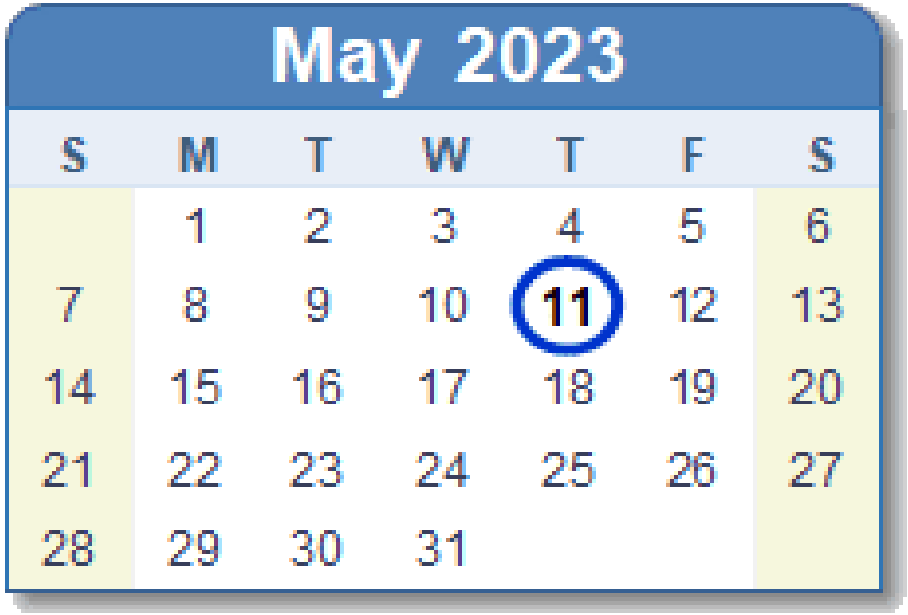
inQuiseek Consulting

GETTING BACK TO NORMAL AFTER THE PHE ENDS!

May 11, 2023



Thursday, May 11th 2023

COVID-19 Public Health Emergency (PHE)

Based on current COVID-19 trends, the Department of Health and Human Services (HHS) is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, to expire at the end of the day on May 11, 2023. Our response to the spread of SARS-CoV-2, the virus that causes COVID-19, remains a public health priority, but thanks to the administration's whole-of-government approach to combatting the virus, we are in a better place in our response than we were three years ago, and we can transition away from the emergency phase.

Over the last two years, the Biden Administration has effectively implemented the largest adult vaccination program in U.S. history, with nearly 270 million Americans receiving at least one shot of a COVID-19 vaccine.

We have come to this point in our fight against the virus because of our historic investments and our efforts to mitigate its worst impacts. Addressing COVID-19 remains a significant public health priority for the Administration, and over the next few months we will transition our COVID-19 policies, as well as the current flexibilities enabled by the COVID-19 emergency declarations, into improving standards of care for patients. We will work closely with partners, including state, local, tribal, and territorial agencies, industry, and advocates, to ensure an orderly transition.

