity through:

- Enhanced physician reimbursement
- "Top of license" practice
- Streamlined deployment

Locational Flexibilities

Leverage telehealth and alternate sites of care to:

- Enhance hospital capacity
- Facilitate isolation ("cohorting") of COVID and non-COVID patients

Administrative Flexibilities

Minimize administrative burdens by temporarily suspending certain:

- Patient notifications
- Documentation requirements
- Federal reporting

COVID-19 Testing & Reporting: Overview

New flexibilities expand the circumstances under which providers may administer and bill for COVID tests, including through expansions to practitioner scope of practice.

New state and federal mandates require hospitals to:

- ✓ Confirm suspected cases of COVID and influenza
- ✓ Collect and report COVID data
- ✓ Publicize the cash price of COVID tests

COVID Testing: Flexibilities for Providers

Ordering & Administering COVID-19 Tests

Collection of throat, nasopharyngeal, and saliva swab specimens may be:

- Ordered via standing order from a physician or NP for anyone "suspected of suffering from" COVID-19
- Ordered and administered by an RN or a pharmacist
- Performed by an unlicensed individual (subject to completing DOH training)

Blood draws for antibody testing

- Non-nursing staff members who complete DOH-approved training may perform nursing tasks (such as blood draws) under the supervision of a nurse
- Pharmacists may order and administer COVID antibody tests

Coverage of Diagnostic Testing in General

Medicare will cover diagnostic tests performed or supervised by any PA, NP, CNS, or certified nurse midwife acting within scope of practice

Medicaid will cover laboratory tests that are:

- Administered in non-office settings (e.g., parking lots)
- FDA-authorized COVID-19 tests for self-collection.

Coverage of COVID-19 Testing

Medicare

- Tests for COVID-19, influenza, and respiratory syncytial virus may be ordered by any practitioner acting within scope of practice. Medicare documentation requirements are waived if no written order.
- Each Medicare beneficiary is entitled to one COVID-19 test *without* an order from a treating practitioner.

NY Medicaid has issued guidance on billing for COVID-19 specimen collection, diagnostic testing, and antibody testing.

Medicare and Medicaid will reimburse health care providers to "counsel patients to isolate/quarantine at the time of COVID-19 testing," using existing codes for E/M or other services, as applicable. (See MLN SE20011 for details.)

Source: *CMS interim final rules (3/31, 5/8, 9/2); MLN Matters SE20011; HHS PREP Act Declaration; NY EOs 202, 202.1, 202.10, 202.44, 202.69.*

COVID Testing: State Testing Mandate

DOH Requires Testing of Suspected COVID & Flu Cases

- Any hospital patient known to be exposed to either COVID-19 or influenza, or who exhibits symptoms of either COVID-19 or influenza, must be tested for both.
- A hospital shall administer both a COVID-19 and influenza test within 48 hours after death if: (1) a person dies while in or en route to the hospital, (2) there is a clinical suspicion that COVID-19 or influenza was a cause of death, and (3) no such tests were performed in the 14 days before death.
- Any positive occurrence of COVID-19 or influenza found in a patient, or after a patient's death, shall be reported to DOH immediately upon receipt of both test results.

DOH has also released guidance on the appropriate use of rapid molecular tests, such as the Abbott ID NOW.

Source: *DOH emergency regulations*.

COVID Testing: Federal & State Reporting Mandates

NYS Requirements for Data Collection & Reporting

- Licensed healthcare professionals administering COVID-19 tests must ***report results to DOH within 24 hours*** using the Electronic Clinical Laboratory Reporting System (ECLRS). DOH may set shorter reporting times as it deems necessary.
- Healthcare professionals who administer COVID-19 tests ***must ask for, and report to the ECLRS, the following information***:
  - The patient's local address (and permanent address, if different)
  - Whether the individual attends school and, if so, what school
  - The individual's place of employment, if any, including an indication of whether the individual works or volunteers in an elementary, secondary or postsecondary school

Federal Reporting Requirements

- Hospitals must report COVID-19 data directly to HHS on a daily basis in accordance with HHS guidance here and here
- HHS expects to ramp up enforcement effective November 18, as described in this enforcement overview

Note: The requirements above apply to healthcare providers.
Hospital-based *laboratories* are subject to additional requirements not discussed here.

Source: *NY EO 202.61, 202.72; CMS interim final rule (9/2).*

COVID Testing: Federal Price Transparency Mandate

Price Transparency

- Providers that offer COVID diagnostic tests must publish on its website the cash price of a COVID test.
- If a provider does not have its own website, the provider must:
  - Upon request, make the cash price available in writing within two business days
  - Publicize the cash price through signage (if applicable).

Source: *CMS interim final rule (11/2)*

Workforce Flexibilities: Overview

Hospitals can maximize practitioner capacity by enhancing reimbursement and streamlining supervision and deployment.

COVID-related flexibilities allow hospitals to:

- ✓ Disregard certain restrictions on **licensure, privileging, and credentialing**
- ✓ Enhance **physician reimbursement & benefits**
- ✓ Allow clinicians to **practice at the top of their license**

Note: Licensed practitioners are shielded from malpractice liability for services that are (1) directly related to diagnosing COVID-19 or treating a known/suspected case of COVID-19; (2) within their scope of practice; and (3) rendered in good faith without gross negligence.

Source: *NY S7506B (Article 30-D), as amended by SB 8835 (similar flexibility previously provided through Executive Order).*

Workforce Flexibilities: Streamlined Deployment

Relaxed Rules on Licensure and Credentialing

New practitioner licensure flexibilities:

- A practitioner may ***practice in New York*** as long as they hold a license in good standing in another state or a Canadian province

  This flexibility applies to: MD, PA, nurse (NP, LPN, RN), radiologic technologist, clinical nurse specialist, special assistant, licensed social worker, respiratory therapy technician,* various types of counselors and therapists* *[*For these practitioners, NY waiver permits out-of-state licensure, but not Canadian licensure]*

- ***Recent graduates*** may, in some circumstances, practice under the supervision of a licensed practitioner. Applies to: physicians and DOs; also NPs, RPNs, and LPNs (but limited to 180 days)
- ***Graduates of foreign medical schools*** may practice if they have at least 1 year of graduate medical education.

