COVID-19: AN ADVOCATES GUIDE TO MEDICARE-RELATED CHANGES

April 17, 2020

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1. INTRODUCTION

The global COVID-19 crisis has led to many changes in health care rules, including in the Medicare program. Most of the changes are slated to be temporary, but advocates will need to watch which provisions do and do not remain after the crisis. While a number of the changes affect health care providers, including payment and waivers of certain requirements, this Advocates Guide focuses on COVID crisis changes that relate to beneficiaries and their access to covered care. The Guide describes, but does not analyze or critique these changes.

As of April 16, 2020, Congress had passed three bills relating to the COVID-19 crisis:

1. On 3/6/2020, the President signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act, H.R. 6074 (sometimes referred to as COVID Bill #1);

2. On 3/18/2020, the President signed into law the Families First Coronavirus Response Act, H.R. 6201 (COVID Bill #2); and

3. On 3/27/2020, the President signed into law the Coronavirus Aid, Relief, and Economic Security (CARES) Act, H.R. 748 (COVID Bill #3).

While there are some Medicare coverage provision changes in these three bills, most of the Medicare-related changes have been issued by the Centers for Medicare & Medicaid Services (CMS) through regulation and sub-regulatory guidance (see CMS’ webpages devoted to the COVID crisis here and here; note that CMS has compiled a list of their ongoing waivers here). On April 6, 2020, CMS published an Interim Final Rule (hereinafter referred to as the IFR), at 85 Federal Register 19230 (April 6, 2020), available here.

Most of the Medicare-related changes have been made retroactive to March 1, 2020, and will last until the Public Health Emergency (PHE) related to the COVID-19 crisis is lifted.

As of April 16, 2020, Congress is discussing a fourth COVID bill. For the most up-to-date information, and any revisions to this Advocates’ Guide, see the Center for Medicare Advocacy’s website at: https://www.medicareadvocacy.org/medicare-info/covid-19-coronavirus-and-medicare/.

2. OVERVIEW OF MEDICARE-RELATED COVID CHANGES

Recognizing the urgency of the COVID crisis, CMS has stated that pre-crisis Medicare policy could inhibit maximum use of provider capacity and access to care that could be effective in efforts to mitigate the impact of the pandemic on Medicare beneficiaries and the American public. Accordingly, CMS has looked for practical ways to remove barriers to urgent and necessary health care.

There are new rules regarding Medicare telehealth and telecommunications to replace in-person visits, expanded policies for inpatient stays to protect beneficiaries and providers, and revised definitions of many outpatient services to make the health care delivery system as flexible and productive as possible. The overarching goal is to navigate the health care crisis by temporarily re-prioritizing health care delivery and Medicare coverage. One of the biggest policy changes relating to Medicare is the broad expansion of what are considered coverable telehealth services. As noted in the Interim Final Rule (IFR), “[s]tarting on March 6, 2020, Medicare can pay for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient’s place of residence.”1
Since many of the temporary Medicare-related rules involve the use of telehealth services, advocates should be aware that Medicare beneficiaries can be charged cost-sharing for such services. As noted in the IRF, however, “the Office of Inspector General (OIG) issued a Policy Statement to notify physicians and other practitioners that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations” under federal programs, including Medicare.2

3. SPECIFIC MEDICARE COVERAGE CHANGES

A. MEDICARE PART A

Acute Care Hospitals

- Extra days in a hospital can be covered for inpatients who would have been discharged but were diagnosed with COVID-19 and had to stay longer under quarantine.3
- Differential charges for a private room are lifted if the room is medically necessary.4
- Hospitals and other entities will temporarily be able to perform tests for COVID-19 for people at home and in other community-based settings, under certain circumstances.5
- Hospitals will not be required to have written policies about processes and visitation of patients who are in COVID-19 isolation.6
- Hospitals will also have more time to provide patients with a copy of their medical record.7
- Hospital discharge 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, as outlined in 42 CFR §482.43(a)(8), §482.61(e), and 485.642(a)(8).8
- Hospitals are allowed greater flexibility to furnish inpatient services, including routine services, outside the hospital.9 Although hospitals need to continue to exercise sufficient control and responsibility over the use of hospital resources in treating patients regardless of whether that treatment occurs in the hospital or outside the hospital under arrangements with other providers.10

