Overview of COVID-19 Interim Final Rule CMS-5531-IFC

Kate Walsh, CPC
Data Operations Consultant

Together, We Are Craneware — Founded in 1999

CMS-5531-IFC Housekeeping Items

- The Rule was released by CMS on April 30th 2020 and can be read in its entirety at the following link: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

- CMS has waived the 30-day delay of implementation for the rule and has made all policy changes outlined in the rule retro-actively effective back to either January 27th 2020 or March 1st, 2020 - depending on the specific policy

- This presentation is a high level overview of CMS-5531-IFC. For a more comprehensive summary of the rule please review Craneware's Insight Article titled "**CMS Interim Final Rule – Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE)"**

- Throughout this presentation CMS-5531-IFC will be referred to as the IFC or the April 30th IFC

- When referencing CMS's previous COVID-19 interim final rule, CMS-1774-IFC, this rule will be referred to as the March 31st IFC
  - To view our recorded educational webinar on CMS-1774-IFC please visit our Craneware COVID-19 landing page:
    - https://public.craneware.com/news/covid-19-coding-and-billing

Contents

- Scope of practice changes for specific provider types
- Changes to order requirements for COVID-19 diagnostic laboratory tests
- Medicare coverage guidelines for COVID-19 antibody testing
- New guidance for hospitals and physicians for reporting diagnostic laboratory COVID-19 specimen collections
- Overview of how hospitals can bill for certain outpatient services rendered to patients in their homes under the CMS 1135 Temporary Expansion Site waiver
- Updates to professional telehealth regulations
- CMS clarification on waivers related to NCD/LCD requirements

Scope of Practice Updates

Scope of Practice Updates

- Scope of Practice Disclaimer:
  - All scope of practice changes noted by CMS in the IFC are subject to individual state laws and each clinician's individual state scope of practice
    - Review these documents carefully to ensure these expanded services are allowed by your individual state
  - It is also important to note that these changes are approved on an interim basis only for the duration of the declared COVID-19 public health emergency

Scope of Practice Updates

- Physicians Assistants (PAs) can now perform diagnostic tests without the supervision of a Physician

- Nurse Practitioner (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs), and Physician Assistants (PAs) can now supervise the performance of diagnostic tests
  - Prior to the IFC these non-physician practitioners were able to order and directly furnish certain diagnostic tests subject to individual scope of practice by-laws
  - Through the IFC, these provider types are now able to supervise others who are licensed to perform diagnostic tests (i.e. laboratory tests, respiratory imaging, etc.)
  - These non-physician practitioners will need to continue to maintain the required statutory relationships with supervising or collaborating physicians

Scope of Practice Updates

- Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants (OTAs) can now furnish maintenance therapy
  - The treating therapist (PT or OT) who established or is responsible for the maintenance program plan can delegate when it is clinically appropriate for the performance of maintenance therapy services to be performed by PTAs and OTAs
  - Modifiers “CO” and “CQ” should be appended to claims to indicate when maintenance therapy services are rendered by a PTA or OTA

- In the IFC CMS clarified that Pharmacists already meet the definition of “auxiliary personal” who can provide services “incident-to” the services of billing physicians or non-physician practitioners
  - The “incident-to” service must be allowed by the Pharmacist’s state scope of practice
  - All supervision requirements for the specific service must still be followed
  - In the IFC CMS specifically referenced that medication management services may be performed by Pharmacists under the “incident-to” guidelines - if allowed by state by-laws
  - “Incident-to” services are billed by the supervising physician or non-physician practitioner