A hospital may deploy practitioners while their ***medical staff privilege*** applications/renewals are pending. An ambulatory surgical center (ASC) may forgo reappraisal of staff privileges and scope of procedures performed.

New York has relaxed certain requirements for new staff regarding physical exams and immunization records, as described here.

Medicare & Medicaid offer ***streamlined enrollment procedures*** and will reimburse for services rendered in New York by a practitioner with out-of-state license *(if not excluded from the program or excluded from licensure in any state).*

Source: *CMS blanket waivers; NY EOs 202, 202.1, 202.5, 202.10, 202.15, 202.18.*

Workforce Flexibilities: Physicians

Enhanced Physician Reimbursement & Benefits

Hospitals may enter into **"financial relationships" with physicians** that would normally create risk under the Stark Law, including:

- ***Enhanced reimbursement*** *(e.g., hazard pay)*
- ***In-kind benefits*** for MDs and their families *(e.g., housing, childcare, meals, laundry, or transportation)*
- ***Lease/sale of space or equipment*** at below-market rates

Note: Hospitals can already provide such benefits to non-physicians, although there may be Anti-Kickback Statute implications if a clinician can make referrals to the hospital.

Medicare Substitute Billing *(Locum Tenens)*

A physician (or PT) may use the ***same substitute for the entire time*** he/she is unavailable to provide services during the emergency period, plus up to 60 continuous days after the emergency period expires. *(Normally, a 60-day limit applies.)*

Source: *CMS blanket waivers & interim final rule (5/8); HHS PREP Act Declaration; NY EOs 202, 202.10.*

Workforce Flexibilities: Non-Physician Practitioners

Enhanced Ability for Practitioners to Work at Top of License

Medicare

- NPs and PAs may supervise the care of Medicare patients
- Where required by Medicare, physician supervision may be achieved remotely by telemedicine

Medicaid. NPs, PAs, and clinical nurse specialists (CNSs) may order Medicaid home health services *(now a permanent change)*

NY Scope of Practice.

- NY has lifted requirements for physician supervision/written agreements for NPs, PAs, and medical assistants (incl. anesthesia services by a certified registered nurse anesthetist with a master's or doctorate)
- Respiratory care services may be provided by any qualified practitioner *(no need for written plan)*

Pharmacists, pharmacy interns, and pharmacy technicians

- Pharmacists may order & administer COVID-19 vaccines and ACIP-recommended child vaccines (subject to completing an ACPE training)
- Pharmacy interns and technicians may administer COVID-19 vaccines and ACIP-recommended child vaccines under the supervision of a pharmacist (subject to completing an ACPE training)

Source: *CMS blanket waivers & interim final rule (5/8); HHS PREP Act Declaration; NY EOs 202, 202.10.*

Workforce Flexibilities: Medical Residents

- ***Teaching physician*** may supervise residents using telehealth*
- The ***primary care exception*** for residents now includes additional E/M and other services*
- For purposes of ***GME***, a hospital may claim the time FTE residents spend at other hospitals (or alternative sites of care) in lieu of time spent training at the primary hospital. *(The resident's presence at a nonteaching hospital will not trigger establishment of IME and/or DGME FTE resident caps.)*

**These flexibilities do not apply with respect to "surgical, high-risk, interventional, or other complex procedures, services performed through an endoscope, or anesthesia services."*

Source: *CMS interim final rules (3/31 & 5/8).*

Locational Flexibilities: Overview

By leveraging alternative sites of care, hospitals can increase capacity and minimize contagion by separating COVID and non-COVID patients.

COVID-related flexibilities allow hospitals to:

- Expand use of **telehealth** to additional services and settings
- Establish **new temporary sites of care**
- **Re-designate existing clinical spaces**, including specialty units/facilities
- Conduct **emergency medical screenings** in alternate locations

Source: *CMS blanket waivers; NY EOs 202.1, 202.5, 202.10.*

Locational Flexibilities: Telehealth Coverage

Medicare and NY Medicaid have substantially expanded the range of covered telehealth services.

Program	Covered Services	Eligible Practitioners	Permissible Locations	Tech Platforms
Medicare	• Practitioner services • ED visits, critical care • Hospital observation • Mental health counseling (Full list here)	Any practitioner eligible to bill Medicare for professional services *(now including OTs, PTs, and speech language pathologists)*	Both patient and practitioner may be anywhere *(including at home)* No restrictions on urban vs. rural	Common video technologies like FaceTime, Skype, or Zoom Audio-only for certain services, as listed in the Physician Fee Schedule
New York State Medicaid	Coverage for all Medicaid providers in all situations, if "appropriate for the care of the member," as described here.		Same as above *(home or clinical setting, urban or rural)*	Common video technologies (as above) Audio-only services, as appropriate, for assessment, monitoring, and E/M

Reimbursement Implications

- Medicare and Medicaid telehealth services are billed at regular rate for the applicable service
- Different rates apply to certain telephonic assessments, although CMS's May 8 interim final rule increased the RVU for certain audio-only E/M services (99441 to 99443)
- For Medicare telehealth services rendered during an inpatient stay, hospitals should bill their A/B MAC for the originating site facility fee on a 012x type of bill (TOB).

Source: *CMS blanket waivers & interim final rules (3/31 & 5/8); CARES Act; HHS OCR guidance; NY Medicaid guidance; Medicare FFS FAQs.*

Locational Flexibilities: Other Telehealth Issues

HHS and CMS have granted additional flexibilities to streamline telehealth access and delivery.

Enhanced Access

- Medicare/Medicaid will reimburse services by a practitioner with an out-of-state license
- Hospitals may provide medical staff with free access to telehealth technology
- Providers may waive or reduce cost-sharing for Medicare/Medicaid telehealth visits

Relaxed Documentation Requirements

- Practitioners may render telehealth services from their home without reporting home address on Medicare enrollment
- Hospitals may enter into streamlined telemedicine agreements without meeting all current federal requirements (e.g., requirement to privilege distant-site practitioners)

Source: *CMS blanket waivers & interim final rule; CARES Act; HHS OCR & OIG guidance; NY Medicaid guidance.*

Locational Flexibilities: Alternative Sites of Care

"Hospitals without walls": CMS has waived Medicare/Medicaid conditions of participation (COPs), and New York has waived facility licensure and certification standards.