Resources

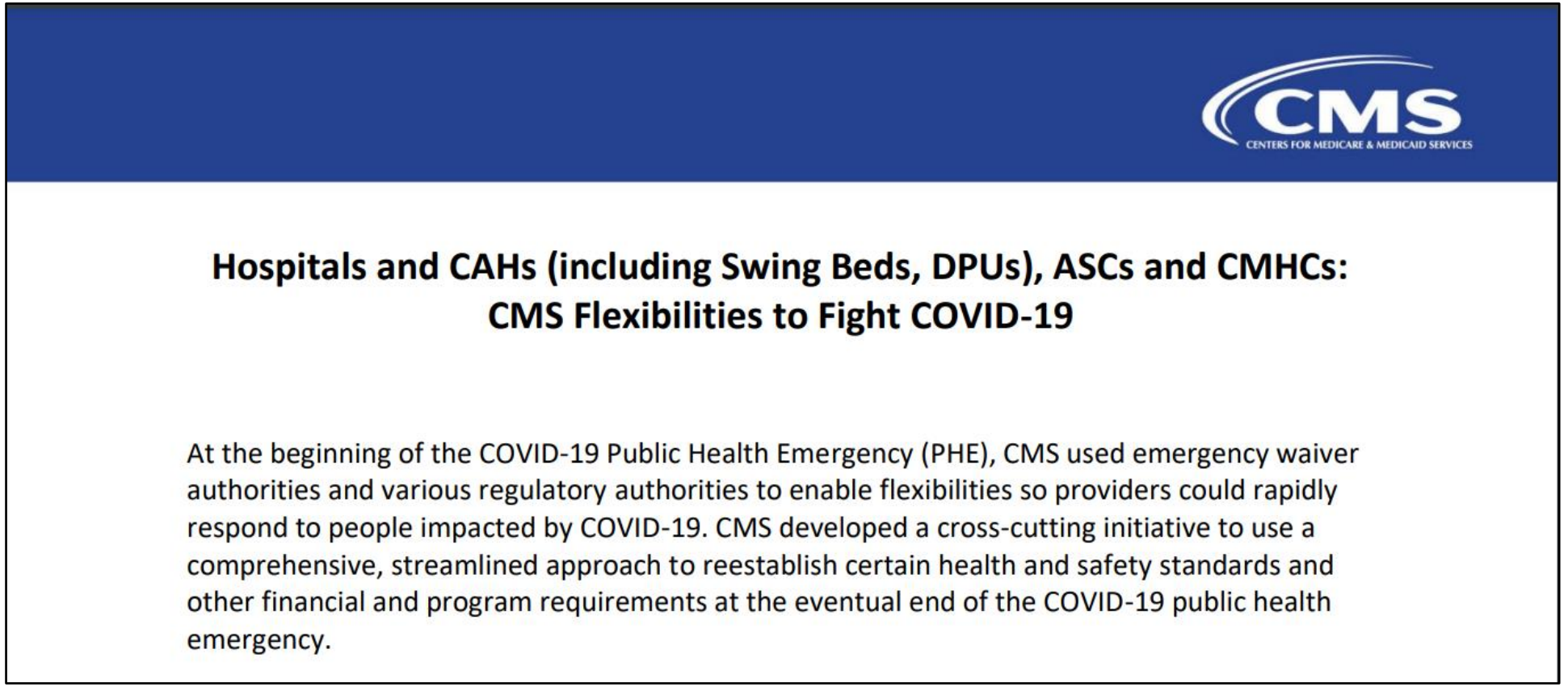
February 27, 2023 CMS Fact Sheet: CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency (The PDF version of this Fact Sheet can be found here - PDF.)

February 9, 2023 HHS Secretary Xavier Becerra Letter to U.S. Governors

February 9, 2023 Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap

https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html

CAHS AND RURAL PPS HOSPITALS



Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

ALL SERVICES MUST BE PERFORMED IN A HOSPITAL DEPARTMENT WHEN THE PHE ENDS

CMS Hospitals Without Walls (Temporary Expansion Sites)