Medicare Order Requirements for COVID-19 Diagnostic Laboratory Tests

Together, We Are Craneware — Founded in 1999 —

Recap of Available COVID-19 Laboratory Codes & Reimbursement Rates

MEDICARE PAYMENT FOR LAB SERVICES

LAB SERVICE	MEDICARE PAYMENT	BILLING CODE
CDC RNA Based Lab Test	**Approx. $36**	HCPCS code U0001
Non- CDC Lab Test that uses any technique, multiple types or subtypes (includes all targets)	**Approx. $51**	HCPCS code U0002
Non CDC Lab Test using RNA based technique	**Approx. $51**	CPT code 87635
Serology (antibody) test	**TBD**	CPT code 86328 CPT code 86769
Lab Test Using High Through-Put Technology	**$100** *(effective 4/14)*	HCPCS code U0003; HCPCS code U0004

Source: https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

Physician Order for COVID-19 Lab Test Furnished to Medicare Beneficiaries

- Effective March 1st and for the duration of the PHE:
  - CMS will not require an order from a treating physician or nonphysician practitioner for COVID-19 diagnostic lab tests to be covered
  - CMS is also removing the order requirement from influenza and respiratory syncytial virus (RSV) diagnostic laboratory tests when these tests are used to rule out or confirm a COVID diagnosis
    - CMS states in the IFC when COVID-19 tests become more readily available they believe it will no longer be medically necessary to perform flu or RSV tests to rule out or confirm a COVID diagnosis
      - Ensure the medical record clearly supports the need for any rule out tests
  - CMS list of applicable COVID/Flu/RSV CPT and HCPCS codes: https://www.cms.gov/files/document/covid-ifc-2-flu-rsv-codes.pdf
  - HOWEVER CMS notes state requirements around ordering diagnostic tests would still apply – review these guidelines carefully
  - When tests are furnished without a Physician's order CMS states the lab conducting the test is required to directly notify the patient of the results

Medicare Coverage for COVID-19 Serology Antibody Testing

Together, We Are Craneware — Founded in 1999 —

Medicare Coverage for COVID-19 Serology Antibody Testing

- In the IFC CMS states it will not be creating an NCD specific to COVID-19 antibody testing, rather CMS decided to established coverage guidelines for COVID-19 antibody tests within the rule itself

- Per the IFC:
  - "We are finalizing on an interim basis, that during the PHE for the COVID-19 pandemic, Medicare will cover FDA-authorized COVID-19 serology tests as they are reasonable and necessary under section 1862(a)(1)(A) of the Act **for beneficiaries with known current or known prior COVID-19 infection or suspected current or suspected past COVID-19 infection**. We are amending § 410.32 to reflect this determination of coverage."

- We would advise checking with your MACs directly to determine how they plan to implement these coverage guidelines as there were no covered/non-covered diagnosis codes noted in the IFC

COVID-19 Diagnostic Laboratory Specimen Collection Codes

COVID-19 Specimen Collection by Independent Laboratories

- In the March 31st IFC CMS announced the creation of two new HCPCs codes that can be charged by independent laboratories when trained lab personnel travel to collect COVID-19 specimens from homebound and non-hospital inpatients:
  - G2023: Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source
  - G2024: Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHS, any specimen source

- The billing requirements for G2023 and G2024 have not been changed

COVID-19 Specimen Collection by Hospitals, Physicians & Other Practitioners

- In the IFC CMS acknowledged the vital importance of diagnostic COVID testing as well as the additional resources required to preform such testing safely (e.g. PPE, adequate space, trained personnel, etc.)

- Therefore, in the IFC CMS announced it will be providing additional payment for “assessment and COVID-19 specimen collection” to support testing by hospitals, physicians and other practitioners

- The specimen collection billing guidelines for these provider types are detailed on the following slides, **note these billing policies are retroactively effective back to March 1st 2020**

COVID-19 Specimen Collection by Physicians & Other Practitioners

- CMS is now advising Physicians and other Non-Physician Practitioners (who are authorized under their individual state scope of practice) to report CPT 99211 for “assessment of COVID-19 symptoms and exposure, and specimen collection”

- CPT 99211 can be charged for COVID-19 assessment and specimen collection rendered to either new or established patients