Potential Alternative Sites of Care

New Temporary Sites of Care

Provide hospital-level care in hotels, community centers, or school gymnasiums

Re-designated Clinical Spaces

Re-enroll an ambulatory surgical center (ASC) as a hospital

Specialty Units/Facilities

Flexible use of beds designated for acute care, psych, or inpatient rehab

An alternative site of care must be:

- Under the hospital's control & oversight, and
- State-approved to ensure "safety and comfort for patients and staff"

Hospitals should follow DOH guidance when seeking approval to establish alternative sites of care.

See CMS's fact sheet and the Appendix for additional details.

Medicare Reimbursement

- Services provided at alternate site are reimbursed at regular hospital rate
- 20% Medicare DRG increase for COVID 19-related discharges *(incl. out-of-network Medicare Advantage payments).* Effective Sept. 1, a positive COVID-19 test must be documented in the record.
- Medicare covers quarantine days following inpatient stay, even after patient becomes ineligible for inpatient-level care
- Provider-based departments may be located off campus, incl. in patient homes

Source: *CMS blanket waivers & interim final rule (5/8); CMS Medicare coverage guidance; CARES Act s.3710.*

Locational Flexibilities: Diverting ED Patients

Hospital emergency departments (EDs) may divert patients to alternative sites for emergency medical screenings (MSEs).

Patient with COVID-19 Symptoms

Hospital ED

Redirection and Logging

On-Campus Alternative Screening Site

(≤ 250 yards of hospital)

Off-Campus Alternative Screening Site

(Must be under hospital's control, absent a CMS waiver)

Hospitals may request to divert ambulances by: (1) going on "diversionary status" when the ED is at capacity, or (2) participating in government-approved communitywide ambulance protocols. **All EMTALA obligations still apply to any patient who presents to the ED**.

Source: *CMS Emergency Medical Treatment and Labor Act (EMTALA) guidance & blanket waivers.*

Administrative Flexibilities: Overview

Hospitals may prioritize clinical care by suspending or relaxing non-critical administrative functions.

COVID-related flexibilities allow hospitals to:

- Streamline **clinical documentation** practices
- Suspend certain **review and reporting** activities
- Relax certain "**physical environment" conditions of participation**
- Delay or suspend certain **patient notification and confidentiality** requirements
- Suspend collection of **cost sharing** for certain services

Note: DOH has promulgated emergency regulations requiring each hospital to develop a "Surge and Flex Response Plan."

Administrative Flexibilities: Cautionary Note

CMS has begun to unwind certain previously granted administrative flexibilities

- Although CMS initially suspended many types of provider surveys, CMS directed states in August to ***resume certain types of provider survey, certification, and enforcement activities***.
- Effective August 17, the Medicare Administrative Contractors (MACs) have ***resumed post-payment reviews*** of items/services provided under Medicare FFS before March 1, 2020. *(The Targeted Probe and Educate program will restart later.)*

Administrative Flexibilities

Clinical Documentation	▪ CMS waivers: – Permit streamlined medical records, which may be finalized >30 days after discharge – Allow increased reliance on standing orders, as well as verbal orders *(with read-back verification and later authentication)* – Suspend requirement for individualized nursing care plans and written outpatient nursing policies ▪ New York State recordkeeping requirements apply, however *(the prior NY waiver was repealed effective May 8 (EO 202.28))*
Reporting Requirements	▪ ***CMS*** has relaxed timelines and requirements for: – QAPI – 2019 cost reporting (revised due date of August 31 for the period ending 12/31/19) – Occupational Mix survey (now due September 3) – CMS Innovation Center Models – Reporting ICU deaths – GME Affiliation Agreements (deadlines now extended to January 1, 2021) – Applications to the Medicare Geographic Classification Review Board ▪ The ***IRS*** has relaxed the timeline for filing a community health needs assessment (CHNA) ▪ ***DOH*** has relaxed reporting requirements for hospital-associated infections for incidents occurring between January and June 2020

See the Appendix for more details on these flexibilities

Source: *CMS blanket waivers; CMS Guidance; DOH DHDTC DAL 20-10.*

Administrative Flexibilities

Physical Environment COPs	CMS has relaxed COPs related to the following: ▪ Inspection, Testing & Maintenance (ITM) requirements ▪ Placement of alcohol-based hand-rub dispensers ▪ Fire drills
Patient Notification & Confidentiality Requirements	▪ Delay in responding to medical records requests ▪ Reduced discharge planning requirements, but hospitals must also comply with new discharge requirements related to nursing homes (see NY Executive Order 202.30 and this guidance) ▪ No need to provide notice of advance directive policies ▪ Flexibility on delivery of Medicare notices (e.g., MOON, ABN) ▪ Providers may use PHI to contact patients who've recovered from COVID-19 to provide information about donating blood & plasma ▪ Limited HIPAA waivers (only certain consent/privacy rules, and only for 72 hours after activation of hospital disaster protocol)
Cost Sharing	▪ Medicare: No cost sharing for COVID testing and testing-related services (both FFS & Medicare Advantage) ▪ Medicaid: No cost sharing for COVID testing *or* treatment

See the Appendix for more details on these flexibilities

Source: *CMS blanket waivers; HHS OCR HIPAA Guidance.*

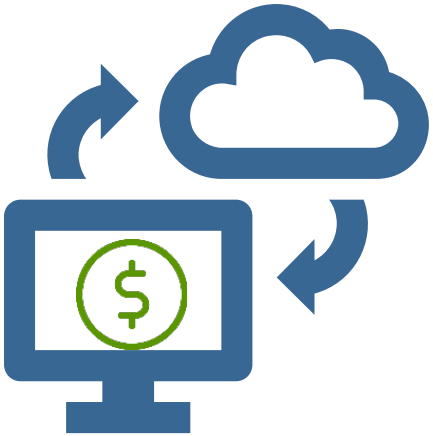
Revenue Cycle Implications & Billing Guidance

Revenue Cycle Implications & Billing Guidance

Secure enhanced reimbursement and avoid billing issues by using appropriate codes and modifiers, supported by proper documentation in the medical record.