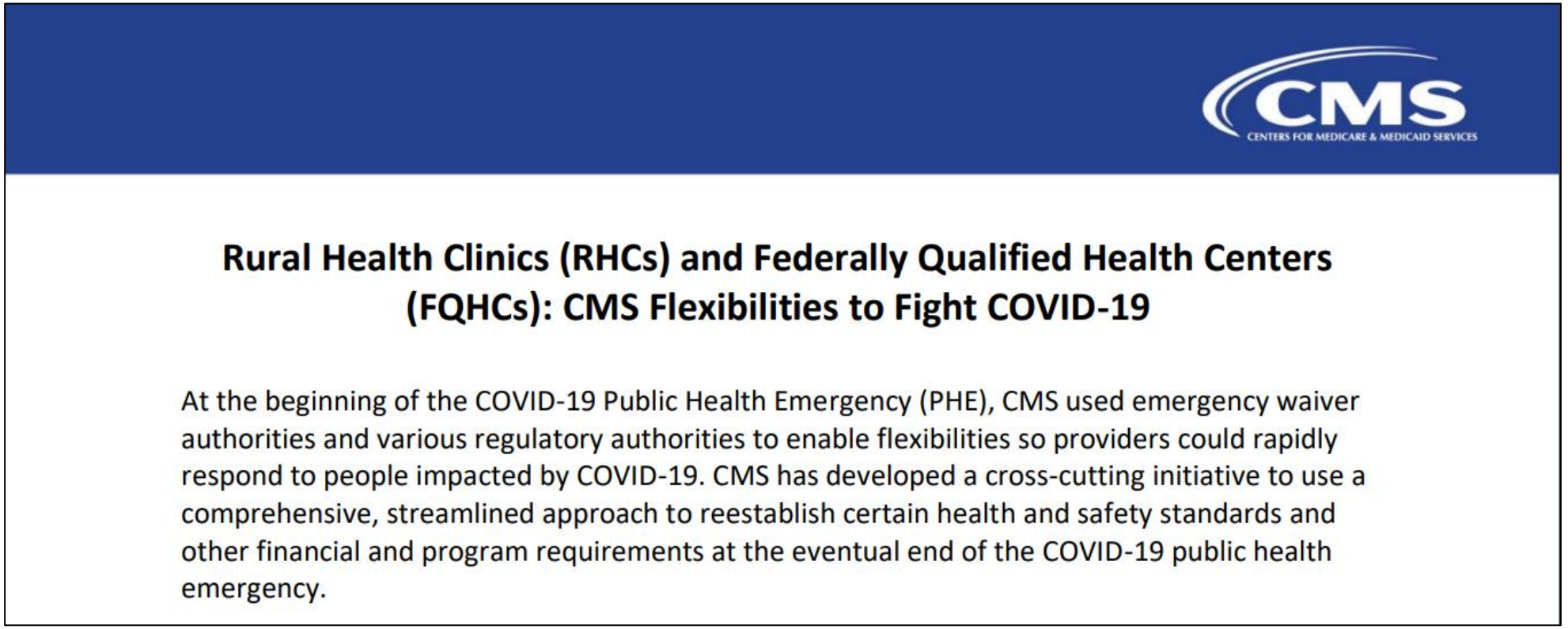
- *Hospitals Able to Provide Care in Temporary Expansion Sites*: As part of the CMS Hospital Without Walls initiative during the PHE, hospitals could provide hospital services in other hospitals and sites that otherwise would not have been considered part of a healthcare facility, or could set up temporary expansion sites to help address the urgent need to increase capacity to care for patients. During the PHE, CMS provided additional flexibilities for hospitals to create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations, such as hotels or community facilities. During the PHE, hospitals are expected to control and oversee the services provided at an alternative location. **When the PHE ends, hospitals and CAHs will be required to provide services to patients within their hospital departments, pursuant to Hospital and CAH conditions of participation at 42 CFR part 482 and part 485, Subpart F, respectively.**

ACUTE, SNF AND SWINGBEDS

During the PHE, there were a several waivers that created fuzzy lines between acute and SNF beds. These allowed the management of patient surge and flexibilities in using resources. When the PHE ends:

- 3-day acute stay prior to SNF or Swingbed is reinstated
- SNF Beds or other distinct part units cannot be used for acute care
- Number of Swingbeds reverts back to pre-PHE
- CAH Length of Stay of 96 hours is resumed

RURAL HEALTH CLINICS



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS has developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

THESE BLANKET WAIVERS FOR RHCS WILL END:

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Certain Staffing Requirements.** 42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.

- **Physician Supervision of NPs in RHCs and FQHCs.** 42 CFR 491.8(b)(1). We are modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

THESE BLANKET WAIVERS WILL END:

- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

THIS MEANS: NO STAFFING WAIVERS AFTER THE PHE ENDS.

