Topic: Duration of Waivers

1. Does yesterday’s [4/30/20] IFC publication restart the “60 days from publication” clock for potential expiration of these rules?

CMS has consistently answered this question with the following response: Waivers for the current PHE under section 1135 of the Social Security Act will end no later than the termination of the COVID-19 PHE period, or 60 days from the date the waiver or modification is first published unless the Secretary of the Department of Health and Human Services extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.


Finally, we would hope that CMS will issue a public notice stating the expiration date for the waivers.

Topic: Hospitals Without Walls

2. For hospitals without walls - could we utilize a standalone fee for service clinic located about 17 miles from our CAH RHC as an offsite RHC location for services [such] as relocating well visits to this space in surge or letting outreach providers that are under a PSA in the RHC so that they are in a “clean space”?

The Medicare Conditions of Participation (COPs) ordinarily require each of an RHC’s locations to be independently approved as an RHC. See 42 CFR §491.5(a)(3)(iii). The COPs also require each such site to be located within a rural area designated as a “shortage area.” See 42 CFR §491.5(a)(1). However, as a response to the COVID-19 public health emergency, CMS has temporarily waived these requirements. This waiver removes the location restrictions to provide existing RHCS with the flexibility to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes allowing the RHC to establish temporary expansion locations in areas that are outside of the location requirements outlined in the Conditions of Participation for the duration of the public health emergency.
Responses are based on information available as of May 5, 2020

**Topic: Telehealth**

3 I have a question. If a COVID patient is inpatient in a critical care unit and the intensivist is monitoring that patient remotely (from a distant site), is there any specific documentation that needs to accompany the record to denote that distant site monitoring by the physician?

CMS has not issued guidance on whether particular documentation is required; however, CMS answered an FAQ as follows:

**Question:** How does a health care provider bill for telehealth services?

**Answer:** The IFC directs physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. We believe this interim change will maintain overall relativity under the PFS for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth. During the PHE, the CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. Practitioners should continue to bill these services using the CMS1500/837P. [https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf](https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf) (Question 5, p. 25).

Based on this response, we would recommend that the physician documentation include a notation that the physician is conducting the evaluation via remote monitoring and that the equipment being used has both audio and video capabilities. If the equipment does not have both audio and video capabilities, the offsite monitoring may not qualify as a reimbursable service. In addition, state law should be reviewed to determine if there are any requirements for documentation that must or should be included in the record, such as patient consent or disclosure of clinician name and credentials.

**Does the PT change allow for hospitals are allowed to bill these telehealth on UB’s?**

4 On April 30, 2020, CMS announced further waivers and a second Interim Final Rule that established additional flexibilities related to which clinicians may provide services via telehealth and how hospitals may bill for services provided remotely to hospital outpatients. In its press release, available at [https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid](https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid), CMS stated as follows:

Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider based department of the hospital. Examples of such services include counseling and educational service as well as therapy services. This change expands the types of healthcare providers that can provide using telehealth technology. [sic]

In its May 5, 2020, Office Hours call, HHS representatives confirmed that this does not change how a hospital should report services that would usually be furnished in person but, due to the public health emergency and under these interim flexibilities, may now be furnished remotely, and thus the same billing
mechanisms would continue to apply.

Would the telehealth waivers for using Facetime, Zoom, etc., apply to other communication not specifically telehealth related? For example, using FaceTime to give instructions to a spouse who cannot visit patient and needs to assist patient at home.

OCR has not directly addressed this use of telehealth technology, but to the extent such communications would usually be undertaken in person and in furtherance of treatment of the individual, this would likely fall within the scope of the enforcement discretion. Although OCR’s enforcement discretion for use of such applications applies only to the good-faith provision of telehealth during the public health emergency, “telehealth” is broadly defined. Specifically, OCR’s FAQs (available at https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf) define telehealth as “the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration.”

Topic: Disclosures of Health Information

No leniency regarding employees who test +? Co-workers insisting they be notified when a co-worker, with whom they have been working alongside, tests positive. We have been arguing that is a breach of employee privacy.

An employer should not disclose the identity of the employee who has tested positive. Instead, co-workers should be provided with de-identified information sufficient for them to take necessary precautions to protect themselves and others and stop the spread of the virus. For example, an employer might notify immediate co-workers that someone with whom they have interacted has tested positive but not disclose the employee’s name. There may be some instances in which employees can deduce which co-worker tested positive, particularly if the workplace is small. While it is okay for employers to entertain questions related to the safety of the workplace, they should not confirm the identity of the sick person and should encourage other employees who press for details to exercise discretion in light of privacy concerns.

As a further note, if an employer/healthcare provider has treated the individual (e.g., the employee was treated at the employing hospital), the employee/patient’s information should be treated the same way as any other patient’s, with the full protections of HIPAA. HHS has issued a bulletin that outlines permitted disclosures under HIPAA, including to persons at risk of contracting or spreading a disease (in accordance with state or other law); this bulletin may be accessed here: https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf.

You discussed HIPAA and COVID. Can you please describe best practice for disclosures to first responders?


Notably, this is not an area which is subject to enforcement discretion. Instead, HHS’s guidance outlines disclosures that are already permitted under the existing regulatory framework. Accordingly, providers
should continue to follow all of their standard HIPAA protocols with regard to these disclosures. One important consideration in disclosures to first responders is to ensure that minimum necessary requirements are followed. For example, a hospital might provide a list of known COVID-positive patients to an EMS dispatch for use on a per-call basis, but such list should not be published publicly or provided directly to EMS personnel.

Topic: Reopening

8 What was your comment re: the change needed for Informed Consent when reopening?

We suggest including a consent related to coronavirus within a provider’s standard consent form (i.e., we do not necessarily recommend a separate, freestanding consent focused on coronavirus). Below is an example of the type of language that might be appropriate. However, we also note that the language may need to be tailored to the specific provider’s situation, and obtaining such consent is not a carte blanche for unnecessary or substandard care.

“I understand that the 2019 novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious, and is believed to be spread by person-to-person contact. I recognize that the staff of [name of provider] has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, I recognize and accept the risk of becoming infected by virtue of proceeding with the above-referenced procedure.”

9 We are a CAH without positive cases in our facility or county. We do not have the ability to provide “rapid” COVID-19 testing. Is there any specific guidance we could view for reopening our surgery department other than what was discussed?

The current “Guidelines for Opening Up America Again,” found at https://www.whitehouse.gov/openingamerica/#criteria, should be followed in their entirety when restarting elective procedure until further guidance is issued. These guidelines state that all patients must be screened for potential symptoms prior to entering a facility, and that staff must be routinely screened for symptoms. With regard to testing, the guidelines state that when adequate testing capability is established, patients and staff should be screened by lab testing. We also recommend conferring with your local health departments and being prepared to cease elective surgeries in the event there is a surge of cases in your community.

The information provided here is general in nature and does not establish an attorney-client relationship or constitute legal advice, which can be provided only with regard to specific and complete factual information.
For more information, please visit www.agg.com or contact:

R. Michael Barry, Partner
404.873.8698
michael.barry@agg.com

H. Carol Saul, Partner
404.873.8694
carol.saul@agg.com

Rebekah N. Plowman, Partner
404.873.8758
rebekah.plowman@agg.com

Madison M. Pool, Associate
404.873.8514
madison.pool@agg.com