# **PYA** End of the PHE Compliance Checklist

**READ ME:** The end of the COVID-19 public health emergency (PHE) means the end of federal regulatory waivers and flexibilities. Providers must now roll back policies and practices implemented in reliance on those waivers and flexibilities. Unless stated otherwise, return to normal operations must be completed before May 12, 2023.

PYA has prepared this checklist to help providers identify the work to be done by that date. Rather than summarizing each waiver and flexibility (e.g., "CMS changed the timeline from 5 to 21 days"), the checklist states the rule that will be in effect following the end of the PHE (e.g., "The timeline is 5 days"). For each item, we cite the relevant regulation, as applicable.

This checklist focuses primarily on waivers and flexibilities relating to the Medicare program. It does not address the following:

- Waivers and flexibilities made permanent or terminated prior to 1/1/2022
- Reimbursement for COVID-19 vaccinations, testing, and treatment
- Modifications to Medicare value-based purchasing programs
- CMS-approved state Medicaid program waivers and flexibilities
- State and local waivers and flexibilities

Note the following are not impacted by the end of the PHE. Any changes to or discontinuation of these requirements will be the subject of separate regulatory action:

- FDA emergency use authorization for COVID-19 vaccines, tests, and treatments
- Hospital and long-term care facility COVID-19-related reporting requirements
- Health care provider vaccine mandates
- OSHA's Healthcare Emergency Temporary Standard
- Duties and obligations relating to Provider Relief Fund payments

We have categorized the waivers and flexibilities by the type of provider most directly impacted. Because a waiver or flexibility may impact more than one provider type, one should review each section to identify all relevant post-PHE changes.

This checklist is current as of April 26, 2023. PYA will update the checklist as additional guidance becomes available. This checklist does not constitute and cannot be relied upon as legal, tax, accounting, banking, financial, or any other form of professional or other advice. We have made a reasonable effort to address all waivers and flexibilities, but we do not and cannot warrant the completeness of this checklist.

## 1. Applicable to Multiple Provider Types

### A. Medicare Provider Enrollment

1. CMS will resume normal application processing timelines
2. Practitioners who have opted out of the Medicare program will no longer be permitted to cancel their opt-out status earlier than allowed by regulation (42 CFR 405.445)
3. Effective January 1, 2024, practitioners who render telehealth services from their home will be required to report their home address on their Medicare enrollment

### B. Medicare Appeals

All regulatory flexibilities relating to Medicare appeals (e.g., extended timeframes) will terminate

### C. COVID-19 Diagnostic Testing and Reporting

Providers of COVID-19 diagnostic tests will no longer be required to post cash prices for those tests; however, all hospital price transparency rules will remain in effect

### D. State licensure requirements

CMS will defer to state law on issues regarding licensure requirements

### E. Fraud and abuse

1. Any financial arrangement with a physician entered into in reliance on the Stark Law blanket waivers must be brought into compliance with a Stark Law exception (including fair market value) or be terminated, except appropriate repayment terms agreed to prior to the end of the PHE may continue beyond that date
2. Any financial arrangements entered into in reliance on OIG's FAQs regarding the application of its administrative enforcement authorities to arrangements directly connected to the PHE must be brought into compliance with the fraud and abuse laws or terminated (https://oig.hhs.gov/coronavirus/authorities-faq.asp)

*Continued on next page.*

© 2023 PYA, P.C.

No portion of this resource may be used or duplicated by any person or entity for any purpose without the express written permission of PYA.

## 2. Medicare Telehealth Flexibilities

A. Reimbursement for telehealth services under the Medicare Physician Fee Schedule

1. Geographic and location restrictions will be waived through 12/31/24
    - Waiver is permanent for tele-behavioral health services subject to certain restrictions effective 1/1/25
2. Reimbursement for PT, OT, S/L pathologist, and audiologist telehealth services will continue through 12/31/24
3. Reimbursement for audio-only services (audio-only E/M (CPT 99441-43) and specified behavioral health & education services) will continue through 12/31/24
4. Reimbursement for RHCs and FQHCs for medical telehealth services under G2025 will continue through 12/31/24 (reimbursement for tele-behavioral health services as RHC/FQHC services are now permanently covered)
5. Reimbursement for Category 3 telehealth services will continue through 12/31/23; reimbursement for services added to the telehealth services list during the PHE not designated as Category 1, 2, or 3 telehealth services will continue through 10/9/23 (these dates are subject to change during the 2024 MPFS rulemaking process)
6. Discontinue any waiver of beneficiary co-payment or deductible associated with telehealth and virtual services (due to expiration of HHS Office of Inspector General notice of enforcement discretion)
7. By 09/09/23, comply with HIPAA Rules in provision of telehealth services including, but not limited to, entering into business associate agreement with telehealth technology vendor
8. Through 12/31/23, continue use of -95 modifier and continue to identify location at which practitioner would perform face-to-face services as place of service for telehealth services