- The staffing requirements in 42 CFR § 491 must be in place:
  - NP or PA must be staffed at least 50% of all RHC Patient Care Hours as posted.
  - The RHC must have a designated Medical Director (Physician) who is responsible for the medical direction of the clinic and who performs chart audits to determine if NPP are following the medical management policies. The medical director must be able to see patients and provide medical services. The RHC Medical Director role is separate and distinct from any state required collaborative or supervisory role.
  - The flexibility for RHC providers to be working from home or alternate locations will end. RHC providers must provide face-to-face services in an approved encounter location.

THIS MEANS: NO SATELLITE OR OFF SITE RHC LOCATIONS WHICH ARE NOT INDEPENDENTLY CERTIFIED AS NEW RHCS AFTER THE PHE ENDS.

- No RHC services can be performed off-site or at temporary or satellite locations.
  - Each location must be certified at a qualified location with its own CCN number.
  - Each location must be in a currently designated Primary Care Healthcare Shortage Area or in a currently designated Medically Underserved Area.
  - Each location must be in a rural area as defined by the Census Bureau.
  - If the temporary location is in the process of becoming certified but is not certified at the time that the PHE ends, the services at that location are not considered RHC services until the new certification is obtained.
  - No expansion site services can be held out as services of the main RHC after the PHE ends.

IF THE PHE ENDS IT WILL BECOME MORE DIFFICULT TO RECEIVE A WAIVER FROM THE PRODUCTIVITY STANDARDS

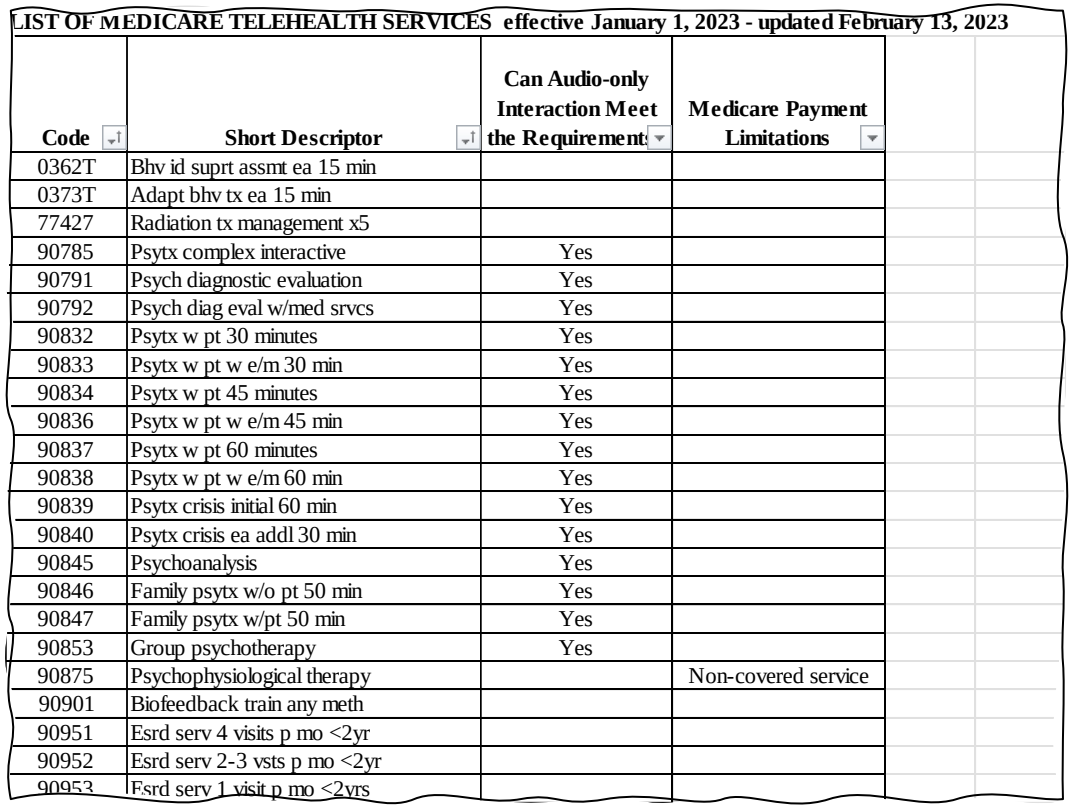
- RHCs have always had the ability to request a waiver from the productivity standards if circumstances warranted such a request.
  - Because of the staffing difficulties during COVID, the MACs granted all productivity standard waiver requests.
  - For many of the grandfathered provider-based RHCs, their grandfathered rate was determined while under a productivity waiver.
  - Therefore many RHCs have a sizable AIR cap due to the waiver.
  - If volumes aren't back to before COVID times the AIR could take a hard hit.
  - Contact your cost report preparer to determine the effect of the productivity standards to next year's rate.