Long-Term Care Hospitals (LTCHs)

- An LTCH can maintain its designation even if more than 50 percent of its cases are less intensive. The current LTCH site-neutral payment methodology can be temporarily paused.11

Skilled Nursing Facilities (SNFs)

- The 3-day inpatient hospital stay requirement for Part A SNF coverage has been waived; regardless of whether the care the beneficiary requires has a direct relationship to COVID-19.12
• **SNF benefits for residents who have exhausted Part A benefits are extended for another 100 days if there is any arguable nexus to the PHE.** (The 100 day coverage limit is waived.) – CMS rules conflict, however, regarding whether the waiver must be related to COVID-19. See end of this SNF Section for further discussion of the conflict.

• Nurse practitioners, in addition to physicians, may now perform some medical exams on Medicare patients at skilled nursing facilities so that patient needs, whether COVID-19 related or not, continue to be met in the face of increased care demands.

**Infection Control**
- Communal dining and all group activities are cancelled.
- Active screening of residents and staff, including staff who work at multiple facilities is required.
- Recommendations for social distancing are provided.

**Discharge Practices**
- If residents are suspected of having COVID-19, facilities should contact local health department for guidance.
- Transfer to hospital is not required, even if the facility does not have an airborne infection isolation room (AIIR), if the facility can follow CDC infection prevention and control practices.
- Residents may need hospital for higher level of care.
- If residents do not require hospitalization, they can be discharged home, in consultation with state or local public authorities, “if deemed medically and socially appropriate.”
  - Residents should wear facemasks and isolate in their rooms with the door closed until discharged home.
- In general, if two or more certified long term care (LTC) facilities want to transfer or discharge residents between themselves for the purposes of cohorting, they do not need any additional approval to do so. However, if a certified LTC facility would like to transfer or discharge residents to a non-certified location for the purposes of cohorting, they need approval from the State Survey Agency.

**Admission Practices**
- Facilities can admit patients diagnosed with COVID-19 from a hospital, as long as they follow CDC guidance for transmission-based precautions.
  - Facilities that cannot follow these precautions should not admit patients with COVID-19.
- If possible, facilities should dedicate a wing/unit for residents coming from or returning from hospital stays; such residents should remain in those units for 14 days.

**Visitors**
- All visitors are banned, except for certain compassionate care situations, such as end-of-life situations.
• Visitors should perform hand hygiene and use personal protective equipment, such as facemasks, and restrict visit to resident’s room “or other location designated by the facility.”
• Ombuds visits are restricted except in compassionate care situations (and case-by-case review by facility).
• Visitors are advised to monitor themselves for 14 days after leaving facility.¹⁹

• **Guidance for Nursing Homes**
  • Provide alternative means of communication for residents – phone, videoconference.
  • Create a listserv to update families.
  • Assign a staff member as the primary contact to communicate with families.
  • Offer a phone line with voice recording, updated at set times daily.²⁰
  • Additional guidance added April 2:
    • Implement symptom screening of everyone, including residents, staff, visitors, outside health care workers, and vendors.
    • Ensure all staff are using appropriate PPE, to the extent that PPE is available, and consistent with CDC guidance.
    • Ensure that staff wear facemasks “and full PPE when providing care to a resident with known or suspected COVID-19.”
    • Use separate staff for COVID-19-positive residents and, with State and local leaders, “designate separate facilities or units within a facility” to cohort COVID-19-positive residents and residents whose COVID-19 status is unknown. Ensure that COVID-19-positive units and facilities “have the capacity, staffing, and infrastructure to manage higher intensity patients, including ventilator management” and maintain “strict infection control practices and testing protocols.”
    • Use consistent assignment of staff to residents.
    • Inform residents and families of restrictions on visits and “procedures for placement in alternative facilities for COVID-19-positive or unknown status.”²¹
  • Additional Guidance added April 19:
    • In a memo, CMS reinforces “an existing requirement that nursing homes must report communicable diseases, healthcare-associated infections, and potential outbreaks to State and Local health departments. In rulemaking that will follow, CMS is requiring facilities to report this data to the Centers for Disease Control and Prevention (CDC) in a standardized format and frequency defined by CMS and CDC. Failure to report cases of residents or staff who have confirmed COVID-19 and Persons under Investigation (PUI) could result in an enforcement action.” CMS also announces that it will issue a “new requirement for facilities to notify residents’ and their representatives to keep them up to date on the conditions inside the facility, such as when new cases of COVID-19 occur.”²²

**Frequently Asked Question:** Does CMS intends extension of covered SNF days to apply only to COVID-19 impacted beneficiaries or to all beneficiaries?