- Assessment and specimen collection can be performed by a physician’s auxiliary staff so long as “incident-to” and supervision requirements are met

- The national unadjusted reimbursement rate for CPT 99211 is $23.46 (CMS did not change or update this rate)

COVID-19 Specimen Collection by Hospitals

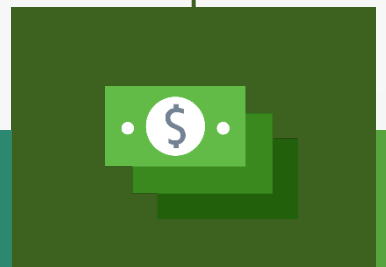
- In the IFC CMS announced the creation of a new HCPCs code, C9803, for hospitals to report for “assessment of symptoms and specimen collection” for COVID-19
  - C9803: Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source

- In the IFC CMS states the national unadjusted reimbursement rate for HCPCS C9803 will be $22.98

- However, CMS assigned HCPCS C9803 to a status indicator of Q1, meaning the code is conditionally packaged– and all normal status indicator bundling logic will apply
  - If C9803 is billed in conjunction with a clinic visit, ED visit, observation services and/or any other primary service the code will be bundled and no separate reimbursement will be made for Medicare claims
  - Per CMS C9803 will be separately reimbursed if billed in conjunction with a diagnostic lab test assigned to status indicator A - so long as no other primary services are reported on the same claim

- We would caution that the IFC did not state when Medicare claims processing systems will be updated to accept this new code. To avoid claim rejects and/or incorrect denials we advise contacting your MAC directly to check code availability prior to claim submission

New Hospital Billing Options for Outpatient Services Rendered to Patients in Their Homes



Together, We Are Craneware — Founded in 1999 —

CMS 1135 Waiver for Temporary Expansion Sites

- The Temporary Expansion Sites waiver allows hospitals, for the duration of the COVID-19 Public Health Emergency (PHE), to temporarily relocate existing on or off-campus provider-based departments to new locations
  - The relocation(s) must not be in conflict with your state's emergency preparedness or pandemic response plans
  - All Medicare Conditions of Participation (CoPs) not waived by CMS must be met at the temporary expansion site(s)
  - The temporary location(s) can previously have been clinical or non-clinical spaces
  - Most importantly **these temporary expansion sites can be a patient's own home**

- Any temporary location(s) would still be considered a provider-based hospital department (PBD), and all PBD billing and payment regulations would still apply

Hospital PBDs – Excepted vs Non-Excepted Status

- Hospital PBDs are currently grouped into one of two categories; excepted or non-excepted
  - If a hospital PBD relocates during the COVID PHE (even to the patient's home) it will still be considered either an excepted or non-excepted hospital PBD

- The guidelines governing whether a PBD is excepted or non-excepted have not been changed or waived by CMS

- In order to be considered an excepted PBD:
  - The PBD must have been billing for services prior to November 2, 2015, and the PBD cannot have relocated or changed ownership;
  - The PBD qualifies for an exception under section 16001 or 16002 of the 21st Century Cures Act; **or**
  - The PBD is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital

Hospital PBDs – Excepted vs Non-Excepted Status

- Excepted or Non-Excepted status directly affects reimbursement

- Excepted PBDs:
  - Are reimbursed the full hospital outpatient prospective payment system (OPPS) rate for items and services furnished at the excepted location
  - Items and services billed from excepted PBDs are required to have modifier PO appended

- Non-Excepted PBDs:
  - Are reimbursed the physician fee schedule (PFS) rate, rather than the OPPS rate, for items and services furnished at non-excepted locations
  - Items and services billed from non-excepted PBDs are required to have modifier PN appended

- **This reimbursement and billing methodology has not been changed or waived by CMS**