WHAT ABOUT MEDICARE MEDICAL TELEHEALTH AFTER THE PHE ENDS?

- The flexibilities given to provide telehealth will not end until 12/31/2024.
- The last Wednesday in July, the House overwhelming passed H.R. 4040, Advancing Telehealth Beyond COVID–19 Act of 2021. This legislation would extend a variety of Medicare telehealth flexibilities, currently set to expire on the 152nd day after the end of the Public Health Emergency (PHE), to now continue through December 31, 2024.

  Notably, this legislation would allow RHCs to continue as telehealth distant site providers through 12/31/2024 and delay the in-person requirements for mental health services furnished via telehealth for that duration as well. It also expands the duration for which certain telehealth services can be furnished via audio-only communications.

WHERE TO FIND THE CMS APPROVED TELEMEDICINE LIST



LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated February 13, 2023

Code	Short Descriptor	Can Audio-only Interaction Meet the Requirement	Medicare Payment Limitations
0362T	Bhv id suprt assmt ea 15 min		
0373T	Adapt bhv tx ea 15 min		
77427	Radiation tx management x5		
90785	Psytx complex interactive	Yes	
90791	Psych diagnostic evaluation	Yes	
90792	Psych diag eval w/med srvcs	Yes	
90832	Psytx w pt 30 minutes	Yes	
90833	Psytx w pt w e/m 30 min	Yes	
90834	Psytx w pt 45 minutes	Yes	
90836	Psytx w pt w e/m 45 min	Yes	
90837	Psytx w pt 60 minutes	Yes	
90838	Psytx w pt w e/m 60 min	Yes	
90839	Psytx crisis initial 60 min	Yes	
90840	Psytx crisis ea addl 30 min	Yes	
90845	Psychoanalysis	Yes	
90846	Family psytx w/o pt 50 min	Yes	
90847	Family psytx w/pt 50 min	Yes	
90853	Group psychotherapy	Yes	
90875	Psychophysiological therapy		Non-covered service
90901	Biofeedback train any meth		
90951	Esrd serv 4 visits p mo <2yr		
90952	Esrd serv 2-3 vsts p mo <2yr		
90953	Esrd serv 1 visit p mo <2yrs		

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Code

CURRENT MEDICARE TELEHEALTH BILLING POLICIES

Name of Telehealth Service	Brief Description	How to Bill	Amount (2023)
Virtual Check-In or Virtual Care Communications	Remote evaluation – G2010 Brief communication with patient (5 min) – G2012	G0071 No modifier necessary Rev Code 052X	$23.72
Chronic Care Management	99484, 99487, 99490, 99491, 99424, and 99425 = G0511 99492, 99493 = G0512	G0511 – Care Management G0512 – Psychiatric Care Management	G0511 - $77.94 G0512 - $146.73
Digital e-visits	Online digital evaluation and management 99421-99423	G0071 No modifier Rev Code 052X	$23.72
Telehealth Visits	One to one substitutes for in-person services/visits List of allowable services maintained by CMS **Coverage through 12/31/2024**	**G2025** Modifier 95 optional Modifier CS (for services where cost sharing is waived) Rev Code 052X Costs and encounters carved out of cost report	$98.27
Mental Health Telehealth Visits	CPT Codes that can be billed with 0900 revenue code **Permanent coverage**	Rev Code 0900 Use proper mental health CPT code Modifier CG always Modifier 95 if audio-video Modifier FQ if audio-only Count costs and encounters on cost report	All-Inclusive Rate