• **Question:** Can a Medicare Part A beneficiary who has exhausted his or her SNF benefits, but continues to need and receive skilled care in the SNF (e.g., for a qualifying feeding
tube), renew SNF benefits under the section 1812(f) waiver regardless of whether or not the SNF or hospital was affected by the COVID-19 emergency?

- **Answer**: If the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60 day “wellness period.”

- **But See…** CMS states elsewhere: “for certain beneficiaries who recently exhausted their SNF benefits, [the waiver] authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).”

**Inpatient Rehabilitation Facilities (IRFs, also known as Inpatient Rehab. Hospitals/IRHs)**

- The **intensive rehabilitation therapy requirement** for IRF coverage, commonly defined as the “3-hour” rule, is relaxed, but IRFs should instead make a note in the medical record to explain why this requirement is not able to be met due to specified issues arising from the COVID-19 crisis.

- Telehealth services can be used for the required **3 physician supervision visits per week**.

- The post-admission physician evaluation can count as one of the “face-to-face” visits, if it is performed.

- The **post-admission physician evaluation** requirement, at §412.622(a)(4)(ii), is removed for all IRFs.

**Psychiatric Hospitals**

- Licensed practitioners, rather than licensed independent practitioners, will be allowed to practice in Psychiatric Hospitals, pursuant to state laws.

**Home Health**

- Physician Assistants and Nurse Practitioners are allowed to order home health services.

- Occupational therapists from home health agencies can now perform initial assessments on certain homebound patients, allowing home health services to start sooner and freeing home-health nurses to do more direct patient care.

- The requirement for a nurse to conduct an onsite visit every two weeks for home health aide supervision is waived. This includes waiving the requirements for a nurse or other professional to
conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the patient’s Plan of Care, as this may not be physically possible during the COVID crisis.  

**Home Health and Telecommunication**

- For home health coverage, Medicare continues to require in-person visits (defined as when a home health agency employee enters the beneficiary’s home and provides a covered service) and only in-person visits are counted toward the bundled payment an agency receives from Medicare.
- Once a home health agency achieves the number of in-person visits to exceed a low-utilization payment amount (LUPA), all additional visits (in-person or telecommunication) will count toward the full bundled payment.
- Telecommunication technology, tele-visits, and remote-monitoring can be substituted for in-person visits only when the physician:
  - Notes the technology in the Plan of Care (this can be retro-changed prior to final billing),
  - States how the use of technology is tied to patient-specific needs, and
  - States how the use of such technology will help to achieve the goals outlined in the Plan of Care.  

**Telehealth “visits”** are allowed to fulfill many **face-to-face** visit requirements for clinicians to see their patients in order to qualify for Medicare home health coverage. Individuals can use commonly available interactive apps with audio and video capabilities to visit with their clinician.

**Homebound definition** expanded to include that it is medically contraindicated for individual to leave home:

- Due to a confirmed or suspected diagnosis of COVID-19, or
- The patient has a condition that may make the patient more susceptible to contracting COVID-19
- The record must indicate:
  - A physician certification that it is medically contraindicated for a person to leave home.
  - Documentation as to why the individual condition of the patient is such that leaving home is medically contraindicated.
  - Documentation that the medical contraindication makes it such that there exists a normal inability for an individual to leave home and leaving home safely would require a considerable and taxing effort.
- Example of a covered home health service from the Interim Final Rule “Even if the patient is confined to the home because of a suspected diagnosis, a home health visit solely to obtain a nasal or throat culture would not be considered a skilled service because it would not require the skills of a nurse to obtain the culture as the specimen could be obtained by an appropriately trained medical assistant or laboratory technician. However, a home health nurse, during an otherwise covered skilled visit, could obtain the nasal or throat culture to send to the laboratory for testing.”

**Hospice**

- The requirements for a nurse to conduct an onsite visit every two weeks for hospice aide supervision is temporarily waived. This would include waiving the requirements for a nurse or other professional
to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan.  