Excepted vs Non-Excepted Status During Temporary Relocation

- Non-excepted PBDs will retain their non-excepted status even if temporarily relocated due to the PHE (including a temporary relocation to the patient's home)
  - Items and services rendered by non-excepted PBDs should continue to be billed with modifier PN even if temporarily relocated
  - **Non-excepted PBDs do not need to request for an exemption or notify the RO of a relocation**

Excepted vs Non-Excepted Status During Temporary Relocation

- Typically when an excepted PBD relocates it loses it's excepted status and becomes non-excepted
- For the duration of the PHE CMS is allowing hospitals to apply for an extraordinary circumstances exemption to allow on-campus or excepted off-campus PBDs to retain there excepted status even if they relocate due to the PHE (including a temporary relocation to the patient's home)
- Per CMS hospitals do not need to wait for the application to be approved to begin billing for services rendered at the relocated excepted PBD (with modifier PO)
- However, if the hospital's extraordinary circumstances application were to be denied, the hospital would need to submit corrected claims indicating the services were provided at a non-excepted PBD (with modifier PN)

Extraordinary Circumstances Relocation Application for Excepted PBDs

- The application request to keep a PBD's excepted status during relocation should be emailed to your CMS Regional Office and must include:
  - The hospital's CCN number
  - The address of the current PBD(s)
  - The address(es) of the relocated PBD(s)
  - The date which they began furnishing services at the new PBD(s)
  - A brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19
  - An attestation that the relocation is not inconsistent with the hospital state's emergency preparedness or pandemic plan

- This email request must be sent to your CMS Regional Office within 120 days of beginning to furnish and bill for services at the relocated on- or off-campus PBD

- "To the extent that a hospital may relocate to an off-campus PBD that otherwise is the patient's home, only one relocation request during the COVID-19 PHE is necessary. In other words, the hospital would not have to submit a unique request each time it registers a hospital outpatient for a PBD that is otherwise the patient's home; a single submission per location is sufficient."

Extraordinary Circumstances Relocation Application for Excepted PBDs

- Remember, the extraordinary circumstances relocation application is optional

- The application, if granted, allows excepted and on-campus PBDs to relocate and to bill for services rendered at these temporary locations with modifier PO

- Excepted and on-campus PBDs that relocate and choose not to submit an extraordinary circumstances relocation application may still bill for services rendered at these temporary locations – they would just need to append modifier PN to items and services furnished at these temporary locations

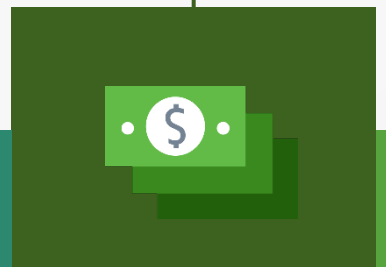
- Hospitals planning to relocate excepted or on-campus PBDs should examine the payment differential when billing for services under the PO or PN modifiers
  - In the specific example of outpatient therapy services many of these services are already reimbursed at the MPFS rate (even when rendered in the outpatient part B setting) – meaning there is no payment differential when billing these services with modifier PN vs PO
  - **Note this is not true for all services rendered in PBDs, each service line will need to be reviewed independently**

CMS Breakdown of Relocation Payment Rates for Excepted and Non-Excepted PBDs

Provider-Based Department (PBD) Type	Non-PHE Payment Policy Before Relocation	Non-PHE Payment Policy if PBD Relocates Off-Campus (Absent Extraordinary Circumstance Approval)	Payment Policy During PHE Following Off-Campus Relocation
On-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	Full OPPS*
Excepted* Off-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	Full OPPS*
Non-Excepted Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent
New (since pandemic) Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent

*PBD department relocations would need to receive extraordinary circumstances relocation approval and the relocation must not be inconsistent with state emergency preparedness or pandemic plan. Once the COVID-19 PHE ends, these relocated PBD would be expected to shut down or return to their original location; otherwise, they would be paid the PFS-equivalent rate unless, at the discretion of the CMS Regional Office, they are granted a permanent extraordinary circumstances relocation exception under our normal policy. We note that, during the COVID-19 PHE, hospitals would have flexibility to do partial relocations, and relocate their PBD to multiple new off-campus locations, including the patient's home.