Billing Guidance

COVID-19 Billing Codes	Use COVID-19 diagnosis, testing, treatment codes to access enhanced coverage & reimbursement. Current codes for COVID testing are listed here.
Modifiers	Use modifiers to ensure smooth billing when exercising emergency flexibilities.
Clinical Documentation	Ensure appropriate documentation of emergency flexibilities, especially regarding alternative sites of care
Telehealth Billing	Bill appropriately for professional telehealth services



*Billing codes & modifiers are listed in the **Appendix***

Source: *MLN Matters MM11960 & SE20011; NY Medicaid coverage guidance.*

Thank You

For additional questions, please contact
COVIDProviderSupport@cityhall.nyc.gov

Appendices

Appendix: Key Federal Legislation & Executive Action

- **Section 1135 Waivers issued by the Department of Health & Human Services (HHS) and CMS**
  - CMS Webpage with New Waivers & Flexibilities for Health Care Providers
    - Full text of CMS blanket waivers (last updated September 29, 2020)
    - CMS summary of the waivers most relevant for hospitals (last updated November 4, 2020)
    - CMS Fact Sheet on alternative sites of care for hospitals (May 26, 2020)
    - Additional detail re: waivers of the Stark Law's prohibitions on physician self-referrals
    - CMS Guidance for Ambulatory Surgical Centers (ASCs) Temporarily Enrolling as Hospitals (April 3, 2020)
  - Manatt primer on the 1135 waiver authority
- **CMS Interim Final Rules**
  - Interim Final Rule **effective March 31, 2020;** Manatt summary here
  - Interim Final Rule **effective May 8, 2020**
  - Interim Final Rule **effective September 2, 2020**
  - Interim Final Rule **effective November 2, 2020**; CMS fact sheet here
- **The CARES Act, enacted on March 27, 2020** (Manatt summary here)
- **Telehealth & HIPAA**
  - CMS fact sheet & FAQs re: telehealth & HIPAA (March 17, 2020)
  - Manatt summary of telehealth flexibilities (as of March 18, 2020)
  - OCR HIPAA guidance re: commonly used telehealth technologies (March 17, 2020)
  - OIG guidance on waiving cost sharing and providing free/discounted access to telehealth technology
- **Medicare Coverage and Billing**
  - CMS guidance: Medicare Fee-for-Service (FFS) Response to COVID-19, MLN Matters SE20011 (last updated October 16, 2020)
  - CMS guidance: COVID-19 Policies for IPPS Hospitals, LTCHs, and IRFs, SE20015 (last updated September 11, 2020)
  - CMS FAQs on Medicare FFS Billing during COVID-19 (last updated October 28, 2020)
  - CMS guidance: Medicare Advantage and Medicare Part D: CMS, Information Related to COVID-19 (Mar. 10, 2020)
- **CMS Guidance on suspension of non-emergency surveys, infection control practices, and EMTALA here and here**
  - Manatt summary of EMTALA guidance & 1135 waivers (June 3, 2020)
- **HHS PREP Act Declarations** (last updated September 3, 2020) **and related guidance** (October 20, 2020)
- **HHS ASPR COVID-19 Hospital Resource Compilation**
- **CMS Guidance on Innovation Center Models here** (June 3, 2020)

Appendix: Key State Executive Actions and City Resources

New York Executive Orders and Department of Health (DOH) Guidance, catalogued by Manatt here.

- **Executive Orders** may be renewed in 30-day increments, in accordance with N.Y. Executive Law § 29-a. The Governor has renewed most of the healthcare-related waivers and directives through December 3 (except as expressly terminated), although some are currently scheduled to expire in mid November. (See the renewal language EO Nos. 202.69, 202.70, and 202.72).
  - Particularly relevant Executive Orders include:

No. 202 (March 7, 2020)	No. 202.1 (March 12, 2020)	No. 202.5 (March 18, 2020)
No. 202.10 (March 23, 2020)	No. 202.15 (April 9, 2020)	No. 202.18 (April 16, 2020)
No. 202.30 (May 10, 2020)	No. 202.40 (June 9, 2020)	No. 202.44 (June 21, 2020)
No. 202.61 (Sept. 9, 2020) *Manatt summary here*		

- **Medicaid Coverage Guidance**
  - NY DOH Medicaid Update: New York State Medicaid Coverage and Reimbursement Policy for Services Related to Coronavirus Disease 2019 (COVID-19) (last updated Mar. 27, 2020)
  - NY DOH guidance: Medicaid Update, Telehealth & Telephonic Services During COVID-19 (last updated May 29, 2020)
  - Telehealth FAQs (last updated May 1, 2020)
  - NY DOH Medicaid Billing Guidance for COVID-19 Testing and Specimen Collection

NYC Resources

- NYC DOHMH guidance for providers regarding COVID-19, including with respect to testing and reporting
- NYC summaries of federal and state funding and regulatory activity

Appendix: Telehealth

See here for the list of Medicare services that may be furnished via audio-video telehealth and billed at the usual Medicare rate (last updated October 14). See below for a sample of newly eligible CPT codes.

(See here for telehealth guidance in the New York Medicaid program.)

- **Emergency Department Visits, Levels 1-5**
  (CPT codes 99281-99285)
- **Initial and Subsequent Observation and Observation Discharge Day Management**
  (CPT codes 99217-99220; CPT codes 99224-99226; CPT codes 99234-99236)
- **Initial hospital care, hospital discharge day management**
  (CPT codes 99221-99223; CPT codes 99238- 99239)
- **Initial nursing facility visits, All levels (Low, Moderate, and High Complexity), nursing facility discharge day mgmt.**
  (CPT codes 99304-99306; CPT codes 99315-99316)
- **Critical Care Services**
  (CPT codes 99291-99292)
- **Domiciliary, Rest Home, or Custodial Care services, New and Established patients**
  (CPT codes 99327- 99328; CPT codes 99334-99337)
- **Home Visits, New and Established Patient, All levels**
  (CPT codes 99341- 99345; CPT codes 99347-99350)
- **Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent**
  (CPT codes 99468- 99473; CPT codes 99475-99476)
- **Initial and Continuing Intensive Care Services**
  (CPT codes 99477-994780)
- **Care Planning for Patients with Cognitive Impairment**
  (CPT code 99483)
- **Psychological and Neuropsychological Testing**
  (CPT codes 96130-96133; CPT codes 96136- 96139)
- **Therapy Services, Physical and Occupational Therapy, All levels**
  (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- **Radiation Treatment Management Services**
  (CPT code 77427)

Appendix: Alternative Sites of Care (NY State Law)

NY Executive Orders modify various hospital site requirements under NY state law, although some waivers have now been terminated.