B. Reimbursement for telehealth services under the Hospital Outpatient Prospective Payment System

1. Discontinue billing originating site fee (HCPCS Q3014) for telehealth services furnished to a beneficiary in his or her home
2. Discontinue billing HCPCS G0463 for telehealth services
3. Discontinue billing for education and management services (e.g., DSMT) furnished by hospital staff via telehealth
4. Discontinue billing for PT, OT, and S/L pathologist services furnished by hospital staff via telehealth
5. Hospital may bill HCPCS C7900-C7902 for behavioral health services furnished by hospital staff via telehealth to a beneficiary in his or her home (subject to specific requirements)

C. Use of telehealth to perform required face-to-face visits/frequency limitations

1. Re-certification of eligibility for hospice and required face-to-face assessments for home health may be performed via telehealth through 12/31/24
2. For subsequent inpatient visits, use of telehealth will be limited to once every 3 days (CPT 99231-99233)
3. For subsequent SNF visits, use of telehealth will be limited to once every 14 days (CPT 99307-99310)
4. For critical care consults, use of telehealth will be limited to once per day (HCPCS G0508-G0509)
5. Discontinue use of telehealth for required face-to-face visits for home dialysis patients
6. Discontinue use of telehealth for required face-to-face visits for inpatient rehabilitation facility patients
7. To the extent NCD or LCD requires face-to-face visit for evaluations and assessments, these visits no longer can be performed via telehealth
8. Only teaching physicians in residency training settings located outside an MSA will be able to meet presence for key portions requirement via telehealth (but not for complex procedures, endoscopy and anesthesia services)
9. Only teaching physicians in residency training settings located outside an MSA can direct, manage, and review via telehealth care furnished by residents at certain primary care centers (but cannot bill level 4 or 5 office/outpatient E/M visit furnished by resident unless physically present for key portion of the service)
10. Opioid treatment programs may perform periodic assessments by telephone through 12/31/23; thereafter, assessments performed using two-way interactive audio-video communication will be permitted

D. Use of telehealth to prescribe controlled substances

Discontinue prescribing any controlled substance following telehealth visit unless prescribing provider previously performed an in-person medical evaluation of the patient (Drug Enforcement Administration published a proposed rule on March 1 to permit such prescriptions in limited circumstances)

*Continued on next page.*

## 3. Physicians and Other Practitioners

A. Physician/practitioner supervision of services

1. Providing direct supervision virtually will be permitted through 12/31/23; thereafter, any service requiring direct supervision of a physician/practitioner will require such individual to be physically present in the same suite of offices and immediately available to assist
2. Comply with all NCD/LCD requirements that a specific practitioner type or physician specialty furnish or supervise a service (Chief Medical Officer or equivalent at a hospital or facility will no longer have the authority to vary those requirements based on staffing considerations)

B. Substitute billing arrangements (locum tenens)

Comply with requirement that locum tenens physician or physical therapist can provide services to Medicare patients over a continuous period of no longer than 60 days

C. Virtual services

1. Discontinue virtual check-ins (HCPCS G2010 and G2013), e-visits (HCPCS G2250 and G2251), and remote physiologic and remote therapeutic monitoring for new patients
2. Require at least 16 days of monitoring data in a 30-day period to bill for remote physiologic and remote therapeutic monitoring (discontinuation of 2-day exception for patients with suspected or confirmed cases of COVID-19)

D. Discontinue billing CPT 99211 based solely on clinical staff assessment of patient and specimen collection

E. Comply with current clinical indications in LCDs for therapeutic continuous glucose monitors and NCDs/LCDs for respiratory-related devices, home infusion pumps, and home anticoagulation therapy

F. Specialists must satisfy the procedural volume requirements contained in the NCDs for Percutaneous Left Atrial Appendage Closure, Transcatheter Aortic Valve Replacement, Transcatheter Mitral Valve Replacement, and Ventricular Assist Devices to perform those procedures