Billing for Outpatient Services in Temporary PBDs (Including the Patient's Home)



Billing for Outpatient Services in Temporary PBDs (Including the Patient's Home)

- Within the IFC CMS outlines the types of hospital services it believes can be rendered in these temporary PBDs (including when the PBD is relocated to the patient's home). Per CMS these hospital services will fall into one of the 3 categories/billing scenarios listed below:
  - Hospital outpatient therapy, education, and training services that can be furnished other than in-person, and are furnished in a temporary expansion location
  - Hospital outpatient clinical staff services furnished in-person to the beneficiary in a temporary expansion location
  - Hospital services associated with a professional service delivered by telehealth

- Each of these 3 scenarios requires:
  - The patient be a registered outpatient of the hospital,
  - All Medicare CoPs that have not been waived are met at the temporary expansion site (including the patient's home),
  - The hospital clinician is licensed/permitted to perform the service per their individual state scope of practice/CMS regulation
  - All required levels of supervision are still provided; and
  - Documentation in the medical record supports the medical necessity of the service

- **These policy changes/billing scenarios are retroactively effective back to March 1st 2020**

Scenario 1:
Hospital Outpatient Therapy, Education and Training Services in a Temporary PBD

- In the IFC, CMS acknowledges there are certain therapy and education services that are typically provided by hospital employed clinicians and these services are typically billed for directly by hospitals on UB04 claim forms – without an associated professional claim for the service

- CMS states it believes a certain subset of these therapy, education and training services can be effectively furnished by clinical hospital staff through the use of telecommunication technology to patients in their homes so long as the patient's home is made a PBD of the hospital

- It is important to note that although CMS is allowing these services to be rendered via telecommunications technology, these are NOT telehealth services and they should not be billed as such (do not report these services with modifier 95)

- Hospitals should bill for these services as they normally would if furnished directly in the hospital provider-based department, with modifier PO or PN attached as appropriate based on the excepted or non-excepted status of the relocated PBD

Scenario 1:
Hospital Outpatient Therapy, Education and Training Services in a Temporary PBD

- CMS has outlined applicable CPT and HCPCS codes that fall in the category of therapy/education/training services that can be provided remotely by hospital clinical staff within the following link:
  - List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC (ZIP)

- Some examples on the list include (but are not limited to):
  - Medical Nutrition Management CPTs 97802 & 97803
  - Diabetes Self Management Training HCPCs G0108 & G0109
  - Assorted PT and OT eval and treatment CPT codes
  - Certain partial hospitalization program (PHP) therapy services

- CMS notes that this list may not be all-encompassing and that they will be reviewing and updating the list periodically as needed
  - If you intend to provide a therapy/education/training service that is not explicitly noted on this list we would advise discussing with your MAC prior to performing/billing the service to confirm coverage

Scenario 2:
Hospital Outpatient Services Furnished In-Person at a Temporary PBD

- The second category of services are those that are still required to be rendered in-person but CMS acknowledges can be furnished directly by hospital clinical staff at a temporary PBD (including the patient's home) without the need for any distinct work by a physician/NPP (although supervision requirements must still be met)

- Per CMS, examples of such services include (but may not be limited to) wound care, chemotherapy administration and other drug administration services

- CMS has not published a list of CPT or HCPCS codes that would fall within this second category of services
  - Remember all CoPs not waived by CMS still need to be met at the temporary PBD (including the patient's home)
    - Hospitals will need to evaluate which services can be rendered safely in a given patient's home and to what extent non-waived CoPs can still be followed

Scenario 2:
Hospital Outpatient Services Furnished In-Person at a Temporary PBD

- CMS also cautioned that hospitals should check to see if a patient is currently under a Home Health Agency (HHA) plan of care
  - If the patient has a current home health plan of care, CMS states the hospital should only provide services to the patient that cannot be furnished directly by the HHA