Executive Order No. 202.10 suspends the following laws **"to the extent necessary to permit and require general hospitals to take all measures necessary to increase the number of beds available to patients"**:

- N.Y. Public Health Law § 2803
- 10 NYCRR Parts 400, 401, 405, 709*, 710, 711, and 712

Hospitals should follow DOH guidance **when seeking approval to establish alternative sites of care**.

Executive Order No. 202.44 allows DOH to approve "**temporary dedicated birthing sites** operated by currently-licensed birthing hospitals and currently-licensed birthing centers."

(Note: Executive Order No. 202.28 ***terminated*** **the previously granted waiver of construction and building codes** "to the extent necessary to allow, upon approval by the Commissioner of Health or the Commissioner of OPWDD" (Executive Order No. 202.5):

- The temporary changes to physical plant, bed capacities, and services provided;
- The construction or establishment of temporary hospital locations and extensions; and
- The increase in and/or exceeding of certified capacity limits.

For additional detail on the Governor's expectations for hospitals' use of these waivers, see the full text of Executive Orders Nos. 202, 202.1, 202.5, and 202.10, as well as DOH's emergency regulations requiring each hospital to develop a "Surge and Flex Response Plan."

Appendix: Alternative Sites of Care (Environment)

To support alternative sites of care, CMS blanket waivers modify certain hospital Conditions of Participation related to "Physical Environment"

Waived Rule	Blanket Waiver Text
Physical environment 42 CFR 482.41	[To allow for flexibilities during surges,] CMS will permit non-hospital buildings/space to be used for patient care and quarantine sites, provided that the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. [As part of this waiver,] CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients. Refer to: 2012 LSC, sections 18/19.3.3.2.
Outside window/door 42 CFR 482.41(b)(9)	[This rule normally requires hospitals] to have an outside window or outside door in every sleeping room. CMS will [waive these] requirements to permit these providers to utilize facility and non-facility space that is not normally used for patient care to be utilized for temporary patient care or quarantine.
Provider-based departments 42 CFR 413.65	[CMS will] allow hospitals to establish and operate as part of the hospital any location meeting those conditions of participation for hospitals that continue to apply during the PHE. This waiver also allows hospitals to change the status of their current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the state or local pandemic plan. This extends to any entity operating as a hospital (whether a current hospital establishing a new location or an Ambulatory Surgical Center (ASC) enrolling as a hospital during the PHE pursuant to a streamlined enrollment and survey and certification process) so long as the relevant location meets the conditions of participation and other requirements not waived by CMS.

Appendix: Alternative Sites of Care (Required Policies)

CMS blanket waivers relax facilitate alternative temporary sites of care by allowing hospitals to forgo developing written policies and procedures specifically tailored to new, temporary care sites.

***Note*: Although NY previously issued a waiver permitting hospitals to "adopt existing policies and procedures … at a new, temporary facility," that waiver has been repealed effective May 8, 2020 (per NY Executive Order 202.28).**

Waived Rule	Blanket Waiver Text
Food & dietetic service 42 CFR 482.28(b)(3)	CMS is waiving the requirement … to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals would not need to be maintained at surge capacity sites[, as long as this flexibility is] not inconsistent with a State or pandemic/emergency plan.
Emergency appraisal policies & procedures 42 CFR 482.12(f)(3)	[W]ritten policies and procedures for staff to use when evaluating emergencies are not required for surge facilities[, as long as this flexibility is] not inconsistent with a state's emergency preparedness or pandemic plan.
Emergency preparedness policies & procedures 42 CFR 482.15(b), (c)(1)-(5)	CMS is waiving [the requirements for] the hospital to develop and implement emergency preparedness policies and procedures, and [for] the emergency preparedness communication plans for hospitals to contain specified elements with respect to the surge site. The requirement under the communication plan requires hospitals … to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and [critical access hospitals], and volunteers. This would not be an expectation for the temporary expansion site.

Appendix: Alternative Sites of Care (Swing Beds)

CMS blanket waivers increase flexibility with respect to Medicare "swing beds," which allow hospitals to provide either acute care or nursing-home-level care

CMS is waiving the requirements at 42 CFR 482.58(a)(1)-(4) to allow hospitals to **establish skilled nursing facility (SNF) swing beds payable under the SNF prospective payment system (PPS)**. This waiver provides additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF. This waiver applies to all Medicare-enrolled hospitals, except psychiatric and long term care hospitals.

In order to qualify for this waiver, hospitals must:

- Not use SNF swing beds for acute level care.
- Comply with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
- Be consistent with the state's emergency preparedness or pandemic plan.

To add swing bed services, hospitals must call the CMS Medicare Administrative Contractor (MAC) enrollment hotline, and must attest to CMS that:

- They have made a good faith effort to exhaust all other options;
- There are no skilled nursing facilities within the hospital's catchment area that are willing or able to accept patients because of the COVID-19 public health emergency (PHE);
- The hospital meets all waiver eligibility requirements; and
- They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

Appendix: Alternative Sites of Care (Specialty)

Federal flexibilities regarding specialty units and facilities *(1/2)*

CMS blanket waivers permit hospitals to relocate patients as necessary across inpatient units.

- Housing acute care patients in excluded distinct part units designated for inpatient psychiatric or rehabilitation care.
- Housing psych or rehab inpatients in the acute care unit.