*Continued on next page.*

## 4. Hospitals

A. Hospitals Without Walls (Waivers and Flexibilities Relating to Expanded Hospital Capacity)

1. Discontinue use of any temporary expansion sites (hospital must provide services to patients within their hospital departments in compliance with applicable Conditions of Participation)*
2. Discontinue use of non-patient care areas to furnish services (e.g., converted conference room) (42 CFR 482.41)*
3. Ensure each sleeping room has outside window or outside door (42 CFR 482.41(b)(9))*
4. Return any provider-based department relocated to a new off-campus location during the PHE to its original location (or such relocated department will be treated as non-exempted provider-based department (with the exception of relocated exempted provider-based department that applies for and receives an extraordinary circumstances relocation exception))
5. Discontinue billing under Medicare OPPS for therapy and educational services furnished remotely by hospital staff to a patient at home as the patient's home can no longer be treated as hospital outpatient department (distinguish from OPPS payment effective in 2023 for behavioral health services furnished remotely by hospital staff to patient at home)
6. Discontinue billing under Medicare OPPS for services furnished by hospital staff physically present in a patient's home (e.g., infusion, wound care) as the patient's home no longer can be treated as hospital outpatient department
7. Discontinue billing HCPCS code C9803 for COVID-19 testing specimen collection
8. Comply with EMTALA requirements regarding location of medical screening examinations (discontinue off-site patient screenings)*
9. Discontinue use of hospital swing beds to furnish post-acute services billed under SNF PPS (except small rural hospitals otherwise permitted to use swing beds)
10. Discontinue housing acute care patients in excluded distinct part units
11. Discontinue housing excluded inpatient psychiatric unit and inpatient rehabilitation unit patients in acute care units
12. Ensure each Medicare inpatient discharged to a SNF satisfies the 3-day prior hospitalization requirement
13. For hospitals presently classified as Sole Community Hospitals, resume normal eligibility requirements (42 CFR 412.92(a))
14. For hospitals presently classified as Medicare-Dependent hospitals, resume normal eligibility requirements (42 CFR 412.108(a))
15. Continue (or commence) participation in Acute Hospital Care at Home waiver program through December 31, 2024

B. Waivers and Flexibilities Relating to Expanded Workforce Capacity

1. Ensure each Medicare patient is under the care of a physician (vs. other licensed practitioners) (42 CFR 482.12(c))
2. Ensure all CRNAs provide services under the supervision of a physician (42 CFR 482.52(a))*
3. Specify in writing personnel qualified to perform specific respiratory care procedures and level of supervision required for those procedures (42 CFR 482.57(b)(1))
4. Adhere to all medical staff credentialing and privileging requirements (42 CFR §482.22(a)(1)-(4))
5. Ensure that all practitioners furnishing telehealth services to hospital patients pursuant to agreements with distant site hospitals or distant-site telemedicine entities have been credentialed and granted privileges in compliance with regulatory requirements (42 CFR §482.12(a) (8)– (9))*