- Hospitals should bill for these in-person services as they normally would if furnished directly in the hospital provider-based department, with modifier PO or PN attached as appropriate based on the excepted or non-excepted status of the relocated PBD

Scenario 3:
Hospital Services Associated with a Professional Telehealth Service

- Prior to the IFC, hospitals were only able to bill telehealth originating site facility fee, HCPCS Q3014, if the patient was physically present at the hospital while receiving a professional telehealth service

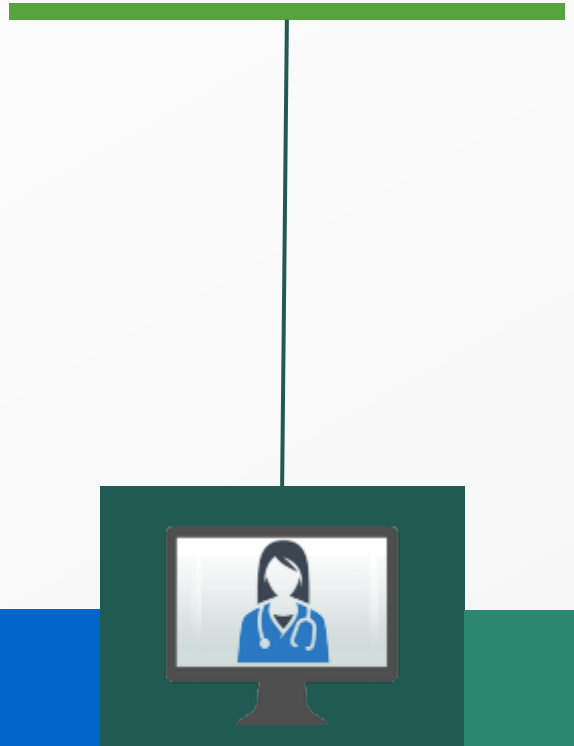
- In the IFC, CMS acknowledged that hospitals often provide administrative and clinical support for professional telehealth services, even when the patient is not physically present at the hospital

- CMS is now allowing hospitals to report HCPCS Q3014 when a patient receives a professional telehealth service in a temporary PBD (including the patient's home) by a provider who would ordinarily render such a service within the hospital's outpatient department(s)
  - E.g. if Doctor X typically treats patients in the hospital but also in private practice, the hospital would only be able to charge Q3014 for supportive telehealth services provided to the hospital's registered outpatients

Scenario 3: Hospital Services Associated with a Professional Telehealth Service

- Although not explicitly stated in the IFC, in this 3rd scenario you are again treating the patient's home as a temporary expansion site of the hospital PBD. Therefore, it is our interpretation modifiers PN or PO would need to be appended to Q3014 when utilizing this waiver flexibility
  - We have sent an inquiry to CMS to clarify this point - we will provide updated guidance if necessary once a response from CMS is received

Updates Related to Professional Telehealth Services



Updates to Professional Telehealth Services

- There has been no change in policy that would allow hospitals to bill for professional telehealth services on a hospital UB04 claim form
  - Although as outlined previously the scenarios for which hospitals can bill the telehealth originating site facility fee, HCPCs Q3014, have been expanded

- For Medicare beneficiaries, telehealth remains a professional service billable on a professional claim (CMS 1500 claim form or it's electronic equivalent)

- Consequently, the policy changes detailed on the following slides are applicable to professional claims only

Updates to Professional Telehealth Services

- CMS is waiving it's previous limitation on the types of practitioners who are allowed to bill for telehealth services
  - Under the updated regulations all providers who are eligible to bill Medicare for their professional services may now provide telehealth services to Medicare beneficiaries
    - This would include (but is not limited to) Physical Therapists, Occupational Therapists and Speech Language Pathologists

