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Utilization Review Plan	https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf 42 CFR §482.1(a)(3) 42 CFR 482.30 - Condition of participation: Utilization ...	CMS is waiving the entire utilization review condition of participation Utilization Review (UR) at §482.30, which requires that a hospital must have a UR plan with a UR committee that provides for a review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided.	
Discharge Planning (Including Critical Access Hospital)	https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf 42 CFR 482.43(a)(8) 42 CFR 482.61(e) 42 CFR 485.642(a)(8) 42 CFR 482.43 (c)(1) 42 CFR 482.43(c)(2) 42 CFR 482.43(c)(3) 42 CFR 485.642(a)(8)	1. CMS waiving the requirement to provide detailed information regarding discharge planning, described below: • The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. The hospital must ensure that the post-acute care data on quality measures and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. 2. CMS is waiving all the requirements related to post-acute care services so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS is waiving the more detailed requirement that hospitals ensure those patients discharged home and referred for HHA services, or transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, must: • Include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient. • Inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services. • Identify in the discharge plan any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the	CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b). CMS is waiving all the requirements and subparts at 42 CFR §482.43(c) related to post-acute care services so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country.

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		Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.	
Advance Directives	https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf Social Security Act §1902(a)(58) Social Security Act §1902(w)(1)(A) Social Security Act §1852(i) Social Security Act 1866(f) 42 CFR 489.102	CMS is waiving the requirement for hospitals and CAHs to provide information about their advance directive policies to patients.	
Inpatient Rehabilitation Facilities Regarding the "60 Percent Rule"	https://www.cms.gov/files/document/covid-inpatient-rehab-facilities.pdf	CMS is allowing IRFs to exclude patients from the freestanding hospital's or excluded distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF **(commonly referred to as the "60 percent rule")** if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such.	
3-Day Prior Hospitalization SNF Placement and Exhausted SNF Benefits	Social Security Act 1812(f)	CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances.	

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Home Health Initial Assessments	https://www.cms.gov/files/document/covid-final-ifc.pdf https://www.cms.gov/files/document/covid-home-health-agencies.pdf https://www.cms.gov/files/document/covid-final-ifc.pdf 42 CFR 484.55 (a) 42 CFR 409.43 42 CFR 424.22 Social Security Act §1814 (a)(2)(A) and (C) Social Security Act 1835(a)(2)(A) Social Security Act 1861(aa)(5) and (gg) Social Security Act 1834(m)	1. CMS is allowing HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. 2. HHS is utilizing enforcement discretion with regards to the requirements in order to allow a patient to be under the care of a nurse practitioner or clinical nurse specialist who is working in accordance with State law, or a physician assistant who is working in accordance with State law, and for such physician/practitioner: • order home health services; • establish and periodically review a plan of care for home health services (e.g., sign the plan of care); • certify and re-certify that the patient is eligible for Medicare home health services. 3. On an interim basis, CMS is finalizing that to the extent an NCD or LCD (including articles) would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements would not apply during the PHE for the COVID-19 pandemic.	Extending the 5-day completion requirement for the comprehensive assessment to 30 days. This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long-term care facilities. This will allow for maximizing coverage by already scarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity. The definition of "confined to the home" (that is, "homebound") allows patients to be considered "homebound" if it is medically contraindicated for the patient to leave the home. As an example for the PHE for COVID-19 pandemic, this would apply for those patients: (1) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or (2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19. A patient who is exercising "self-quarantine" for one's own safety would not be considered "confined to the home" unless a physician certifies that it is medically contraindicated for the patient to leave the home. This will provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. HHS will not conduct audits to ensure that only physicians provided orders, signed and dated the plans of care, and certified/recertified

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			patient eligibility for claims submitted during this public health emergency.
Certain National Coverage Determination and Local Coverage Determination	https://www.cms.gov/files/document/covid-final-ifc.pdf National Coverage Determination (NCD) for Home Use of ... National Coverage Determination (NCD) for Sleep Testing ... Respiratory Assist Devices - Medicare National Coverage Determination (NCD) for Intrapulmonary ... Oxygen and Oxygen Equipment LCD and PA - Medicare National Coverage Determination (NCD) for Home Prothrombin ... National Coverage Determination (NCD) for Infusion Pumps ... Local Coverage Determination (LCD) for External Fusion Pump	CMS is finalizing on an interim basis that we will not enforce the clinical indications for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs (including articles) allowing for maximum flexibility for practitioners to care for their patients. This enforcement discretion will only apply during the PHE for the COVID-19 pandemic. These policies include, but are not limited to: ●NCD 240.2 Home Oxygen. ● NCD 240.4 Continuous Positive Airway Pressure for Obstructive Sleep Apnea. ● LCD L33800 Respiratory Assist Devices (ventilators for home use). ● NCD 240.5 Intrapulmonary Percussive Ventilator. ● LCD L33797 Oxygen and Oxygen Equipment (for home use). ● NCD 190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management. ● NCD 280.14 Infusion Pumps. ● LCD L33794 External Infusion Pumps.	
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	https://www.cms.gov/files/document/covid-dme.pdf DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, and ...	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required.	Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.
Ambulance Transports	https://www.cms.gov/files/document/covid-final-ifc.pdf Social Security Act 1861(s)(7) 42 CFR 410.40(e) and (f)	CMS indicates ambulance transports may include any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF, community mental health	