*Continued on next page.*

*Note: those items designated with * also apply to Critical Access Hospitals*

## 4. Hospitals (continued)

C. Waivers and Flexibilities to Reduce Administrative Burden

1. Comply with Life Safety Code and Health Care Facilities Code requirements (42 CFR 482.41(b)(1)(i))*
    - Requirements for placement of alcohol-based hand rub dispensers
    - Fire drill requirements
    - Prohibition on temporary walls and barriers between patients
2. Conduct facility and equipment inspection, testing, and maintenance with regular frequencies and activities (42 CFR 482.41(d))*
3. Develop and keep current a nursing plan of care for each patient (42 CFR 482.23(b)(4))*
4. Maintain policies and procedures establishing which outpatient departments are not required to have a registered nurse present (42 CFR 482.23(b)(7))
5. Comply with all Conditions of Participation requirements regarding utilization review (including maintenance of UR plan and UR committee to review medical necessity of admission, duration of stay, and services provided) (42 CFR 482.1(a)(3) and 482.30)
6. Comply with all Conditions of Participation requirements regarding quality assessment and performance improvement program (including scope of program and setting priorities for performance improvement activities) (42 CFR 482.21(a)–(d) and (f))*
7. Use verbal orders for drugs and biologics (other than vaccinations) on infrequent basis only (42 CFR 482.23(c)(3)(i))*
8. Ensure all orders, including verbal orders, are dated, timed, and authenticated promptly by ordering practitioner or another practitioner responsible for patient's care (42 CFR 482.23(c)(2))
9. Use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if such orders and protocols (a) have been reviewed and approved by medical staff and nursing and pharmacy leadership; (b) are consistent with nationally recognized and evidence-based guidelines; and (c) are periodically and regularly reviewed by medical staff and nursing and pharmacy leadership (42 CFR 482.24(c)(3))
10. Complete medical records within 30 days following patient discharge (42 CFR §482.24(c)(4)(viii))
11. Comply with requirements regarding organization and staffing of medical records department, form and content of medical record, and record retention (42 CFR §482.24(a)-(c))
12. Report deaths of ICU patients with restraints (even if death attributable to disease process) by no later than close of next business day (42 CFR 482.13(g))
13. Provide information to inpatients regarding hospital's advance directive policies at time of admission (42 CFR 489.102)*
14. Comply with discharge planning requirements relating to notification of right to select post-acute care provider, provision of list of post-acute care providers, and disclosure of certain financial interests (42 CFR §482.43(c))
15. Comply with discharge planning requirements relating to sharing of information regarding post-acute care providers scores on quality and resource use measures (42 CFR 482.43(a)(8), 482.61(e))*
16. Discontinue re-use of face masks in sterile compounding areas (42 CFR §482.25(b)(1))*
17. Adhere to patient rights requirements (waiver of these requirements applied only to hospitals impacted by widespread outreach of COVID-19, as determined by CDC guidelines)
    - Timeframes for providing copy of medical record (42 CFR 482.13(d)(2))
    - Written policies and procedures on visitation of patients in COVID-19 isolation and quarantine processes (42 CFR 482.13(h))
    - Limits on use of seclusion (42 CFR 482.13(e)(1)(ii))

*Continued on next page.*

*Note: those items designated with * also apply to Critical Access Hospitals*

| 5. Teaching Hospitals and Teaching Physicians |
|---|
| A. Do not count resident's time for activities at his/her home or patient's home for purposes of Medicare DGME or IME payments |
| B. Do not claim residents sent to other hospitals in IME and DGME FTE resident counts |
| C. Residents' presence at non-teaching hospitals will trigger establishment of IME and/or DGME FTE resident caps at those non-teaching hospitals (and for DGME, it will trigger establishment of PRAs at those non-teaching hospitals) |
| D. Any added beds will be considered in determining hospital's IME payments (discontinuation of IME payment held harmless for temporary bed increases) |
| E. Any change to teaching inpatient psychiatric facility's or teaching inpatient rehabilitation facility's average daily census will be considered in determining facility's teaching status adjustment payments |
| F. Only teaching physicians in residency training settings located outside an MSA can meet presence for key portions requirement via telehealth (but not for complex procedures, endoscopy and anesthesia services) |
| G. Only teaching physicians in residency training settings located outside an MSA can direct, manage, and review via telehealth care furnished by residents at certain primary care centers (but cannot bill level 4 or 5 office/outpatient E/M visit furnished by resident unless physically present for key portion of the service) |

| 6. Critical Access Hospitals |
|---|
| A. Discontinue use of more than 25 beds (42 CFR 485.620) |
| B. Adhere to 96-hour length of stay requirements (42 CFR 485.620) |
| C. Discontinue use of any off-site locations established to provide surge capacity that do not meet requirements for rural location and location relative to other hospitals and CAHs (42 CFR 485.60(b)) |
| D. MD/DO must be physically present at the facility for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH (responsibilities no longer can be performed exclusively on a remote basis) (42 CFR 485.631(b)(2)) |
| E. Medicare beneficiary must have qualifying three-day prior hospitalization to qualify for swing bed coverage |
| F. Comply with minimum personnel qualifications for nurse practitioners, physician assistants, and clinical nurse specialists (42 CFR 485.604) |

*Continued on next page.*

| 7. Long-Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities) |
| --- |
| A. Medicare beneficiary must have qualifying three-day prior hospitalization to qualify for SNF coverage |
| B. Medicare beneficiary must start and complete 60-day “wellness period” to renew SNF benefits |
| C. Discontinue COVID-19 testing for residents and staff required under 42 CFR 483.80(h) (note authority to impose civil money penalties for non-compliance with continue through May 11, 2024) |
| D. Ensure patients’ right to share a room with roommate of choice when practicable and right to refuse transfer to another room at the facility for specified purposes (42 CFR 483.10(e)(5),(7)) |
| E. Comply with requirements for preadmission screening for individuals with mental disorders and/or intellectual disabilities (42 CFR 483.20(k)) |
| F. Adhere to all requirements of 42 CFR 483.10(c) and 483.15(c) and (d) with regard to all resident transfers and discharges (exceptions for transfers and discharges for certain cohorting purposes terminate) |
| G. Comply with Life Safety Code requirements regarding placement of alcohol-based hand rub dispensers |
| H. Effective 07/01/23, Medicare-enrolled immunizers (e.g., pharmacies) no longer will be able to bill directly and get direct payment from the Medicare program for vaccinating Medicare SNF residents |

