Policy and Practice: A CMS Update

Webinar for CAFP members

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Disclaimer

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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Objectives

- Gain familiarity with current agency priorities and initiatives, including the recently announced Innovation Center (CMMI) Strategy Refresh
- Understand key policy changes related to the Physician Fee Schedule and Quality Payment Program for calendar year 2022
- Review updates for billing Cognitive Assessment and Chronic Care Management codes
- Identify key elements of the CMS COVID-19 Pandemic Response including the Acute Hospital Care at Home waiver and current vaccine recommendations
- Questions/discussion

CMS Priorities

- Advance health equity by addressing the health disparities that underlie our health system
- Build on the Affordable Care Act and expand access to quality, affordable health coverage, and care
- Engage our partners and the communities we serve throughout the policymaking and implementation process
- Drive innovation to tackle our health system challenges and promote value-based, person-centered care
- Protect our programs' sustainability for future generations by serving as a responsible steward of public funds
- Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms

Innovation Center (CMMI) Strategy Refresh

https://innovation.cms.gov/strategic-direction-whitepaper

Innovation Center Strategic Objective 1: Drive Accountable Care

Aim:
Increase the number of people in a care relationship with accountability for quality and total cost of care.

Measuring Progress:

- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

https://innovation.cms.gov/strategic-direction-whitepaper

Innovation Center Strategic Objective 2: Advance Health Equity

Aim:
Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

Measuring Progress:

- All new models will require participants to collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health. *
- All new models will include patients from historically underserved populations and safety net providers, such as community health centers and disproportionate share hospitals.
- Identify areas for reducing inequities at the population level, such as avoidable admissions, and set targets for reducing those inequities.

*Data would be collected in a manner in which PHI complies with HIPAA and other applicable laws.

https://innovation.cms.gov/strategic-direction-whitepaper

Innovation Center Strategic Objective 3: Support Care Innovations

Aim:
Leverage a range of supports that enable integrated, person-centered care such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

Measuring Progress:

- Set targets to improve performance of models on patient experience measures, such as health and functional status, or a subset of Consumer Assessment of Healthcare Providers and Systems (CAHPS®)* measures that assess health promotion and education, shared decision-making, and care coordination.
- **All models will consider or include patient-reported outcomes as part of the performance measurement strategy.**

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

https://innovation.cms.gov/strategic-direction-whitepaper

Innovation Center Strategic Objective 4: Improve Access by Addressing Affordability

Aim:
Pursue strategies to address health care prices, affordability, and reduce unnecessary or duplicative care.

Measuring Progress:

- Set targets to reduce the percentage of beneficiaries that forgo care due to cost by 2030.
- All models will consider and include opportunities to improve affordability of high-value care by beneficiaries.

https://innovation.cms.gov/strategic-direction-whitepaper

Innovation Center Strategic Objective 5: Partner to Achieve System Transformation

Aim:
Align priorities and policies across CMS and aggressively engage payers, purchasers, providers, states and beneficiaries to improve quality, to achieve equitable outcomes, and to reduce health care costs.

Measuring Progress:

- Where applicable, all new models will make multi-payer alignment available by 2030.
- All new models will collect and integrate patient perspectives across the life cycle.