Similarly, **freestanding specialty facilities may provide surge capacity to acute care hospitals** under CMS's interim final rule (3/31), which permits "routine services to [] be provided under arrangements outside the hospital." The newly permissible services are those defined at Social Security Act section 1861(b)(1) & (2):

- Bed and board; and
- Such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients.

These flexibilities are **permitted only if the bed is "appropriate"** for the type/level of care provided, as described in the blanket waivers. "For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for."

Medicare billing. The hospital should bill at the applicable prospective payment system (PPS) rate (inpatient, psych, or rehab), and should "annotate the patient's medical record to indicate":

- The type of care provided;
- The type of bed/unit in which care was provided; and
- The fact that the patient was relocated to a different unit "because of capacity or other exigent circumstances related to the COVID-19 emergency."

Appendix: Alternative Sites of Care (Specialty)

Federal flexibilities regarding specialty units and facilities *(2/2)*

Inpatient rehabilitation facilities (IRF)

- **The 60% rule**. Under the CMS blanket waiver, inpatient rehabilitation facilities and units (IRFs) may exclude patients from the "for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the '60 percent rule') if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such." This waiver also applies to "facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF."
- **The 3-hour rule**. The CARES Act waives the federal requirement that IRF patients must receive at least 15 hours of therapy per week (i.e., 3 hours per day, 5 days per week) for the facility to be eligible for payment under Medicare's IRF PPS. CARES Act § 3711 (waiving 42 CFR 412.622(a)(3)(ii)); *see also* interim final rule (5/8).
- **Coverage requirements for freestanding IRFs**. CMS's interim final rule (5/8) waives certain coverage requirements for freestanding IRFs (specifically, CFR §§ 412.29(d), (e), (h), and (i) and 412.622(a)(3)-(5)) as necessary for IRFs to relieve acute care hospital capacity during the COVID-19 PHE. This waiver applies when a state is in phase 1 (or prior to entering phase 1) of the White House Guidelines for Opening Up America Again, but are no longer available when the state is in phase 2 or phase 3.

Long-term care hospitals: Medicare payment rules. The CARES Act waives two limitations on Medicare payment for long-term care hospitals (LTCHs) :

- The "50% rule," which imposes a payment penalty if less than 50% of an LTCH's discharges are paid at the standard LTCH rate rather than the site-neutral rate; and
- The LTCH site-neutral payment rate itself, but only as applied to an admission that is in response to the COVID-19 public health emergency

Appendix: Alternative Sites of Care (IME)

CMS's interim final rule (5/8) made the following modifications to Indirect Medical Education (IME) payments

A teaching hospital's IME payment adjustment (an enhanced payment to recognize higher indirect patient care costs due to intern and resident training) is largely tied to the ratio of full time equivalent (FTE) interns and residents to hospital beds. An increase in the number of available beds at a hospital with no changes to the number of residents would normally result in a decrease in a hospital's IME payments. Similar payment adjustments, called "teaching status adjustments," are applied to inpatient rehabilitation facilities (IRFs) and inpatient psychiatric facilities (IPFs) that train medical interns and residents, and are based on a calculation that includes the average daily census of the facility.

During the COVID-19 PHE, CMS is changing its policies to protect eligible hospitals that temporarily increase the number of beds in response to COVID-19—as well as IRFs and IPFs that take more patients to help increase capacity to care for COVID-19 patients—from experiencing teaching status adjustment reductions that would otherwise be triggered under the payment formula.

Specifically, **CMS will consider a hospital's bed count to be the same as it was on the day before the COVID-19 PHE was declared for purposes of determining a hospital's IME payment**. (In effect, temporary beds allowed under PHE flexibilities will be excluded from the calculation to determine IME payment.) Similarly, CMS will freeze the IRF's or IPF's teaching status adjustment payments at their value on the day before the PHE was declared.

Appendix: Administrative Flexibilities (Documentation)

CMS's blanket waivers modify certain documentation requirements, as described below. However, New York State recordkeeping laws apply. *(State recordkeeping requirements were previously waived, but that waiver was terminated eff. May 8, 2020 in NY Executive Order 202.28.)*

Waived Rule	Statutory/Blanket Waiver Text
Medical Records 42 CFR §482.24(a)-(c)	CMS is waiving requirements [that address] the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements, and these flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. CMS is waiving §482.24(c)(4)(viii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge from a hospital.
Verbal orders 42 CFR 482.23, 482.24, 485.635(d)(3)	CMS is [providing] additional flexibility related to verbal orders where readback verification is required, but authentication may occur later than 48 hours. This will allow more efficient treatment of patients in surge situations. Specifically, the following requirements are waived: • §482.23(c)(3)(i) - If verbal orders are used for the use of drugs and biologicals (except immunizations), they are to be used infrequently. • §482.24(c)(2) - All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient. • §482.24(c)(3) - Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders. This would include all subparts at §482.24(c)(3). • §485.635(d)(3) - Although the regulation requires that medication administration be based on a written, signed order, this does not preclude the CAH from using verbal orders. A practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact.
Nursing care plans, policies, and procedures 42 CFR §482.23(b)(4), (7). 485.635(d)(4)	CMS is waiving the requirements [for] the nursing staff to develop and keep current a nursing care plan for each patient, and [for hospitals and CAHs] to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present… In addition, we expect that hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely of lower priority. These flexibilities … may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

Appendix: Administrative Flexibilities (Reporting)

CMS blanket waivers and guidance modify certain federal reporting requirements.

Waived Rule	Blanket Waiver/Guidance Text
Quality assessment and performance improvement program 42 CFR 482.21(a)-(d) & (f), 485.641(a)-(b), & (d)	CMS is waiving [requirements that] provide details on the scope of the [QAPI] program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated QAPI programs (for hospitals that are a part of a hospital system)[, as long as this flexibility is] not inconsistent with a state's emergency preparedness or pandemic plan. We expect any improvements to the plan to focus on the Public Health Emergency… [T]he requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain.
Cost Reporting	CMS further delayed the filing deadline for the following fiscal year end (FYE) dates. CMS delayed the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS also delayed the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 was August 31, 2020 (representing a one-month delay over the original extension to July 31, 2020). CMS has, in addition, provided guidance on how provider cost reports should account for Provider Relief Fund payments and Small Business Administration Loan Forgiveness. See the Medicare FFS FAQs (Section V) for details.
Wage Index Occupational Mix Survey	CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. [The deadline for FY 2022 was originally July 1, 2020,] but CMS granted an extension for hospitals nationwide affected by COVID-19 until August 3, 2020. Due to continued COVID related concerns from hospitals about meeting this deadline, CMS further extended this deadline to September 3, 2020; the deadline for hospitals to submit revisions to their occupational mix surveys was September 10, 2020.