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		centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), any other location furnishing dialysis services outside of the ESRD facility, and the beneficiary's home.	
Furnishing Dialysis Services to SNF patients	https://www.cms.gov/files/document/covid-19-esrd-facilities.pdf 42 CFR 494.180(d)	CMS is waiving this requirement to allow dialysis facilities to provide service to its patients in the nursing home or skilled nursing facility.	CMS continues to require that services provided to these nursing home residents are under the direction of the same governing body and professional staff as the resident's usual Medicare-certified dialysis facility. Further, in order to ensure that care is safe, effective and is provided by trained and qualified personnel, CMS requires that the dialysis facility staff: furnish all dialysis care and services, provide all equipment and supplies necessary, maintain equipment and supplies in the nursing home, and complete all equipment maintenance, cleaning and disinfection using appropriate infection control procedures and manufacturer's instructions for use.
Hospitals Ability to Provide Inpatient Care in Temporary Expansion Sites	https://www.cms.gov/files/document/covid-final-ifc.pdf https://www.cms.gov/files/document/covid-hospitals.pdf https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers Social Security Act §1861(d)	CMS is providing additional flexibilities for hospitals to create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations or sites not considered part of a healthcare facility such as hotels or community facilities. This flexibility will allow hospitals to separate COVID-19 positive patients from other non-COVID-19 patients to help efforts around infection control and preservation of personal protective equipment (PPE). Hospitals would still be expected to control and oversee the services provided at an alternative location.	
EMTALA	https://www.cms.gov/files/document/covid-hospitals.pdf https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf Social Security Act 1867(a)	This will allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with the state emergency preparedness or pandemic plan.	A waiver of EMTALA sanctions is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay. Hospitals are generally able to manage the separation and flow of potentially infectious patients through alternate screening locations on the hospital campus.

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CMS suspending most Medicare Fee-For-Service (FFS) Medical Review	https://www.cms.gov/files/document/provider-burden-relief-faqs.pdf	CMS has suspended most Medicare Fee-For-Service (FFS) medical review during the emergency period due to the COVID-19 pandemic. This includes pre-payment medical reviews conducted by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate program, and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC). No additional documentation requests will be issued for the duration of the PHE for the COVID-19 pandemic. Targeted Probe and Educate reviews that are in process will be suspended and claims will be released and paid. Current post payment MAC, SMRC, and RAC reviews will be suspended and released from review.	
State Surveys	https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus	CMS is suspending non-emergency survey inspections across the country, allowing inspectors to turn their focus on the most serious health and safety threats like infectious diseases and abuse.	
Telehealth Services	https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf https://www.cms.gov/files/document/covid-final-ifc.pdf https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Code	Under the public health emergency, all beneficiaries across the country can receive Medicare telehealth and other communications technology based services wherever they are located. Clinicians can provide these services to new or established patients.	Starting on March 6, 2020, Medicare can pay for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's place of residence. In the context of the PHE for the COVID-19 pandemic, we recognize that physicians and **other health care professionals** are faced with new challenges regarding potential exposure risks, for people with Medicare, for health care providers, and for members of the community at large. For example, the CDC has urged health care professionals to make every effort to interview persons under investigation for infection by telephone, text messaging system, or video conference instead of in-person. To facilitate the use of telecommunications technology as a safe substitute for in-person services, we are, on an interim basis, adding many services to the list of eligible Medicare telehealth services,

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			eliminating frequency limitations and other requirements associated with particular services furnished via telehealth, and clarifying several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks.
Critical Access Hospital Staff Licensure	https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf 42 CFR 485.608(d)	CMS is deferring to staff licensure, certification, or registration to state law by waiving regarding the requirement that staff of the CAH be licensed, certified, or registered in accordance with applicable federal, state, and local laws and regulations.	This waiver will provide maximum flexibility for CAHs to use all available clinicians.
Critical Access Hospital Status and Location	https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf 42 CFR 485.610 (b) and (e)	CAH be located in a rural area or an area being treated as rural, allowing the CAHs flexibility in the establishment of surge site locations. CAH flexibility in establishing off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers will remove restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs.	In an effort to facilitate the establishment of CAHs without walls, these waivers will suspend restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
Critical Access Hospital Length of Stay	https://www.cms.gov/files/document/covid-hospitals.pdf 42 CFR 485.620 - Condition of participation: Number of ...	CMS is waiving the Medicare requirements that Critical Access Hospitals (CAHs) limit the number of beds to 25, and that the length of stay be limited to 96 hours.	

Sources

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