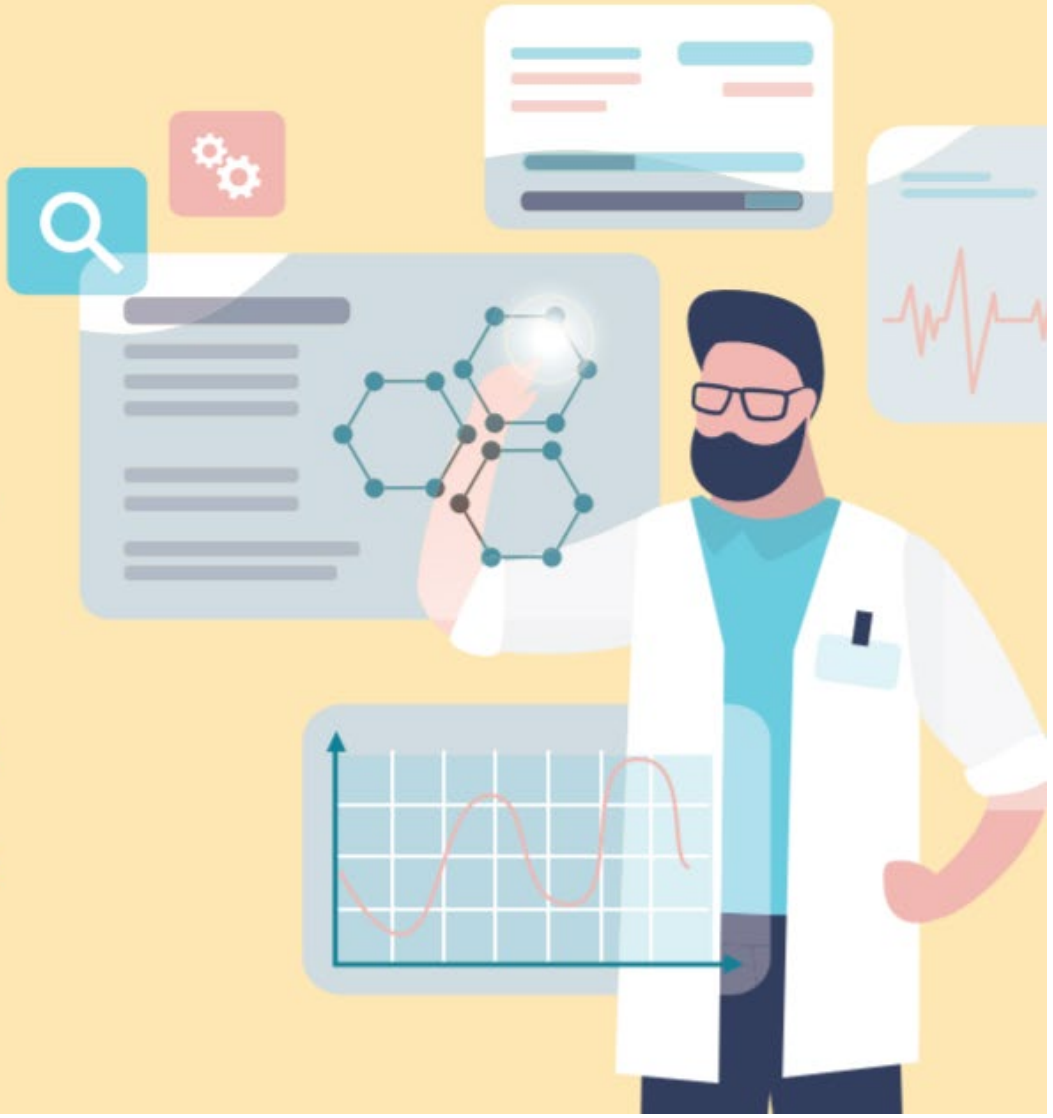
https://innovation.cms.gov/strategic-direction-whitepaper

Categories for Assessing CMS Innovation Center Model Impact	Examples of Metrics
Beneficiary Impacts	• Patient experience • Functional status improvements • Population level metrics, such as avoidable admissions • Quality of care transitions across settings • Access to follow-up care • Coordination across providers • Access to home- and community-based care • Access to telehealth services and other forms of virtual care • Disparities in outcomes by demographic characteristics • Beneficiary costs
Provider Impacts	• Care transformation • Impact on administrative burden • Level of alignment on models across payers • Sustainability of participation in models • Access to actionable, more real-time data to inform care management
Market Impacts	• Level of consolidation • New linkages or relationships between providers • Spread of model elements to other payers • Scalability of model to other regions or payers • Generalizability of impacts to other populations

Streamlining and Harmonizing CMS Innovation Center Models

To build a more harmonized and streamlined portfolio of models, the CMS Innovation Center will consider a number of issues to guide model development and refinement moving forward.

