

## **AACVPR FACT SHEET: VIRTUAL DELIVERY OF CARDIAC AND PULMONARY REHABILITATION OPPORTUNITIES DURING THE COVID 19 PANDEMIC**

Updated February, 2021

The Public Health Emergency (PHE) related to COVID-19 triggered a series of actions by the Centers for Medicare and Medicaid Services (CMS) to address a broad range of health policies impacted by the pandemic. Most of these actions are delineated in Federal Register notices. Further clarifications were obtained by AACVPR in letters from the CMS Administrator to members of Congress who also asked for specific clarifications.

Established cardiac, intensive cardiac, and pulmonary rehab services (CR/ICR/PR) have the option of delivering virtual rehab sessions during the public health emergency (PHE). AACVPR recently learned that [HHS has announced](#) the Public Health Emergency (PHE) will likely remain in place for the entirety of 2021. When a decision is made to terminate this declaration or let it expire, HHS will provide 60 days' notice prior to termination.

Through the *Hospitals without Walls waiver* (Federal Register, Vol 85, No. 90, May 8, 2020/Rules and Regulations. Pgs. 27560-27566) a beneficiary's home may serve as a provider-based department (PBD) for certain hospital outpatient services, including CR, ICR, and PR.

The following information is taken from [CMS instructions](#) for CR/ICR/PR services with the intended use as a general guide in consultation with your institution's billing and compliance departments. The information in this CMS document is current as of January 7, 2021. CMS updates the PDF on a regular basis. Some information may vary based on location and state laws.

It is important to recognize that [hospitals do not bill Medicare for telehealth services](#). Therefore, it would not be appropriate to use the telehealth codes or modifier 95 code with hospital-based CR/ICR/PR outpatient services.

### **Location of Rehabilitation Program**

The CMS process to deliver virtual rehab to Medicare Fee-for-Service (FFS) beneficiaries is determined by identifying the original location of the service:

Is the program on-campus?

Is the program off-campus with excepted status?

This is a service that was at its current provider-based department (PBD) address prior to November, 2015, so is considered excepted (grandfathered) and continues to receive reimbursement at the outpatient payment rate (OPPS).

Is the program off-campus with non-excepted status?

This is a service that established its current PBD address or had an address change after November, 2015. It therefore is non-excepted (not grandfathered) and receives reimbursement based on a "Physician Fee Schedule-equivalent" amount (40% of OPPS).

## Reason for Extraordinary Circumstances Relocation Request

This request ***is NOT required*** of any hospital outpatient service that relocates during the PHE and wishes to participate in the *Hospitals without Walls* waiver.

The purpose of this Extraordinary Circumstances Relocation Request is for reimbursement determination during the PHE. ***It is available for outpatient services that are located on-campus or at an excepted off-campus*** location that are temporarily relocating the location of the service, including the beneficiary's home. This request is necessary to maintain the same reimbursement rate for virtual delivery of certain services that was being received for those hospital outpatient services prior to the PHE.

If a hospital relocates to a temporary location, which includes the beneficiary's home, the hospital has 120 days to submit the *Extraordinary Circumstances Relocation Request* to continue receiving payment under OPSS for services that qualify for the *Hospitals without Walls* waiver. If the Extraordinary Circumstances Relocation Request is not going to be submitted, the modifier "PN" would be applied to each claim instead of the "PO" modifier normally used for these service locations. Payment will then be reduced to the PFS-equivalent rate for the remainder of the PHE.

A hospital may begin furnishing the outpatient services that are normally provided on-campus or excepted off-campus immediately at temporary location(s) with the "PO" modifier ***if*** the hospital submits the *Extraordinary Circumstances Relocation Request* to the applicable CMS Regional Office within that 120-day window. This assures continuation of payment at the same OPSS rate. The list of email addresses for Regional Offices (some are consolidated) to submit this request are on page 38 of the CMS Instructions (1-7-21 revision).

***A non-excepted off-campus provider-based department (PBD) is not eligible for an Extraordinary Circumstances Relocation Request because no payment adjustment is necessary.*** As was required prior to the PHE, the hospital continues to bill the service provided by that department using a "PN" modifier, which indicates it is non-excepted and the service continues to receive payment at the same PFS-equivalent rate it was receiving prior to the PHE.

If a hospital outpatient excepted service chooses not to submit a patient's home address for an *Extraordinary Circumstances Relocation Request*, the hospital can simply bill with the "PN" modifier and receive payment at the PFS-equivalent rate for those services. If a hospital wants to be paid at the OPSS rate, the PBD location (patient's home) address must be sent (see below).

If an excepted outpatient service decides to permanently relocate to a new location after the PHE, the relocated PBD will no longer be considered excepted after the PHE. From that point forward, the "PN" modifier would be used and payment would remain at the PFS-equivalent rate.

