**Cardiac and Pulmonary Rehab Reimbursement**

**during COVID-19 Public Health Emergency**

Compliance Information Sheet – Aug 13, 2020

# Executive Summary

Our cardiac and pulmonary rehab (CR/PR) programs are seeking approval from compliance during the Public Health Emergency (PHE) to bill CPT 93797 and G0424 outpatient service codes for rehab sessions that we will deliver virtually to patients who are in their home.

These codes are typically for unmonitored, on-campus rehab sessions, but with recent CMS Interim Final Rules during the COVID-19 PHE, we believe these billed rehab sessions can be relocated to the patient’s home, with proper virtual supervision. This virtual cardiopulmonary rehab option will allow our department to continue providing care for this high-risk population during the PHE, while limiting their exposure to the virus and keeping them safe.

This document walks through those CMS updates in detail (with links to references), and outlines the clauses that allow for remote CR/PR reimbursement.

# Reference Documents

1. [Medicare IFC: Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC) (PDF)](https://www.cms.gov/files/document/covid-final-ifc.pdf)
	1. Released on March 30th, 2020, this document includes the section 16.E (page 55) outlining “Direct Supervision by Interactive Telecommunications Technology” for cardiac and pulmonary rehab.
2. [Medicare and Medicaid IFC: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-5531 IFC) (PDF)](https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf)
	1. Released on April 30th, 2020, this document adds to the Blanket Waivers and in sections II.E and II.F (pages 33 and 43) outlines that PBDs for outpatient services such as CR/PR can be temporarily relocated to the patient’s home.
3. Proposed Rule: [2021 Outpatient Prospective Payment System (OPPS)](https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-17086.pdf)
	1. Released on August 3rd, 2020, this document clarifies “virtual direct supervision” for CR/PR as originally expanded in the IFC #1 above, and proposes to make that update permanent beginning Jan 1, 2021.

# Overview of CR/PR Related Policy Updates under PHE

There are two main updates related to CMS’s Public Health Emergency policy and regulatory revisions that taken together, allow billing for home-based CR/PR sessions. These are:

1. In the March 30th IFC (reference #1 above), CMS announced that for the duration of the public health emergency, direct physician supervision of CR/PR services could include “virtual presence through audio/visual real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.”
	1. To clarify this further, in the 2021 OPPS Proposed Rule ( reference #3 above) CMS clarified that this flexibility applied to both the direct supervision regulatory requirement as well as the statutory requirement that a physician be immediately available for medical consultation and medical emergencies.
2. In the April 30th IFC 2 (reference #2 above), CMS announced new rules concerning hospital outpatient provider-based departments (PBDs) for the duration of the public health emergency “allowing PBDs to relocate into more than one PBD location, and allowing PBDs to partially relocate while still maintaining the original location. Hospitals can relocate PBDs to the patient’s home and continue to receive the full OPPS payment amount under the extraordinary circumstances relocation exception policy.”
	1. This addition allows the CR/PR outpatient services to be delivered to a patient who is in their home, as long as that patient is a registered outpatient of the hospital and all other statutory and regulatory requirements are met.

# Detailed Description of CR/PR Services and Updates for Virtual Delivery

1. **Background on pre-PHE, on-campus CR/PR services**

Prior to the PHE, CR/PR services were delivered as an on-campus outpatient service. When patients attended onsite rehab sessions, they would schedule for one of our class times, which were conducted as group sessions with up to 12 patients at the same time. The requirements for the billed sessions were that the patient needed to participate for a minimum of 31-minutes in duration, there must be some exercise performed during that time, and there must be direct physician supervision. During the session, the patient would typically exercise and receive counseling and education from the clinical staff.

The standard operations for these sessions was that the physician would not need to be present in the room during the session, but would be in the building and must be “immediately accessible and available for medical consultation and medical emergencies.” The assumption was that the physician could physically get to the room quickly to consult, if called.

1. **Updated requirements for “direct physician supervision”**

In the March 30th IFC (ref #1), CMS announced that for the duration of the PHE, “direct physician supervision” for outpatient services including CR/PR would be met through a virtual presence of the physician.

1. This discussion can be found beginning on page 55, in section 16.E titled Direct Supervision by Interactive Telecommunications Technology.
2. In the last paragraph on page 59, they explicitly call out CR/PR services as being included in this expansion, and that for CR/PR direct supervision can be met with:

“virtual presence through audio/visual real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary of health care provider.”

1. In the explanation beginning on page 56, they outline an example scenario similar to direct supervision of CR/PR, and specify how a physician would not need to be immediately accessible to be physically present, but could furnish assistance to the clinical staff providing the care, through a virtual connection:

“In some cases, depending upon the unique circumstances of individual patients and billing physicians, we believe that telecommunications technology could be used in a manner that would facilitate the physician’s immediate availability to furnish assistance and direction without necessarily requiring the physician’s physical presence in the location where the service is being furnished, such as the office suite or the patient’s home. For example, we believe that use of real-time, audio and video telecommunications technology allows for a billing practitioner to observe the patient interacting with or responding to the in-person clinical staff through virtual means, and thus, their availability to furnish assistance and direction could be met without requiring the physician’s physical presence in that location.