- **How would a model support or advance one or more of the five strategic objectives?**
- **What are the potential impacts of a model on health system transformation for beneficiaries and patients, providers, payers, states, and the Medicare and Medicaid programs?**
- **What is the likelihood of successful execution of a model?**
- **What is the potential for adoption and scaling by other payers and providers?**
- **What is the potential for a model to support innovation in the Medicare and Medicaid programs more broadly?**



https://innovation.cms.gov/strategic-direction-whitepaper

CY 2022 Physician Fee Schedule (PFS) Final Rule

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule

Current Telehealth Flexibilities Under the Public Health Emergency

- **Eligible Practitioners**
  - All health care practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services
  - Healthcare professionals who were not previously authorized under the statute to furnish and bill for Medicare telehealth services—including physical therapists, occupational therapists, speech language pathologists, and others—may receive payment for Medicare telehealth services.

- **Audio-only Telehealth for Certain Services**
  - Beginning on March 1, 2020, telephone evaluation and management and certain behavioral health care and educational services may be furnished via telehealth using audio-only telephones.

PFS 2022: Telehealth and Other Services Involving Communications Technology

- **Mental Health (Consolidated Appropriations Act)**
  - Section 123 of the CAA **removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a mental health disorder**
    - Also requires that there be an in-person, non-telehealth service with the physician or practitioner within six months prior to the initial telehealth service, and thereafter, at intervals as specified by the Secretary.

  - We are implementing these statutory amendments, and finalizing that **an in-person, non-telehealth visit must be furnished at least every 12 months for these services**, that exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record), and that more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

PFS 2022: Telehealth and Other Services Involving Communications Technology (2)

- **CMS is amending the current definition of interactive telecommunications** system for telehealth services – which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner – **to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes** under certain circumstances.

- CMS is **limiting the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology**.

- CMS also **finalized a requirement for the use of a new modifier for services furnished using audio-only communications**, which would serve to verify that the practitioner had the capability to provide two-way, audio/video technology, but instead, used audio-only technology due to beneficiary choice or limitations. We are also clarifying that mental health services can include services for treatment of substance use disorders (SUDs).

PFS 2022: Telehealth and Other Services Involving Communications Technology (3)

- We finalized that **we will extend, through the end of CY 2023, the inclusion on the Medicare telehealth services list of certain services added temporarily to the telehealth services list that would otherwise have been removed from the list as of the later of the end of the COVID-19 PHE** or December 31, 2021.
  - This will allow CMS additional time for us to evaluate whether the services should be permanently added to the Medicare telehealth services list.

- We also have extended inclusion of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023.

- Additionally, we are adopting coding and payment for a longer virtual check-in service on a permanent basis.

Clinical Labor Pricing Update

- **CMS shares provider concerns regarding the need to ensure continued access to quality and affordable care for all beneficiaries in physician office and hospital settings.** Stakeholders have raised concerns that the long delay since clinical labor pricing was last updated has created a significant disparity between CMS' clinical wage data and the market average for clinical labor rates.

- **In consideration of stakeholder comments, we finalized our proposal to update the clinical labor rates for CY 2022 through the use of a four-year transition period.** We have used a four-year transition to incorporate new pricing data in the past and we believe that the use of a phased transition will help provide payment stability and maintain beneficiary access to care.

- The impacts of the clinical labor rate update on PFS payments are largely driven by the share that labor costs represent of the direct PE inputs for each services. We recognize that as we update the clinical labor pricing data, payment for some services will be reduced due to PFS budget neutrality requirements. These services include proportionally more supplies and equipment than clinical labor in their overall cost. However, **other services, such as those primarily furnished by family practice and internal medicine specialties, involve proportionally more clinical labor, will be positively affected by the pricing update.**

Evaluation and Management (E/M) Services

For CY 2022, we are clarifying and refining policies that were reflected in Medicare manual instructions that were recently withdrawn. Specifically, we are making a number of refinements to our current policies for split (or shared) E/M visits, critical care services, and services furnished by teaching physicians involving residents.