| 8. Home Health Agencies |
| --- |
| A. Provide patients with copies of their medical records at no cost upon request within 4 business days (42 CFR 484.110(e)) |
| B. Comply with all requirements for supervision of home health aides (including on-site visits) specified in 42 CFR 484.80(h) |
| C Complete by 9/30/23 any postponed annual on-site visit by an RN to location where patient is receiving care (42 CFR 484.80(h)) |
| D. Complete by 9/30/23 required twelve-hour annual in-service training for home health aides (42 CFR 484.80(d)) |
| E. Comply with all requirements regarding quality assessment and performance improvement program (scope of program not limited to infection control issues) (42 CFR 484.65) |
| F. Complete comprehensive assessments within 5 days and submit OASIS data within 30 days |
| G. Comply with limitations on PTs and SLPs performing initial and comprehensive patient assessments (42 CFR 484.55(a)(2) and (b)(3)) |
| H. Required face-to-face encounters for home health may be performed via telehealth through 12/31/24 |

*Continued on next page.*



800.270.9629 | pyapc.com PYA

| 9. Hospices |
| --- |
| A. Discontinue provision of services using telecommunications technology (42 CFR 418.204(d)) |
| B. Complete by 9/30/23 any postponed annual on-site visit by an RN to the location where a patient is receiving care (42 CFR 418.76(h)(2)) |
| C Complete by 9/30/23 annual training required by 42 CFR 418.100(g)(3) |
| D. Comply with all requirements regarding quality assessment and performance improvement program (scope of program not limited to infection control issues) (42 CFR 418.58) |
| E. By 12/31/23, resume use of volunteers for at least 5% of patient care hours (42 CFR 418.78(e)) |
| F. Comprehensive assessments must be updated by the hospice interdisciplinary team every 15 days (42 CFR 418.54(d)) |
| G. Make available physical therapy, occupational therapy, and speech-language pathology services and provide such services in a manner consistent with accepted standards of practice (42 CFR 418.72) |
| H. Comply with Life Safety Code requirements regarding placement of alcohol-based hand rub dispensers |
| I. Re-certification of eligibility for hospice may be performed via telehealth through 12/31/24 |

| 10. Rural Health Clinics and Federally Qualified Health Centers |
| --- |
| A. Reimbursement for RHCs and FQHCs for medical telehealth services under G2025 will continue through 12/31/24 (reimbursement for tele-behavioral health services as RHC/FQHC services are now permanently covered) |
| B. Non-physician practitioner must be available to furnish patient care services at least 50% of the time RHC/FQHC operates (42 CFR 491.8(a)(6)) |
| C Nurse practitioners must be supervised by RHC/FQHC medical director (42 CFR 491.8(b)(1)) |
| D. Continued use of any location established during the PHE for surge capacity will be dependent on satisfying all regulatory requirements applicable to such location (e.g., location restrictions, survey and certification requirements) |
| E. Payment for virtual communication services (G0071) will be limited to established patients |
| F. Payment under G0071 for online digital evaluation and management services (CPT 99421-99423) will no longer be available; G0071 can only be used for G2012 and G2010 |
| G. Reimbursement for visiting nursing services furnished in the home by RHC/FQHC will be limited to services furnished in areas CMS has determined to have a shortage of home health agencies (42 CFR § 405.2416) |

*Continued on next page.*

| 11. End-Stage Renal Dialysis Facilities |
| --- |
| A. Perform on-time periodic audits for operators of water/dialysate equipment (42 CFR 494.40(a)) |
| B. Be able to demonstrate patient care staff members maintain current CPR certification (42 CFR 494.62(d)(1)(iv)) |
| C Conduct initial comprehensive patient assessments and follow-up |
| D. Implement initial plan of care within specified time frame (42 CFR 494.90(b)(2)) |
| E. Ensure patients have face-to-face visit with physician or non-physician practitioner at least monthly (42 CFR 494.90(b)(4)) |
| F. Perform periodic monitoring of patient's home adaptation, including visits to patient's home by facility personnel in accordance with patient's plan of care (42 CFR 494.100(c)(1)(i)) |
| G. Patient care technicians must achieve certification within 18 months of hiring (42 CFR 494.140(e)(4)) |
| H. Ensure physicians are appropriately credentialed at all locations at which they provide services (42 CFR 494.180(c)(1)) |
| I. Discontinue furnishing dialysis service at any location other than main premises and contiguous locations (42 CFR 494.180(d)) |