- Routine home care can be provided through telecommunications, if it is feasible and appropriate to do so to ensure that patients can continue receiving services that are reasonable and necessary for the palliation and management of their terminal illness and related conditions without jeopardizing the patients’ health or the health of those who are providing such services. 
  - The use of such technology must be included in the Plan of Care and must be tied to patient-specific needs as identified in the comprehensive assessment and the measurable outcomes that the hospice anticipates will occur as a result of implementing the plan of care. 
  - For the purposes of claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim. However, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care as “other patient care services.”

- Telecommunication technology is allowed to fulfill face-to-face visit requirements for clinicians to see their patients in hospice when such a visit is solely for the purpose of recertifying a patient for hospice services.
  - By telecommunications, technology, CMS means the use of multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient (from home, or any other site permissible for receiving services under the hospice benefit) and distant site hospice physician or hospice.
  - Such encounters solely for the purpose of recertification would not be a separately billed service, but rather considered an administrative expense.

- Hospice nurses are relieved of hospice aide in-service training tasks so they can spend more time with patients.

B. MEDICARE PART B

COVID-19 Testing

- Physician ordered COVID-19 test is covered with no cost-sharing in either traditional Medicare or an MA plan.

- Medicare will pay laboratory technicians to travel to a beneficiary’s home to collect a specimen for COVID-19 testing, eliminating the need for the beneficiary to travel to a healthcare facility for a test and risk exposure to themselves or others. There will be additional payment during the PHE in the form of a specimen collection fee of $23.46 generally, and $25.46 for an individual in a SNF or by a laboratory on behalf of a HHA, for COVID–19 testing and to provide a travel allowance for a laboratory technician to collect a specimen for COVID–19 testing from a non-hospital inpatients or homebound patients.

- Medicare Part B will cover beneficiary cost-sharing for provider visits during which a COVID-19 diagnostic test is administered or ordered.
• Note: this does not mean that all COVID related treatment is covered without cost-sharing; according to CMS, “cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of [certain] categories of HCPCS evaluation and management codes”.

COVID-19 Vaccine

When a COVID-19 vaccine is developed, it will be covered under Part B with no cost-sharing.

Telehealth (General)

Medicare beneficiaries are allowed to receive a wider range of healthcare services without having to travel to a facility.

• Telehealth includes services from doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers.

• Telehealth services are distinguished from brief communications or Virtual Check-Ins, which are short patient-initiated communications with a healthcare practitioner, and E-visits, which are non-face-to-face patient-initiated communications through an online patient portal.

• As noted above, Medicare beneficiaries can be charged for cost-sharing for telehealth services, but providers have the option to waive or reduce cost-sharing during the current COVID crisis.

• Providers can deliver telehealth via phone and video chat at home or any health care facility (office, hospital, nursing home, clinic) (but see below re: audio-only).

• Telehealth includes routine visits, mental health counseling, preventive health screenings for cancer and other illnesses.

• During the COVID crisis, telehealth is paid at same rate as in-person services.

• The requirement that patients must have seen the doctor within past 3 years is waived.

• More than 80 additional services are covered by Medicare when furnished via telehealth. These include emergency department visits, initial nursing facility and discharge visits, and home visits, which must be provided by a clinician that is allowed to provide telehealth.

• Virtual Check-In services, or brief check-ins between a patient and their doctor by audio or video device, through audio or video phone, email, secure text or patient portal could previously only be offered to patients that had an established relationship with their doctor. Now, doctors can provide these services to both new and established patients.
However, audio-only telehealth is limited to the following:
- To evaluate beneficiaries by audio phones
- For virtual check-in services, or brief check-ins between (1) a patient and (2) a physician or non-physician practitioner eligible to use evaluation/management codes, regardless of whether the patient is new or established (see below).
  - For example, opioid treatment programs can allow the therapy and counseling portions of the weekly bundles of services, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls (see discussion below)

Clinicians can provide remote patient monitoring services for patients, no matter if it is for the COVID-19 disease or a chronic condition. For example, remote patient monitoring can be used to monitor a patient’s oxygen saturation levels using pulse oximetry.

**Telehealth for Home Dialysis Patients** – The requirement that a nephrologist conduct some of the required periodic evaluations of a patient on home dialysis face-to-face is eliminated during the COVID crisis, allowing these vulnerable beneficiaries to get more care in the safety of their home.

