New Waivers in Response to COVID-19 Pandemic

In an unprecedented move, the Centers for Medicare & Medicaid Services (CMS) has released 15 documents specifying new waivers in response to the COVID-19 pandemic.

Changes include:

• New discharge planning rules for offering patient choice and quality and resource use data are waived. Hospitals may now offer only the names of facilities or providers that can provide the needed care and are willing to accept the patient.

• The UR plan can be suspended, although CMS did not waive the requirements to follow the two-midnight rule for determining status. Practically, this means that continued stay reviews could be suspended, and the inpatient status of a patient can be changed to outpatient with a physician order and without review by a member of the utilization review committee or written notification to the patient.

• Physicians can perform almost every visit in the hospital, skilled nursing facility (SNF), and office via telehealth. If they have synchronous video and audio, they can bill as if they were at the bedside with the patient. That now includes all hospital visits, SNF visits, ED visits, and critical care visits.

• Telephone calls to patients are also billable (retroactive to March 1, 2020)
• Physicians can now order home oxygen for patients who do not meet the CMS requirements. A certification of medical necessity (CMN) will need to be completed at some point, but is not required before the oxygen is delivered, and the face-to-face visit can be a telehealth visit. Durable medical equipment (DME) suppliers will be able to supply the oxygen and bill for it as if the CMS criteria were met. The DME prior authorization program is paused.

• Verbal orders are allowed, and the physical orders do not need to be signed within 48 hours.

• Therapists and social workers may now provide telehealth therapy.

• Residents may perform telehealth visits with attending supervision.

• Discharge planning requirements have been waived. Patients do not need to be offered full choice of providers, and quality and resource use data does not need to be offered.

• Hospitals can provide inpatient care in alternative settings, including hotels and temporary structures, and bill for the care. Ambulatory surgical centers (ASCs) and freestanding emergency departments can either apply to be “a hospital” and provide care and bill for it, or partner with hospitals that can use their facilities and bill for the care.

• Homebound status for home health can be determined without a face-to-face visit if a physician determines they are homebound due to COVID-19 and need skilled care.

• The home health Review Choice demonstration project is paused at provider discretion.

• The post-admission evaluation has been waived for inpatient rehabilitation facilities (IRFs). They also have flexibility if they are unable to provide the required amount of therapy due to staffing issues or patient isolation.

CMS Administrator Seema Verma said that while all the waivers are blanket waivers covering all providers in the country, “if you don’t need the waiver, you shouldn’t be using it. We are calling on local communities to decide what the situation is in their area and make decisions accordingly.”

This list is by no means all-inclusive, and the actual CMS document should be consulted, as should the client’s compliance and legal staff, before making any process changes. Download the CMS Document »

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