Split (or Shared) Visits

- We defined split (or shared) visits as an E/M visit in the facility setting that is performed in part by both a physician and a NPP who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment will be made to the practitioner who performs the substantive portion of the visit.
- Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations.
- Beginning in 2023, the substantive portion of the visit will be defined as more than half of the total time spent by the physician and NPP. For 2022, the substantive portion can be one of the 3 key components (history, physical exam, or medical decision-making), or more than half of the total time (except for critical care, which can only be more than half of the total time).

Evaluation and Management (E/M) Services – 2

Split (or Shared) Visits (continued)

- Split (or shared) visits can be reported for new and established patients, initial and subsequent visits, and prolonged services.
- Modifier -FS should be included on the claim to identify these services to inform policy and help ensure program integrity.
- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.

Critical Care Services – Concurrent and Shared

- When medically necessary, critical care services can be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty.
- Critical care services can be furnished as split (or shared) visits.

Evaluation and Management (E/M) Services – 4

Critical Care Services and Global Procedures

- Critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure.
- Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases).
- New modifier -FT should be included on the claims to identify that the critical care is unrelated to the procedure.
- If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), the appropriate modifiers must also be reported to indicate the transfer of care.

Evaluation and Management (E/M) Services – 5

Teaching Physician Services (Visit Level Selection)

- We are clarifying that when time is used to select the E/M visit level, only the time of the teaching physician may be included (including, but not limited to time spent being present with the resident. Time spent independently by the resident cannot be included.

- Under the primary care exception, for visits allowing medical decision-making (MDM) or time to be used for visit level selection, only MDM can be used to select visit level. This will help ensure appropriate coding to reflect the total medically necessary time.

Implementation of Additional CAA Requirements

Coinsurance for Colorectal Cancer Screening

- CMS finalized the implementation of Section 122 of the CAA, provides a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services (e.g., removal of polyps). The provision calls for a gradual phase down of beneficiary coinsurance liability from 20 percent, beginning in CY 2022 and completing in CY 2030 at 0 percent.

Billing for Physician Assistant (PA) Services

- CMS is implementing section 403 of the CAA, which authorizes Medicare to make direct payment to PAs for professional services that they furnish under Part B beginning January 1, 2022. Medicare currently can only make payment to the employer or independent contractor of a PA. Beginning January 1, 2022, PAs may bill Medicare directly for their professional services, reassign payment for their professional services, and incorporate with other PAs and bill Medicare for PA services.

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides 2 participation tracks:

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM and achieve QP status, you may be eligible for a 5% incentive payment and you will be excluded from MIPS.

QPP Exceptions: Performance Year 2021

There are two exception applications available to clinicians in PY2021:

- The Extreme and Uncontrollable Circumstances Exception application allows you to request reweighting for any or all performance categories if you encounter an extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of your control.

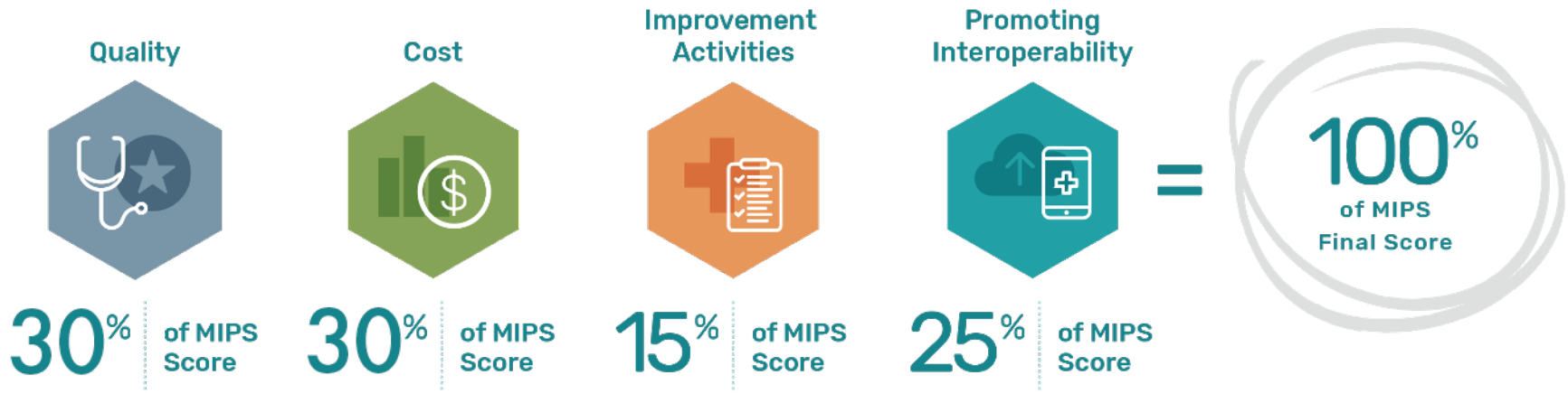
- The MIPS Promoting Interoperability Performance Category Hardship Exception application allows you to request reweighting specifically for the Promoting Interoperability performance category if you qualify for one of the reasons identified below.