| 12. Inpatient Rehabilitation Facilities |
| --- |
| A. Admit only patients who meet standards for rehabilitative care (i.e., discontinue admissions for surge capacity reasons) |
| B. Discontinue use of telehealth for required three-times-per-week face-to-face visits by physician or non-physician practitioner for inpatient rehabilitation facility patients. |
| C. Provide at least 15 hours of therapy per week for each patient (three-hour rule) (42 CFR 412.622(a)(3)(ii)) |
| D. Ensure at least 60 percent of facility's total inpatient population require IRF treatment for one or more of 13 specified conditions (42 CFR 412.29(b)) |
| E. Conduct in-person, weekly interdisciplinary team meetings. Note that rehabilitation physicians may lead these meetings remotely using video, telephone conferencing, or other technology. |

| 13. Long-Term Care Hospitals |
| --- |
| A. Calculation of an LTCH's discharge payment percentage no longer will include all admissions in the numerator |
| B. All LTCH admissions will be subject to the site-neutral payment rate with the exception of those that meet the requirements for exclusion from the rate (42 USC 1395ww(m)(6)) |

| 14. Extended Neoplastic Disease Care Hospitals |
| --- |
| Comply with 20-day average length of stay requirement to maintain exclusion from IPPS (42 CFR 412.23(i)(1) |

*Continued on next page.*

## 15. Intermediate Care Facilities for Individuals with Intellectual Disabilities

| |
|---|
| A. Ensure sufficient Direct Support Staff to relieve Direct Care Staff from support services (42 CFR 483.430(c)(4)) |
| B. Afford clients opportunities to participate in social, religious, and community group activities (42 CFR 483.420(a)(11)) |
| C. Provide each employee with initial and continuing training that enables employee to perform his or her duties (42 CFR 483.430(e)(1)) |
| D. Provide all components of beneficiaries' active treatment programs and training (discontinue COVID-19-related modifications) (42 CFR 483.440(a)) |

## 16. Ambulatory Surgery Centers

| |
|---|
| A. Adhere to all medical staff credentialing and privileging requirements (42 CFR §416.45(b)) |
| B. ASCs that enrolled as hospitals during the PHE must revert to ASC status or pursue hospital licensure |

## 17. Community Mental Health Centers

| |
|---|
| A. Comply with all requirements regarding quality assessment and performance improvement program (including organization and content) (42 CFR 485.917 (a)–(d)) |
| B. Discontinue provision of partial hospitalization and other CMHC services in patient's home |
| C. Comply with requirement that at least 40% of items and services must be furnished to individuals not eligible for Medicare benefits (42 CFR 485.918(b)(1)(v)) |

## 18. Ambulance Services

| |
|---|
| A. Medicare will not reimburse for treatment rendered without transport to a permitted destination |
| B. Medical necessity for non-emergency ambulance transport will need to be certified in writing and signed by physician or certain non-physician personnel (42 CFR 410.40) |

*Continued on next page.*

| 19. Durable Medical Equipment, Prosthetics, Orthotics and Supplies |
| --- |
| A. DME MACs will no longer have flexibility to waive replacement requirements |
| B. Comply with signature and proof of delivery requirements for Part B drugs and DME (no exception for inability to collect signatures) |
| C. Discontinue use of verbal orders for all DMEPOS items |
| D. Fee schedule payments for certain DMEPOS items and services furnished in non-rural, non-competitive bidding areas will no longer be adjusted based on a 75/25 blend of adjusted and non-adjusted rates |

| 20. Laboratories |
| --- |
| A. Medicare will not reimburse for trained technicians to collect samples from homebound beneficiaries or non-hospital inpatient for COVID-19 diagnostic testing |
| B. Medicare will not reimburse for COVID-19 and related testing performed by a laboratory without an order from a physician or non-physician practitioner (not a pharmacist) |
| C. Medicare coverage for COVID-19 serology testing will be at the Medicare Administrative Contractor's discretion |
| D. Increased payments for COVID-19 laboratory tests performing using high throughput technologies will be discontinued |

For questions or comments on this checklist, please contact Martie Ross at mross@pyapc.com or Kathy Reep at kreep@pyapc.com.