Appendix: Administrative Flexibilities (Reporting, cont.)

CMS blanket waivers and guidance modify certain federal reporting requirements.

Waived Rule	Blanket Waiver/Guidance Text
Utilization review 42 CFR 482.1(a)(3), 482.30	CMS is waiving [the requirements for] hospitals participating in Medicare and Medicaid to have a utilization review plan that meets specified requirements. CMS is waiving the entire Utilization Review CoP at §482.30, which requires that a hospital must have a utilization review (UR) plan with a UR committee that provides for review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided[, as long as this flexibility is] not inconsistent with a State or pandemic/emergency plan.
CMS Innovation Center Models See guidance	CMS has modified the financial methodology, quality reporting requirements, and/or model timelines with respect to the following: • Bundled Payments for Care Improvement Advanced • Comprehensive ESRD Care Model (CEC) • Comprehensive Care for Joint Replacement (CJR) Model • Direct Contracting (Global & Professional) • Emergency Triage, Treat, and Transport (ET3) • Home Health Value-Based Purchasing Model (HHVBP) • Independence at Home (Section 3024 of the ACA) • Integrated Care for Kids (InCK) Model • Kidney Care Choices • Maternal Opioid Misuse Model (MOM) • Medicare Care Choices Model • Medicare Diabetes Prevention Program Expanded Model (MDPP) • Medicare ACO Track 1+ Model • Next Generation ACO (NGACO) • Oncology Care Model (OCM) • Primary Care First – Serious Illness Component

Appendix: Administrative Flexibilities (Reporting, cont.)

CMS blanket waivers and guidance modify certain federal reporting requirements.

Waived Rule	Blanket Waiver/Guidance Text
ICU deaths 42 CFR 482.13(g)(1)(i)-(ii)	CMS is waiving [the requirement for] hospitals to report patients in an intensive care unit whose death is caused by their disease process but who required soft wrist restraints to prevent pulling tubes/IVs, may be reported later than close of business next business day, provided any death where the restraint may have contributed is continued to be reported within standard time limits.
GME affiliation agreements 42 CFR 413.79(f)(1) May 12, 1998 HCFA Final Rule (63 FR 26318, 26339, 26341)	During the COVID-19 PHE, instead of requiring that new Medicare GME affiliation agreements be submitted to CMS and the MACs by July 1, 2020 (for the academic year starting July 1, 2020), and that amendments to Medicare GME affiliation agreements be submitted to CMS and the MACS by June 30, 2020 (for academic year ending June 30, 2020), CMS is allowing hospitals to submit new and/or amended Medicare GME affiliation agreements as applicable to CMS and the MACs by January 1, 2021. As under existing procedures, hospitals should email new and/or amended agreements to CMS at Medicare_GME_Affiliation_Agreement@cms.hhs.gov, and indicate in the subject line whether the affiliation agreement is a new one or an amended one.
Medicare Geographic Classification Review Board SSA 1886(d)(10)(C)(ii) 42 CFR 412.256(a)(2)	[CMS is waiving] deadline to submit an application to the Medicare Geographic Classification Review Board (MGCRB) for FY 2022 reclassifications. CMS is postponing the September 1 deadline until 15 days after the public display date of the FY 2021 IPPS/LTCH final rule by the Office of the Federal Register.

Appendix: Administrative Flexibilities (Reporting, cont.)

The IRS has relaxed certain reporting requirements for non-profit hospitals.

Waived Rule	Guidance Text
Community Health Needs Assessment (CHNA) Tax Code 501(r)(3)	For any hospital organization that is required to meet either of the CHNA requirements under section 501(r)(3) between April 1 and December 31, 2020, the CHNA deadline is extended to December 31, 2020. See IRS Notice 2020-56 for more detail; Manatt's summary is available here.

NY DOH has waived certain state reporting requirements in DHDTC DAL 20-10.

Waived Rule	Guidance Text
Hospital-associated infections (HAI) PHL 2819	[DOH] will exercise its enforcement discretion by not enforcing the reporting requirements for HAI data that occur from January 1, 2020 through June 30, 2020. … Additionally, hospital-specific HAI rates for this time period will not be included in the annual NYS HAI report. All hospitals, however, are still required to report outbreaks and/or diseases in accordance with Part 2 of the State Sanitary Code (SSC) and 10 NYCRR 405.11, which includes, but is not limited to, outbreaks or an increased incidence of any hospital-associated infections.

Appendix: Administrative Flexibilities (Environment)

CMS blanket waivers modify certain hospital Conditions of Participation regarding "Physical Environment."

Waived Rule	Blanket Waiver/Guidance Text
Inspection, Testing & Maintenance 42 CFR 482.41(d)	CMS is temporarily [permitting hospitals] to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.
Life Safety Code (LSC) & Health Care Facilities Codes (HCFC) 42 CFR 482.41(b)(1)(i)	CMS is temporarily [permitting hospitals] to adjust scheduled ITM frequencies and activities required by the LSC and HCFC. The following LSC and HCFC ITM are considered critical are not included in this waiver: • Sprinkler system monthly electric motor-driven and weekly diesel engine- driven fire pump testing. • Portable fire extinguisher monthly inspection. • Elevators with firefighters' emergency operations monthly testing. Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing. • Means of egress daily inspection in areas that have undergone construction, repair, alterations, or additions to ensure its ability to be used instantly in case of emergency.
Alcohol-Based Hand Rub (ABHR) Dispensers	[CMS is] waiving the prescriptive requirements for the placement of alcohol based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area. Refer to: 2012 LSC, sections 18/19.3.2.6. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §482.41(b)(7) for hospitals.
Fire Drills	Due to the inadvisability of quarterly fire drills that move and mass staff together, [CMS] will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. Refer to: 2012 LSC, sections 18/19.7.1.6.

