CMS Issues Clarification on Use of Telehealth During the PHE

AMDA – The Society for Post-Acute and Long-Term Care Medicine has been working with the Centers for Medicare & Medicaid Services to gain clarification around telehealth visits and in-person visits in the nursing facility during the public health emergency (PHE). Some confusion stemmed from an April 7, 2022, CMS memo (https://go.cms.gov/3cwK0Vw) that ended the blanket waiver for regulatory physician visits completed via telehealth.

CMS told the Society that, based on the regulatory requirement, regardless of what is allowed to be billed as telehealth the regulations require practitioners to see the resident in person at least once every 30 days for the first 90 days after admission (and once every 60 days thereafter). So a practitioner can continue to conduct any telehealth visit and bill as allowed. However, they must see the resident in person within the specified timelines to be compliant with the CMS requirements. For example, a practitioner could conduct the 99304 evaluation via telehealth as the first visit to a resident of a skilled nursing facility but must still visit the resident in person at some point within the first 30 days.

After the first 30 days, they must continue to conduct at least one in-person visit every 30 days for the next 60 days, and once every 60 days thereafter.

Separate from the list of visits that may be performed via telehealth, CMS has the following regulatory requirements. 483.30(c) Frequency of Physician Visits (https://bit.ly/3suSrlo):

1. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. [Note: “Be seen” means in person.]
2. A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required.
3. Except as provided in paragraphs (c) (4) and (f) of this section, all required physician visits must be made by the physician personally.
4. At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) [https://bit.ly/3pYtTmI] of this section.

If you have any questions about this clarification, please send an email to publicpolicy@paltc.org.

CMS Discontinuing the Use of Certificates of Medical Necessity and Durable Medical Equipment Information Forms

As part of its ongoing efforts to increase access to care and to reduce unnecessary administrative burden for stakeholders, CMS will be discontinuing the use of Certificates of Medical Necessity (CMNs) and Durable Medical Equipment (DME) Information Forms (DIFs) for claims with dates of service on or after January 1, 2023. CMS suppliers must continue to submit CMN and DIF information for claims with dates of service before January 1, 2023, if it is required.

This change in process aligns with the Biden-Harris Administration’s priority of improving access to quality, affordable care and coverage by enabling quicker access to needed medical supplies for people with Medicare. It also enables frontline clinicians to focus on providing direct care and streamlines the coverage process for suppliers.

Originally, CMS required the CMNs and DIFs to help document medical necessity and other coverage criteria for selected DME. Through stakeholder outreach, CMS received feedback that CMNs and DIFs are burdensome and duplicative of information already available on the claim or in the medical record. Additionally, CMS heard that submission of these forms is often particularly difficult for small or rural providers without administrative staff and technical support. In response to this feedback, CMS evaluated options for easing this process and determined it could end the use of these forms.

Get more information on this change here: https://go.cms.gov/3CKzaWQ.