1. **In interpreting this update, we believe that the requirement for direct physician supervision for CR/PR sessions during the PHE is met if:**

**Our CR/PR clinical staff delivering the services can call the physician and immediately initiate a virtual audio/visual real-time communication between the clinical staff and physician, in the event they require a medical consult or have an emergency.**

In addition to these updates in the March 30th IFC, in CMS’s Aug 3rd OPPS Proposed Rule for 2021 (ref #3), they further clarified these expansions under the PHE, AND proposed to make them permanent even after the PHE ends, beginning Jan 1st, 2021.

1. This discussion begins on page 409 of OPPS Proposed Rule, section X.A titled Proposed Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals (CAHs).
2. Cardiac and pulmonary rehab specific discussion starts on the last paragraph on page 413, in section X.A.2 titled Proposal to Allow Direct Supervision of PR, CR, and ICR Services using Interactive Telecommunications Technology.
3. **Update allowing outpatient service location to be in a patient’s home through telecommunications**

In the April 30th IFC 2 for the PHE (ref #2 above), CMS elaborated on some of the [blanket waivers they had issued for the PHE](https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf), including clarification that hospital outpatient services which would ordinarily be delivered on-campus, can be temporarily furnished in an expansion location, including a patient’s home.

1. This discussion begins on page 43, in section II.F titled Furnishing Hospital Outpatient Services in Temporary Expansion Locations of a Hospital or a Community Mental Health Center (including a Patient’s Home)
2. In the third paragraph on page 45, they clearly outline that this location waiver means that these services can be delivered to a patient in their home.

However, as noted above, we have issued numerous blanket section 1135 waivers to give health care providers needed flexibility to address the COVID-19 PHE.21As part of this initiative, we have waived the requirements associated with becoming a PBD of a hospital at § 413.65, as well as certain requirements under the Medicare conditions of participation in §§ 482.41 and 485.623, to facilitate the availability of temporary expansion locations. Because of these waivers, during theCOVID-19 PHE, temporary expansion locations, including beneficiaries’ homes, can become PBDs of hospitals and therapeutic outpatient hospital services furnished to beneficiaries in these provider-based locations can meet the requirement that these services be furnished in the hospital so long as all other requirements are met, including the hospital conditions of participation, to the extent not waived, during the COVID-19 PHE. That is, while certain locations would not normally be permitted to be considered part of a hospital, during the COVID-19 PHE, the section 1135 waivers of the provider-based rules allow temporary expansion locations to become provider-based to the hospital to bill for medically necessary hospital outpatient therapeutic services furnished at those locations, assuming all other applicable requirements are met (including, to the extent not waived, the hospital conditions of participation)

1. On page 46, they identify 3 different categories of services where this waiver may be applied. The category of relevance for CR/PR services is labeled 1. Hospital Outpatient and CMHC Therapy, Education, and Training Services.
2. On page 47 paragraph 1, they discuss how these services can be delivered for this category:

Outpatient therapy, education, and training services require communication and interaction. Facility staff can effectively furnish these services using telecommunication technology and, unlike many hospital services, the clinical staff and patient are not required to be in the same location to furnish them. We have already stated that section 1135 blanket waivers in effect during the COVID-19 PHE allow the hospital to consider the beneficiary’s home, and any other temporary expansion location operated by the hospital during the COVID-19 PHE, to be a PBD of the hospital, so long as the hospital can ensure the locations meet all of the conditions of participation, to the extent not waived. In light of the need for infection control and a desire for continuity of behavioral health care and treatment services, we recognize the ability of the hospital’s clinical staff to continue to deliver these services even when they are not physically located in the hospital.

1. They then reference a list of “[Examples of Hospital Outpatient Services](https://s3.us-west-2.amazonaws.com/secure.notion-static.com/9df0a9a2-6724-4ec9-abf0-b4e5960b86cf/Example_Hospital_Therapy_and_Other_Services_Accompanying_IFC_displayed_April_30_2020.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAT73L2G45O3KS52Y5%2F20200817%2Fus-west-2%2Fs3%2Faws4_request&X-Amz-Date=20200817T123441Z&X-Amz-Expires=86400&X-Amz-Signature=049976cb5bacebd314d65941ed7fa3c0dda4acce14833bd61faf91403a88c758&X-Amz-SignedHeaders=host&response-content-disposition=filename%20%3D%22Example%2520Hospital%2520Therapy%2520and%2520Other%2520Services%2520Accompanying%2520IFC%2520displayed%2520April%252030%25202020.pdf%22)” that can be furnished using telecommunications technology in the patient’s home. While CR/PR are not on this list, they make clear in that document and the IFC that “this list may not include every service that falls into this category.”
2. **With this waiver and IFC clarification, we believe that our CR/PR services can be delivered by clinical staff through telecommunications to patients in their home, and we can bill these sessions using CPT 93797 and G0424.**