Appendix: Administrative Flexibilities (Notifications)

CMS blanket waivers and guidance modify certain patient notification requirements.

Waived Rule	Blanket Waiver/Guidance Text
Discharge planning 42 CFR 482.43(a)(8) & (c), 482.61(e)	[D]ischarge planning will focus on ensuring that patients are discharged to an appropriate setting with the necessary medical information and goals of care. CMS is waiving detailed regulatory requirements to provide information regarding discharge planning… [The hospital] must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to … data on quality measures and data on resource use measures [for LTC facilities and home health agencies]… During this public health emergency, a hospital may not be able to assist patients in using quality measures and data to select a nursing home or home health agency, [and may not be able to receive a comprehensive list of facilities or home health agencies in the geographic area,] but must still work with families to ensure that the patient discharge is to a post-acute care provide that is able to meet the patient's care needs.
Medical record requests 42 CFR 482.13(d)(2)	[CMS is waiving the timeframes normally required for providing, upon request,] a copy of a medical record.
Patient Self-Determination Act SSA 1852(i), 1866(f), 1902(a)(58) & (w)(1)(A); 42 CFR 489.102	CMS is waiving the requirements … to provide information about its advance directive policies to patients.
Required Medicare notices MLN Matters SE20011 *Applies to: ABN, DENC, DND, HINN, IM, NOMNC, MOON, SNFABN*	[Guidance defines flexible notice delivery procedures when] treating a patient with suspected or confirmed COVID-19: • Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely[, including a contact phone number in case the beneficiary has questions]. If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also delivered via email, if a beneficiary has access in the isolation room. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent. • Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

Appendix: Administrative Flexibilities (Confidentiality)

HHS's blanket waiver modify certain confidentiality requirements.

Waived Rule	Blanket Waiver/Guidance Text
Contacting patients about donating blood or plasma (See text)	[HHS OCR guidance clarified that a covered health care provider] may use protected health information (PHI) to identify individuals who have recovered from COVID-19 to provide them with information about how they can donate their plasma containing antibodies to SARS-CoV-2 (the virus that causes COVID-19) for use in potentially treating patients with COVID-19.... [This activity represents] a health care operations activity to the extent that facilitating the supply of donated plasma would be expected to improve the covered health care provider's or health plan's ability to conduct case management for patients or beneficiaries that have or may become infected with COVID-19..... When using or disclosing PHI for health care operations, the covered entity must make reasonable efforts to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure.... A covered health care provider or health plan may identify and contact individuals for this purpose, without authorization, to the extent that this activity does not constitute marketing.... While the HIPAA Privacy Rule permits a covered entity to use PHI to identify and contact its own patients or beneficiaries who have recovered from COVID-19, a covered entity generally cannot disclose PHI to a third party, including another HIPAA-covered entity, without the individuals' authorization, for the third party to make marketing communications about the third party's products or services, unless the third party is making the communication on behalf of the covered entity (i.e., as a business associate).
Time-limited waiver of certain HIPAA rules (See text)	[HHS waived] the following provisions of the HIPAA privacy regulations: (a) the requirements to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of the facility directory (as set forth in 45 C.F.R. § 164.510); (b) the requirement to distribute a notice of privacy practices (as set forth in 45 C.F.R. § 164.520); and (c) the patient's right to request privacy restrictions or confidential communications (as set forth in 45 C.F.R. § 164.522)… [These waivers may be exercised only by hospitals] that have hospital disaster protocols in operation during the time the waiver is in effect, … [and only] for a period of time not to exceed 72 hours from implementation of a hospital disaster protocol.

Appendix: Billing Guidance

Issue	Billing Guidance
COVID-19 testing & treatment codes	
Testing	HCPCS and CPT codes for COVID-19 diagnostic and antibody tests are listed in MLN MM11960.
Treatment	Use the COVID-19 ICD-10 diagnosis code (U07.1) to access Medicare's 20% DRG enhancement for COVID-related inpatient care, available for discharges effective April 1, 2020. Effective for admissions on or after September 1, 2020, claims will be eligible for the 20% increase only if a positive COVID-19 laboratory test is documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. See MLN SE20015 for details. A Medicare add-on payment is available for certain COVID-19 drugs and in both the inpatient and outpatient settings, as described in this CMS fact sheet. Preliminary guidance regarding Medicare coverage of outpatient monoclonal antibody products is available in the Medicare FFS FAQs.
Modifiers for emergency flexibilities	
Medicare	When billing for services that relied on 1135 waivers, use the condition code "DR" (disaster related) for institutional billing (form CMS-1450), and the modifier "CR" (catastrophe/disaster related) for non-telehealth Part B billing, both institutional and non-institutional (form CMS-1500). See MLN SE 20011 for details. When waiving cost sharing for Part B claims, use the modifier "CS" to bill Medicare for the full claim amount.
Medicaid	For COVID-related testing and treatment, report Type of Admission Code "1" for institutional billing, and use Emergency Indicator "Y" for practitioner visits and testing. Undocumented immigrants are eligible for Medicaid coverage of "emergency services," including COVID-19 testing and treatment; use coverage code "07."

Appendix: Billing Guidance (cont.)

Issue	Billing Guidance
Telehealth	
Medicare	Code Place of Service (POS) as if the service was furnished in-person. Use Modifier "95" to indicate the use of telehealth. The CR modifier is not necessary for telehealth services. There are no billing changes for institutional claims. For Medicare telehealth services rendered during an inpatient stay, hospitals should bill their A/B MAC for the originating site facility fee on a 012x type of bill (TOB).
Medicaid	NY DOH has provided detailed billing guidance for both telehealth and telephonic services.
Alternative sites	
Medicare & Medicaid	Hospital services provided in alternative/temporary sites are billed at the hospital's usual rate. A hospital should bill at the appropriate acute care/psych/rehab PPS rate based on services actually rendered, even if the patient was located in a bed designated for a different type of care.