Source: National Association of Rural Health Clinics
https://www.narhc.org/narhc/TA_Webinars1.asp

Medicare Policy Area	Current Policy and Duration of Flexibility/Waiver
Originating Site/Geographic Requirements	Patients can receive telehealth services in their home or anywhere else through December 31, 2024.
Distant Site Requirements	RHC providers can serve as telehealth distant site providers through December 31, 2024. RHC providers can offer telehealth services from any location, including their home, during this period.
Billing/Cost Reporting Requirements	Please see table above. G2025 policy for medical telehealth visits remains in effect through December 31, 2024.
Modality	The Office of Civil Rights allows for "non-public facing" remote communication products to be used for telehealth services, "exercising discretion" on stringent HIPAA compliant platform requirements. This will end immediately when the federal PHE concludes.

Source: National Association of Rural Health Clinics
https://www.narhc.org/narhc/Telehealth_Policy.asp

WHAT ABOUT MEDICARE MENTAL/BEHAVIORAL TELEHEALTH AFTER THE PHE ENDS?

- Mental and Behavioral Health services provided via telehealth are now recognized as RHC encounters and reimburse the AIR. This was a provision of the 2022 MPFS Final Rule.
- The end of the PHE does NOT change this.
- CMS is expected to give further clarification on whether these services must be distant site or if originating site services are also included. To pay the AIR we would expect the services to be distant site; however, CMS has not been clear on this.
- Billing guidance for these mental health telehealth services can be found in SE 22001.

https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf

MENTAL HEALTH TELEHEALTH CODING & BILLING INFORMATION

RHC Claims for Mental Health Visits via Telecommunications Example

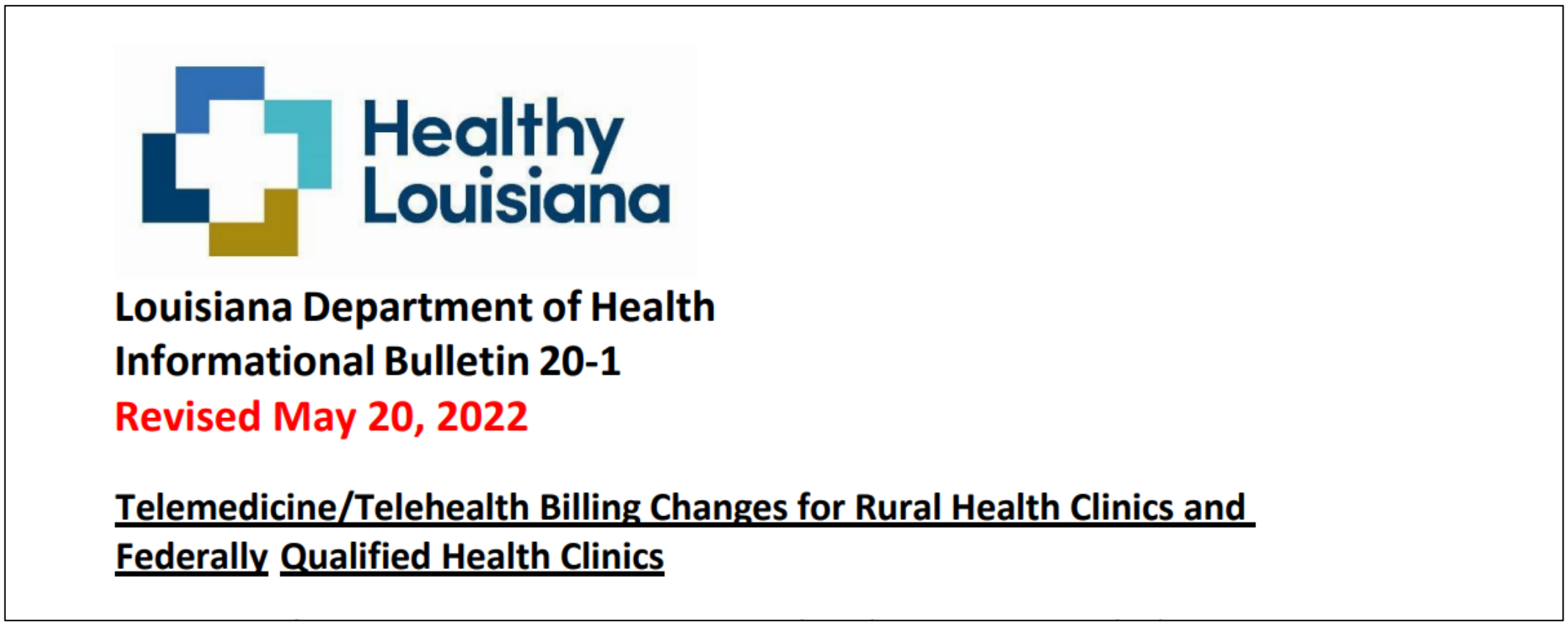
Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