https://qpp.cms.gov/mips/exception-applications#extremeCircumstancesException-2021

Merit Based Incentive Payment System (MIPS)

Overview for Performance Year 2022

MIPS Performance Categories



MIPS scoring is comprised of **4** performance categories

So what? The points from each performance category are added together to give you a MIPS Final Score.

The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

2022 MIPS Final Rule

Performance Threshold and Payment Adjustments

2021 Final

Final Score 2021	Payment Adjustment 2023
≥85 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
60.01–84.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
60 points	• Neutral payment adjustment
15.01–59.99 points	• Negative payment adjustment greater than -9% and less than 0%
0–15 points	• Negative payment adjustment of -9%

2022 Final

Final Score 2022	Payment Adjustment 2024
≥89 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
75.01–88.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment
18.76–74.99 points	• Negative payment adjustment greater than -9% and less than 0%
0–18.75 points	• Negative payment adjustment of -9%

The 2022 performance year/2024 payment year is the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

Quality Payment Program Help & Support

General Resources

- The **Quality Payment Program Service Center** will serve as a primary point of contact to help address your questions and concerns. The Service Center is able to address basic questions as well as more complex scenarios.
  - Connect with the Service Center at 1-866-288-8292 (TTY 1-877-715-6222) or via email at QPP@cms.hhs.gov Monday - Friday 8 am - 8 pm ET

- The **QPP website** provides a centralized location for resources, and specifically, the Support for Small Practices page will provide updates and resources for small practices.
  - We encourage all small, underserved and rural clinicians and their staff to bookmark this page (https://qpp.cms.gov/resources/small-underserved-rural-practices) for easy access to updates and available resources.

- Upcoming **Webinars and trainings** will be listed on the QPP Webinar Library. Recordings, slides and transcripts of past events will also be available and posted to the Webinar Library.

Quality Payment Program Help & Support

Small & Underserved Practices

- **Small and Underserved Practice (SURS) Initiative is ending February 15, 2022**
- What should I do now?
  - Bookmark the QPP website Support for Small Practices page.
  - Sign-up for the QPP listserv.
  - Small practices participating in QPP for PY 2021 should **make plans to submit data early** while technical assistance support is still available. The data submission window for PY 2021 opens on January 3, 2022 and closes on March 31, 2022.
- **Reminder:** Under current policies, we automatically calculate a quality score from Medicare Part B claims measures at the individual and group level. Some small practices may not be aware of the implications of their PY 2021 claims reporting due to some of the policies we introduced at the onset of the COVID-19 PHE. As a result, these small practices may wish to request performance category reweighting **on behalf of the group through the PY 2021 EUC Exception Application, citing COVID-19** as the triggering event.
    - PY 2021 EUC Exception Applications can be submitted by signing in to qpp.cms.gov and clicking Exception Applications on the left-hand navigation.
    - **December 31, 2021** is the deadline to submit an EUC Exception Application for PY 2021.

CMS Care Management

CMS Care Management Web Page

Visit the CMS Care Management page to find CCM resources, including fact sheets, frequently asked questions, and data on chronic conditions in Medicare.