**Therapy Services (Physical Therapy/PT, Occupational Therapy/OT, Speech Language Pathology/SLP)**
- Physical therapists, occupational therapists and speech-language pathologists are not authorized to provide full Medicare-covered telehealth services. Note, though, as referenced below, such providers can provide evaluation and management services.

**Telephone Evaluation and Management (E/M) Services (including Routine Office Visits)**
- There are many circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate.
- Services are available for both new and established patients.
- 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.

**Ambulance Transport**
- The list of destinations for ambulance transportation is expanded to include all destinations, from any point of origin, that are equipped to treat the condition of the patient consistent with Emergency Medical Services (EMS) protocols established by state and/or local laws where the services will be furnished.
• Based on EMS protocols, a patient suspected of having COVID–19 that requires a medically necessary transport may be transported to a testing facility to get tested for COVID–19 instead of a hospital in an effort to prevent possible exposure to other patients and medical staff.

• Ambulance destinations may include, but are not limited to any location that is an alternative site determined to be part of any of the following:
  • Hospital
  • Critical Access Hospital
  • Skilled Nursing Facility
  • Community Mental Health Center
  • Federally Qualified Health Center
  • Regional Health Center
  • Physician’s Office
  • Urgent Care Facility
  • Ambulatory Surgery Center
  • Dialysis Service Center (when an End Stage Renal Disease Facility Not Available)
  • Patient’s Home

• The expanded list of destinations will apply to medically necessary emergency and non-emergency ground ambulance transports of beneficiaries.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

If durable medical equipment, prosthetics, orthotics or supplies are lost, destroyed, irreparably damaged or otherwise unusable or unavailable, contractors can waive the following requirements:

• Face-to-face encounter

• New physician’s order

• New medical necessity documentation

• Suppliers must still include a narrative description on the claim explaining the reason the equipment must be replaced.

• Suppliers must maintain documentation indicating DMEPOS was lost, destroyed, irreparably damaged or otherwise unusable or unavailable as a result of the COVID crisis.

Medicare will cover a broader array of respiratory devices and equipment such as non-invasive ventilators, multi-function ventilators, respiratory assist devices, and continuous positive airway pressure devices. Medicare will also cover respiratory-related devices and equipment for any medical reason determined by clinicians so that patients can get the care they need; previously, Medicare covered them under certain circumstances.

Prior authorization requirements are suspended for power mobility devices (PMDs) and pressure reducing support surfaces (PRSS). Also, the implementation of Prior Authorization (PA) of Lower Limb Prostheses scheduled to begin on May 04, 2020 is delayed.
Medicare Administrative Contractors will continue to accept and review voluntary prior authorization requests for the affected HCPCS codes on the Required Prior Authorization List; however, claims associated with a non-affirmation decision or claims submitted without requesting prior authorization that would normally cause a payment denial will be processed for payment for the duration of the COVID-19 PHE. Claims bypassing prior authorization may be selected for post-payment review after the PHE has ended.56

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

To the extent an NCD or LCD (including Medicare Learning Network (MLN) Articles) requires a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements do not apply during the COVID crisis.

- Some face-to-face encounter requirements for DMEPOS Power Mobility Devices (PMDs) are mandated by statute for program integrity purposes. While statutory requirements are not waived the use of telehealth in accordance with Medicare guidelines was previously permitted for power mobility devices.57

- CMS will not enforce the required clinical indications for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs (including Articles). These policies include, but are not limited to: • NCD 240.2 Home Oxygen. • NCD 240.4 Continuous Positive Airway Pressure for Obstructive Sleep Apnea. • LCD L33800 Respiratory Assist Devices (ventilators for home use). • NCD 240.5 Intrapulmonary Percussive Ventilator. • LCD L33797 Oxygen and Oxygen Equipment (for home use). • NCD 190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management. • NCD 280.14 Infusion Pumps. • LCD L33794 External Infusion Pumps.58

- To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish a service, procedure or any portion thereof, the chief medical officer or equivalent of the facility can authorize another physician specialty or other practitioner type to meet those requirements

- To the extent NCDs and LCDs require a physician or physician specialty to supervise other practitioners, professionals or qualified personnel, the chief medical officer of the facility can authorize that such supervision requirements do not apply.59

Opioid Treatment Programs

Allows the therapy and counseling portions of the weekly bundles, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology if beneficiaries do not have access to two-way audio/video communications technology, provided all other applicable requirements are met.60
Remote Physiologic Monitoring (RPM)

RPM services can be furnished to new patients, as well as to established patients.