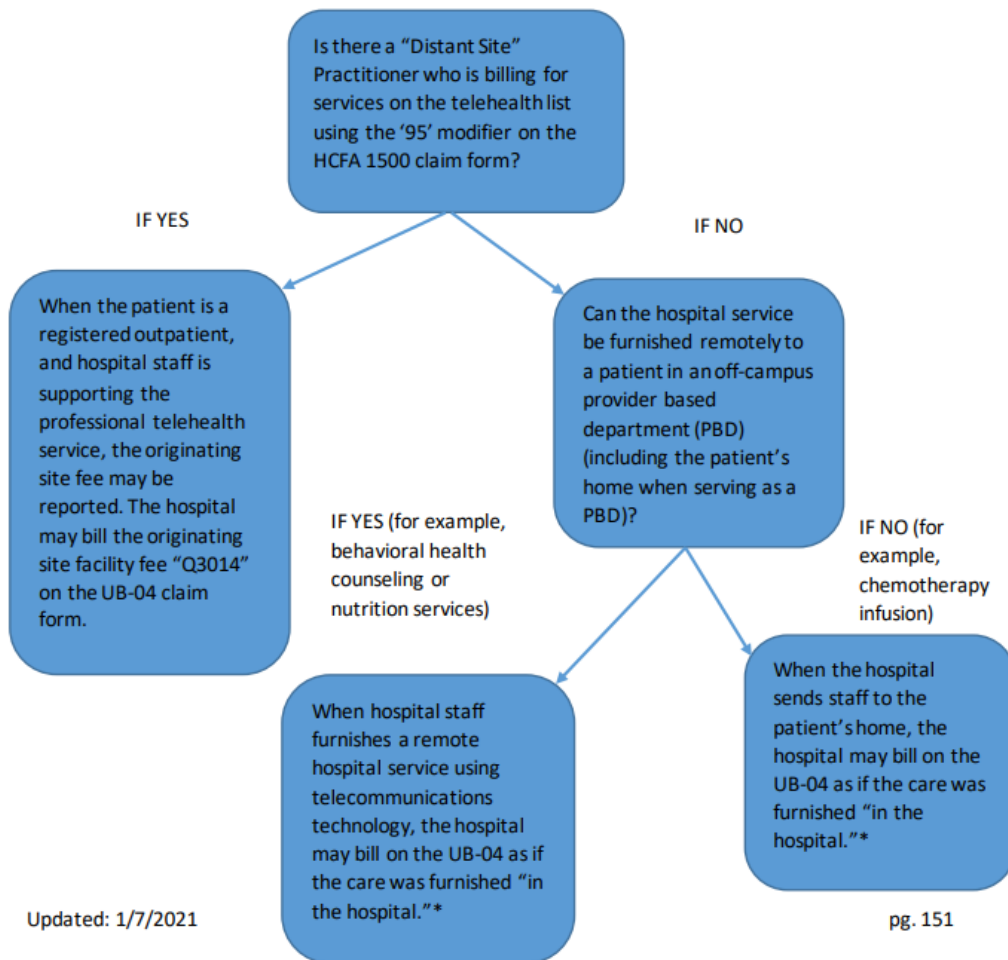
All hospitals should add the "DR" modifier to outpatient claims where any temporary site was utilized. (*MLN Matters Number SE20011* Revised, August 26, 2020, pg. 7)

## Process for Extraordinary Circumstances Relocation Request

The following seven steps are necessary to complete the process for the *Extraordinary Circumstances Relocation Request*. Again, this request is not necessary for hospitals that choose to relocate delivery of CR/ICR/PR sessions to a patient's home as the temporary PBD in response to the PHE. It is necessary to maintain reimbursement at the OPSS rate during the PHE.

A hospital must notify their CMS Regional Office by email with the following information:

- a. Hospital CCN,
- b. Date the services began being furnished at the new location,
- c. Address of the original on-campus or excepted off-campus PBD
- d. New address(es) of the relocated PBDs
  - This is a one-time separate process for each different outpatient service to be delivered to that beneficiary's home; for example, virtual CR would register separately from infusion home visits
  - Each patient's home address requires a separate (one time) submission, sent within 120 days of beginning to furnish and bill for services at the relocated PBD (Home in this case)
  - Patient's home is considered a PBD of the hospital when the patient is registered as a hospital outpatient (Discussed in section II.F of CMS-5531-IFC: Hospitals without Walls)
- e. A brief description of the justification for the relocation, role of relocation in hospital's operations in addressing COVID-19, why the new PBD location is appropriate for furnishing covered outpatient service,
- f. An attestation that the relocation(s) are not inconsistent with state's emergency preparedness or pandemic plan,
- g. A point of contact (name, title, telephone, email) at hospital for the request.



## Rules specific to virtual CR/ICR/PR

CMS regulations for virtual physician supervision of CR/ICR/PR are discussed in the AACVPR Health Policy & Reimbursement Updates published January 6 and January 18, 2021.

For virtual delivery of CR/ICR/PR, the same conditions of coverage must be met, including:

- i. Clinical indications, required education and exercise program components, exercise requirements, session duration requirements, and physician supervision of the services
- ii. MD/DO referral order is obtained prior to enrollment
- iii. Initial assessment, psychological assessment, outcomes assessment
- iv. Individualized treatment plan (ITP) every 30 days, reviewed and signed by a physician

Virtual sessions are delivered by the hospital's clinical CR/ICR/PR staff to the beneficiary in his/her home, using real-time two-way audio and visual synchronous telecommunications technology. These services are billed **only** under the hospital OPPS. There is no professional service with hospital-based CR/ICR/PR that is separately billable under the Physician Fee Schedule.

Procedure codes remain the same for virtual CR/ICR/PR as are used for hospital outpatient CR/ICR/PR services with the virtual modifiers discussed above.

Patient consent may be necessary to document delivery of virtual CR/ICR/PR.

The clinical staff and patient are not required to be in the same location to furnish the service.

*"We recognize the ability of the hospital's clinical staff to continue to deliver these service...Provided a hospital's clinical staff is furnishing hospital outpatient therapy, education, and training services to a patient in the hospital (which can include the patient's home so long as it is provider based to the hospital), and the patient is registered as an outpatient of the hospital, we will consider the requirements of the regulations of 410.27(a)(1) to be met."*

Federal Register, Vol. 85, No. 90, pg. 27563