- Chronic Care Management
- Transitional Care Management
- Advance Care Planning
- Behavioral Health Integration

For comprehensive information about each of the services listed above, visit the CMS Connected Care website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

Chronic Care Management (CCM)

CPT 99490

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

Assumes 15 minutes of work by the billing practitioner per month.

CPT 99491

Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

Complex Chronic Care Management (CCM)

CPT 99487

Complex chronic care management services, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
- Establishment or substantial revision of a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

CPT 99489

Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).

Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

CCM Practitioner Eligibility

Physicians and the following non-physician practitioners may bill CCM services:

- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

NOTE: CCM may be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM. The CCM service is not within the scope of practice of limited-license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.

Only one practitioner may be paid for CCM services for a given calendar month.

This practitioner must only report either complex or non-complex CCM for a given patient for the month (not both).

CPT code 99491 includes only time that is spent personally by the billing practitioner. Clinical staff time is not counted towards the required time threshold for reporting this code.

CPT codes 99487, 99489, and 99490 – Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month.

Many activities count towards the time requirements to bill CCM

- Providing comprehensive care management for patients outside of the typical face-to-face visit:
  - Phone calls
  - Secure messaging
  - Review of medical records and test results
  - Coordination with others on the care team
  - Exchange of health information with other clinicians
- Managing care transitions, including referrals
- Facilitating follow-up visits
- Coordinating with home and community-based clinical service providers

Cognitive Assessment and Care Planning

Medicare covers a separate visit to more thoroughly assess your patient's cognitive function and develop a care plan – use CPT code 99483 to bill for this service

- Increased payment for these services to $282 when provided in an office setting
- Added these services to the definition of primary care services in the Medicare Shared Savings Program
- Permanently covered these services via telehealth

Any clinician eligible to report evaluation and management (E/M) services can offer this service.

- Eligible providers include: Physicians (MD and DO), Nurse practitioners, Clinical nurse specialists, Physician assistants

You can perform the assessment at any of these locations:

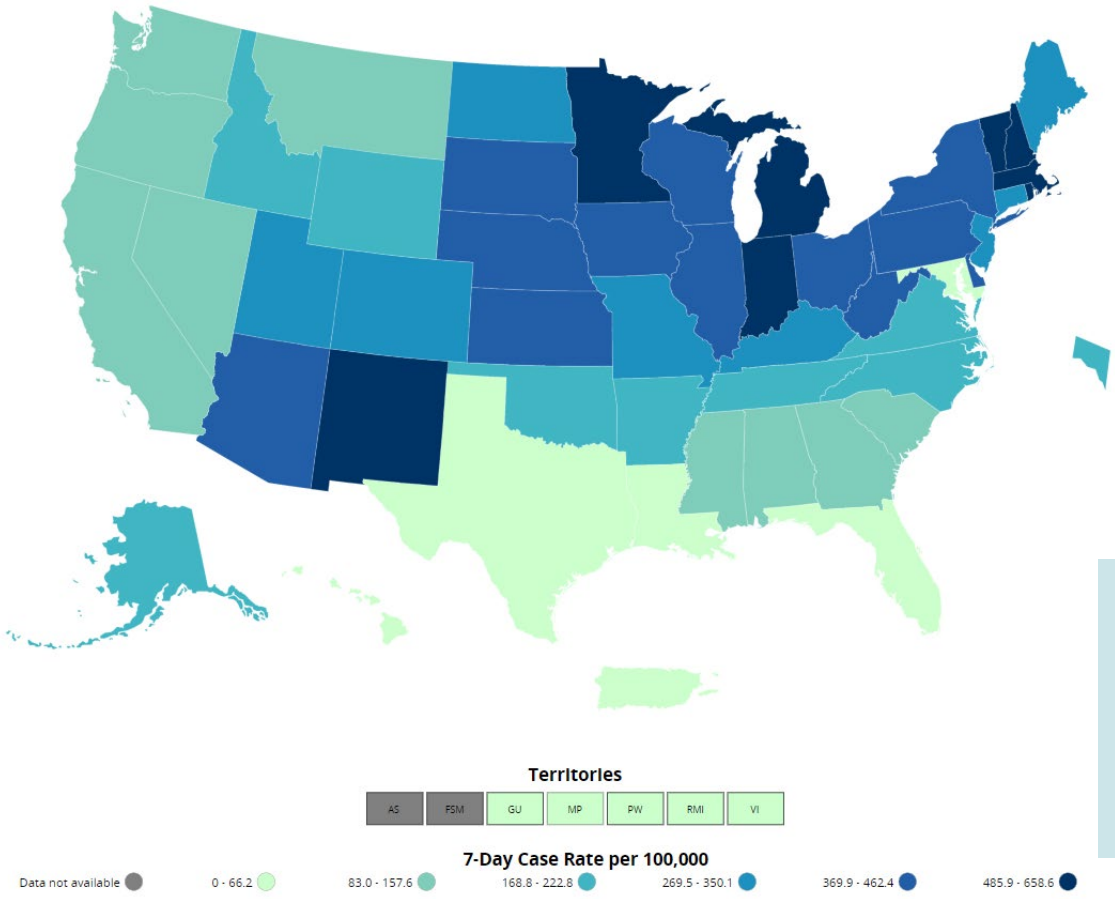
- Office or outpatient setting
- Private residence
- Care facility
- Rest home
- Via telehealth