Mental Health Services	
HCPCS Code	**Short Descriptor**
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

LOUISIANA MEDICAID TELEHEALTH

Distance Site Telehealth has been an RHC service since before COVID-19.

- POS 02 or 10 (home)
- T1015 Code
- All other services reported by CPT/HCPCS Code
- All lines must have -95 modifier
- Reimburses the current RHC Encounter Rate



https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-1_revised20220520.pdf

LOUISIANA MEDICAID RHC BEHAVIORAL HEALTH

Louisiana Department of Health

Informational Bulletin 21-21

Revised January 14, 2022

Changes to Behavioral Health Services in Federally Qualified Health Centers and Rural Health Clinics

COVID VACCINE MANDATE

DOES NOT END WITH THE PHE

REQUIREMENTS FOR ALL CERTIFIED CMS FACILITIES

- All employees and staff (included contracted workers, students and non-patient individuals who are in the facility regularly with patient or employee contact) must be fully vaccinated 10 days prior to beginning work or must have a properly executed and approved exemption.
- Employers must accommodate those individuals to whom exemptions have been granted.
- Full recordkeeping of vaccine/immunization records for the initial dose(s) and any boosters.
- Proof of employee education on COVID-19
- Contingency Plan for the facility if infection rates for the community surge and/or if the workforce is impacted by surge or absences.

COMMON RHC SURVEY DEFICIENCIES NOW THAT SURVEYORS ARE BACK OUT IN THE FIELD

Citation Frequency Report

Region Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		(VI) Dallas Active Providers=826		Total Number of Surveys=61
J0041	PHYSICAL PLANT AND ENVIRONMENT	4	0.5%	6.6%
E0036	EP Training and Testing	3	0.4%	4.9%
E0037	EP Training Program	3	0.4%	4.9%
J0152	PATIENT HEALTH RECORDS	3	0.4%	4.9%
J0044	PHYSICAL PLANT AND ENVIRONMENT	3	0.4%	4.9%
E0006	Plan Based on All Hazards Risk Assessment	3	0.4%	4.9%
E0004	Develop EP Plan, Review and Update Annually	2	0.2%	3.3%
J0042	PHYSICAL PLANT AND ENVIRONMENT	2	0.2%	3.3%
J0043	PHYSICAL PLANT AND ENVIRONMENT	2	0.2%	3.3%
J0125	PROVISION OF SERVICES	2	0.2%	3.3%
J0110	COVID-19 Vaccination of Facility Staff	1	0.1%	1.6%
E0029	Development of Communication Plan	1	0.1%	1.6%
E0031	Emergency Officials Contact Information	1	0.1%	1.6%
E0039	EP Testing Requirements	1	0.1%	1.6%
E0001	Establishment of the Emergency Program (EP)	1	0.1%	1.6%
E0034	Information on Occupancy/Needs	1	0.1%	1.6%
J0023	LOCATION OF CLINIC	1	0.1%	1.6%