- Consent to receive RPM services can be obtained once annually, including at the time services are furnished.
- The physician or other health care practitioner should (but is not required to) review consent information with a beneficiary, obtain the beneficiary’s verbal consent, and document in the medical record that consent was obtained.

Home Infusion Services

Physicians that furnish physicians’ services, including medically necessary injected or infused drugs, in the patient’s home can also do so incident to their professional services, under contract with auxiliary personnel, to leverage additional staff and technology necessary to provide care outside their office setting under direct supervision using interactive audio-video technology.

- For example, physicians may enter into contractual arrangements with a home health agency, a qualified infusion therapy supplier, or entities that furnish ambulance services in order to utilize their nurses or other clinical staff as auxiliary personnel under leased employment. In such instances, Medicare payment for the physicians’ direct and “incident-to” services would be made to the billing practitioner who would then make the appropriate payment to the contracted entity (for example, the HHA).
- Payments would be made in accordance with the physician fee and would not be considered a home health service under the Medicare home health benefit or a service under the home infusion therapy services benefit. Rather, the entity with which the physician contracts would seek payment for any services they provided from the billing practitioner and would not submit claims to Medicare for such services.\(^{61}\)

C. MEDICARE PARTS C and D

Medicare Advantage (MA)\(^{62}\)

Medicare Advantage plans must provide coverage for COVID-19 diagnostic testing, including the associated cost of the visit in order to receive testing. Coverage must be provided at no cost to the beneficiary.\(^{63}\)

- 42 C.F.R. 422.100(m) authorizes special requirements during a disaster or emergency related to Medicare.
- MA plans must:
  - Cover benefits at non-contracted facilities as long as those facilities have participation agreements with Medicare.
  - Waive, in full, gate-keeper referral requirements.
• Provide same cost-sharing for in and out-of-network.
• Make changes immediately without 30-day notification, e.g. reductions in cost sharing, waiver of prior-authorization.

• Examples of possible MA Plan waivers (plans have discretion to do so):
  • Remove prior-authorization requirements
  • Waive cost-sharing for COVID-19 treatments in Dr. office or emergency room (but see above re: COVID-19 diagnostic testing)
  • Waive prescription refill limits; relax restrictions on home delivery
  • Expand access to telehealth
  • Loosen provider-enrollment requirements
  • Suspension of nursing home pre-admission reviews
  • Reimbursement to providers for care delivered in alternate settings

• Telephone Confirmation: Beneficiaries should contact their Medicare Advantage plan to confirm specific waivers – recommend getting full name of customer service individual and note date/time of the call.

• On-line Confirmation: Beneficiaries should copy or electronically save waiver information online that they rely on, in case it should change.

Prescription Refills

• Medicare Part D plans and Medicare Advantage-Prescription Drug plans are required to provide up to a 90-day supply of a prescription medication if requested by a beneficiary.64

• Pharmacists can authorize emergency refills when prescribers are not available to provide refill renewal prescriptions, when consistent with State emergency declarations.65

• CMS permits plans to relax restrictions on use of preferred retail or mail-order pharmacy, but does not require.

D. MISCELLANEOUS

Medicare Enrollment through Social Security (SSA)

Beneficiaries who have stopped working and are seeking immediate enrollment into Medicare Part B, may mail forms directly to the local Social Security office or fax their Part B enrollment forms CMS-40B and CMS L564- Request for Employment Information, along with proof of employment, Group Health Plan (GHP), or Large Group Health Plan (LGHP) to 1-833-914-2016.66

• When completing form CMS L564-Request for Employment Information
  • The beneficiary should state on the form “I want Part B coverage to begin (MM/YY)”
  • If possible, the employer should complete Section B of the Form. However, if the employer is unable to complete Section B, that section may be completed on behalf of the
employer without the employers’ signature and submitted with one of the following forms of secondary evidence:

- Income tax form that shows health insurance premiums paid;
- W-2s reflecting pre-tax medical contributions;
- Pay stubs that reflect health insurance premium deductions;
- Health insurance cards with a policy effective date;
- Explanations of benefits paid by the GHP or LGHP; or
- Statements or receipts that reflect payment of health insurance premiums.