- CMS is waiving the audio and visual requirement for a specific sub-set of telehealth services
  - Professional telehealth services that can be provided via audio-only technology are notated in Column D on the updated list of CMS approved telehealth services
    - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
  - Services not marked as approved for audio-only in Column D are still required to be provided using two-way, real-time interactive, audio and visual communication technologies

Updates to Professional Telehealth Services – Code Level Selection for E&M Services

- In it's March 31st IFC CMS instructed that when E&M services were furnished via telehealth providers should utilize the CMS designated "typical times" for each code when performing code level selection

- In the April 30th IFC CMS notes that it received feedback from providers that this policy is confusing, because often the CMS designated "typical times" do not match the times noted in the CPT code's long description

- Therefore, CMS is reversing it's previous March 31st guidance and is now stating: "the typical times for purposes of level selection for an office/outpatient E/M are the times listed in the CPT code descriptor"

Updates to Professional Telehealth Services – Audio-Only E&M Services

- In the March 31st IFC CMS announced it would now cover audio-only telephone E&M CPT codes 99441-99443, the codes were weighted by CMS based on previously established RVU values set by the AMA

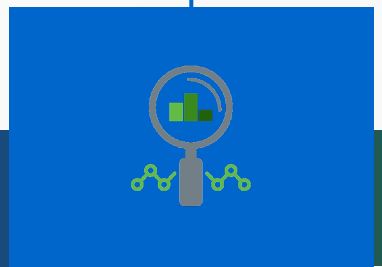
- In the April 30th IFC CMS notes that it has received feedback from providers that these audio-only E&M services are being utilized at a much higher frequency than CMS originally anticipated – and that they are mainly functioning as replacements for telehealth services when beneficiaries do not have access to audio & visual telecommunication systems

- Therefore, in the April 30th IFC CMS announced it will be reweighting the RVU values for codes 99441-99443 so payment for these services will be equivalent to the payment rates for office/outpatient visits with established patients

- CMS is has also added CPTs 99441-99443 to the list of approved telehealth services as approved "audio-only" telehealth services

- In the rule CMS notes it will not be increasing the payment rate for audio-only E&M CPTs 98966-98968 because these codes are reportable by practitioners who cannot independently bill CMS for E&M services – therefore, per CMS, these services are not similar and should not be reimbursed at the same rate as traditional E&M codes

CMS Clarification on Waivers of NCD/LCD Requirements



CMS Clarification on Waivers of NCD/LCD Requirements

- In the March 31st IFC CMS announced it would be waiving the following requirements for all NCDs and LCDs (including associated articles):
  - Any face-to-face or in-person encounter requirements
  - Any specific level of supervision requirements
  - Any specific provider type/specialty requirements
    - CMS is allowing Chief Medical Officers (or equivalent) to authorize another physician specialty to perform such services for the duration of the PHE

- In the March 31st IFC CMS also noted it will not enforce the clinical indications for coverage across: respiratory, home anticoagulation management and infusion pump NCDs and LCDs (including articles)

- In the April 30th IFC CMS announced it will additionally not enforce the clinical indications of coverage noted in NCDs/LCDs related to therapeutic continuous glucose monitors

CMS Clarification on Waivers of NCD/LCD Requirements

- In the April 30th IFC CMS states (based on feedback/comments received) it is concerned that providers are misinterpreting these NCD/LCD requirement waivers

- CMS reminds providers that although clinical indications for certain NCDs and LCDs have been waived, the services rendered must still be reasonable and necessary. Per CMS:
  - "Physicians, practitioners, and suppliers are required to continue documenting the medical necessity for all services. **Accordingly, the medical record must be sufficient to support payment for the services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary**)

Questions?

Stay Informed:
COVID-19 Billing and Coding Updates

https://public.craneware.com/news/covid-19-coding-and-billing

- Recording and slides of this presentation will be posted here ASAP
- Craneware is making publicly available all regulatory guidance for both customers and non-customers