E0030	Names and Contact Information	1	0.1%	1.6%
J0151	PATIENT HEALTH RECORDS	1	0.1%	1.6%
J0040	PHYSICAL PLANT AND ENVIRONMENT	1	0.1%	1.6%
E0032	Primary/Alternate Means for Communication	1	0.1%	1.6%
J0123	STAFFING AND STAFF RESPONSIBILITIES	1	0.1%	1.6%
J0101	STAFFING AND STAFF RESPONSIBILITIES	1	0.1%	1.6%
J0085	STAFFING AND STAFF RESPONSIBILITIES	1	0.1%	1.6%

- Program Evaluation/Louisiana Advisory Board Meeting
- Emergency Preparedness Testing and After-action Reports
- Physician Chart Review (10% in Louisiana)
- Policy and Procedure Review
- Equipment Inspections/Tagging
- Missing Consents or Incomplete Patient Records
- Drug/Supply Storage and Expiration Dates
- 50% NP/PA Staffing
- In Louisiana, 36 hours of patient care a week required

COMMON HOSPITAL SURVEY DEFICIENCIES NOW THAT SURVEYORS ARE BACK OUT IN THE FIELD

Selection Criteria

Begin Year: 2023
End Year: 2023
Display Options: Display top 25 tags
Provider and Supplier Type(s): Hospitals
Region: VI DALLAS
Provider and Supplier Type(s): All Other Hospital Types
Survey Focus: Health

Year Type: Fiscal Year **Year**: 2023 **Quarter**: Full Year

Citation Frequency Report

Region / Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		(VI) Dallas Active Providers=1034		Total Number of Surveys=405
A0144	PATIENT RIGHTS: CARE IN SAFE SETTING	33	3.0%	8.1%
A0395	RN SUPERVISION OF NURSING CARE	22	2.1%	5.4%
A0392	STAFFING AND DELIVERY OF CARE	12	1.2%	3.0%
A0750	INFECTION CONTROL SURVEILLANCE, PREVENTION	11	1.1%	2.7%
A0396	NURSING CARE PLAN	11	1.1%	2.7%
A0115	PATIENT RIGHTS	10	0.8%	2.5%
A0405	ADMINISTRATION OF DRUGS	9	0.9%	2.2%
A0749	INFECTION CONTROL PROGRAM	9	0.9%	2.2%
A0398	SUPERVISION OF CONTRACT STAFF	9	0.9%	2.2%

A0724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	8	0.8%	2.0%
A0145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT	8	0.8%	2.0%
A0286	PATIENT SAFETY	8	0.8%	2.0%
A0131	PATIENT RIGHTS: INFORMED CONSENT	7	0.7%	1.7%
A0123	PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION	6	0.6%	1.5%
A0283	QUALITY IMPROVEMENT ACTIVITIES	6	0.6%	1.5%
A0273	DATA COLLECTION & ANALYSIS	4	0.4%	1.0%
A0620	DIRECTOR OF DIETARY SERVICES	4	0.4%	1.0%
A0438	FORM AND RETENTION OF RECORDS	4	0.4%	1.0%
A0747	INFECTION PREVENTION CONTROL ABX STEWARDSHIP	4	0.4%	1.0%
A0118	PATIENT RIGHTS: GRIEVANCES	4	0.4%	1.0%
A0130	PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING	4	0.4%	1.0%
A0178	PATIENT RIGHTS: RESTRAINT OR SECLUSION	4	0.4%	1.0%
A0168	PATIENT RIGHTS: RESTRAINT OR SECLUSION	4	0.4%	1.0%
A2402	POSTING OF SIGNS	4	0.4%	1.0%
A0063	CARE OF PATIENTS	3	0.3%	0.7%

Patty Harper, RHIA, CHTS-PW, CHTS-IM, CHC®
InQuiseek Consulting
Pharper@inquiseek.com
318-243-2687

Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 25 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. Patty currently serves on the Board of NARHC.