• Other information for beneficiaries who need to apply for Medicare Parts A & B
  - Create an account on ssa.gov to apply for both A & B
  - To locate telephone number to local SS office: [http://secure.ssa.gov/ICON/main.jsp](http://secure.ssa.gov/ICON/main.jsp)

• Local Social Security offices are closed to the public, although some continue to provide services over the phone

• SSA is authorized to extend deadlines for filing “whenever possible”

**Notice Delivery in Institutions**

CMS has relaxed certain requirements surrounding delivery of notices to individuals receiving institutional care who are in isolation, including:

- Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely.

- If the hospital worker is unable to enter a room safely, a contact phone number should be provided for a beneficiary to ask questions about the notice.

- If a hard copy of the notice cannot be delivered, notices to beneficiaries may also be delivered via email, if a beneficiary has access to email in the isolation room.

- Notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and/or when and to where the email was sent.

- Beneficiary representative 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.

**Medicare Appeals**

CMS has issued guidance applicable to appeals in traditional Medicare, Medicare Advantage and Part D. Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs)
in the traditional Medicare program, MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), can do the following:

- Allow extensions to file an appeal

- Waive timeliness requirements for requests for additional information to adjudicate the appeal
  - MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee’s interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization’s decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee’s interest

- Process an appeal even with incomplete Appointment of Representation forms but “communicating” to the other party (beneficiary to provider or provider to beneficiary)

- Process requests for appeal that do not meet the required elements using information that is available

- Use all flexibilities available in the appeals process as if good cause requirements are satisfied.
  - In general, if Medicare appeal deadlines have expired, but a party shows a good cause reason for missing the deadline, the decision-maker (Medicare contractor, MA plan, etc.) has discretion to extend the timeframe for filing an appeal; the COVID-19 crisis by itself can now be used to satisfy good cause requirements

Although the CMS guidance does not address appeals filed by beneficiaries and those assisting them (other than providers), the Center for Medicare Advocacy urges such individuals who are filing appeals in good faith to explicitly note on their appeal documentation that they are requesting good cause allowances for any late filings due to the national COVID-19 emergency.

Information Regarding Providers

- **Licensure Jurisdiction**: Requirements that out-of-state providers be licensed in the state where they are providing services is waive if they are licensed in another state. This applies to Medicare and Medicaid.

- **Enrollment**:
  - A toll-free hot-line is established for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges.
  - The following screening requirements are waived:
    - Application fee (42 C.F.R. 424.514)
    - Criminal background checks associated with FCBC (42 C.F.R. 424.518)
    - Site visits (42 C.F.R. 424.517)
  - All revalidation actions are postponed.
  - Licensed providers are allowed to practice outside their state of enrollment.
  - Pending or new applications from providers are expedited.
Non-Discrimination re: Provision of Health Services

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) issued a bulletin aimed at ensuring that covered entities do not unlawfully discriminate against people with disabilities when making decisions about their treatment during the COVID-19 health care emergency.\textsuperscript{70}

The bulletin notes, in part: “persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person’s relative “worth” based on the presence or absence of disabilities or age. Decisions by covered entities concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence.

\begin{center}
The Center for Medicare Advocacy, established in 1986, is a national nonprofit, nonpartisan law organization that provides education, advocacy and legal assistance to help older people and people with disabilities obtain access to Medicare and quality health care. The Center is headquartered in Connecticut and Washington, DC with additional attorneys throughout the country.
\end{center}
Endnotes:

2 IFR, Page 19243.
3 See https://www.medicare.gov/medicare-coronavirus.
10 IFR, Page 19280.
11 Sec. 3711 of Coronavirus Aid, Relief, and Economic Security (CARES) Act, H.R. 748 (COVID Bill #3).
16 Id.
19 Id.
20 Id.

IFR, Page 19265.


IFR, Page 19266.

IFR, Page 19266.

IFR, Page 19267.

IFR, Page 19258.

IFR, Page 19258.


Section 6003 of Families First Coronavirus Response Act, H.R. 6201 (COVID Bill #2)

Section 3714 of Coronavirus Aid, Relief, and Economic Security (CARES) Act, H.R. 748 (COVID Bill #3).