https://www.cms.gov/cognitive

Current Data on Epidemic

As of 12/9/21

https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days



TOTAL CASES
49,458,520
+125,961 New Cases

7 DAY CASE RATE PER 100,000
249.9

TOTAL DEATHS
790,766
+1,335 New Deaths

CDC | Data as of: December 9, 2021 12:35 PM ET. Posted: December 9, 2021 2:18 PM ET

United States
At a Glance

Cases Total 49,458,520
Last 30 Days

Deaths Total 790,766
Last 30 Days

76.0% of People 5+ with At Least
One Vaccination

The CMS COVID-19 Response

Care by Phone

Patients can consult with a doctor, nurse practitioner, psychologist, and others and

Medicare will cover it.

Telehealth

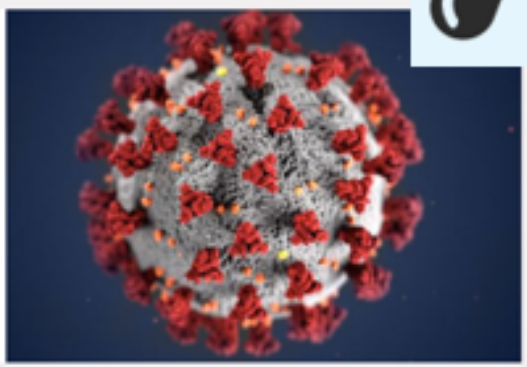
People with Medicare can now get telehealth services from their home, increasing their access to care.

Expanding Hospital Capacity

Community resources like hotels, convention centers and surgery centers can be converted for hospital care.

COVID-19 Vaccine Policies & Guidance

We're giving you the information you need to provide the COVID-19 vaccine. We have many resources about coverage and billing for providers, state Medicaid plans, and private health plans.



COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

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Acute Hospital Care at Home

Overview | Reporting Measures | Resources | Webinars

Acute Hospital Care at Home Individual Waiver Only (not a blanket waiver)

CMS is accepting waiver requests to waive **§482.23(b)** and **(b)(1)** of the Hospital Conditions of Participation, which require nursing services to be provided on premises 24 hours a day, 7 days a week and the immediate availability of a registered nurse for care of any patient.

Waiver requests will be divided into two categories based on a hospital's prior experience. Hospitals must submit the waiver request for individual CMS Certification Numbers (CCNs), not entire systems. For those hospitals which have provided at home acute hospital services to at least 25 patients previously, an expedited process will be conducted and include hospital attestation to specific existing beneficiary protections and reporting requirements. The immediate goal with this group is to allow experienced hospitals to rapidly expand care to Medicare beneficiaries. These hospitals will be required to submit monitoring data on monthly basis.

Key Actions

Request a Waiver

Submit Reporting Measures

Participation

View the Measures

https://qualitynet.cms.gov/acute-hospital-care-at-home

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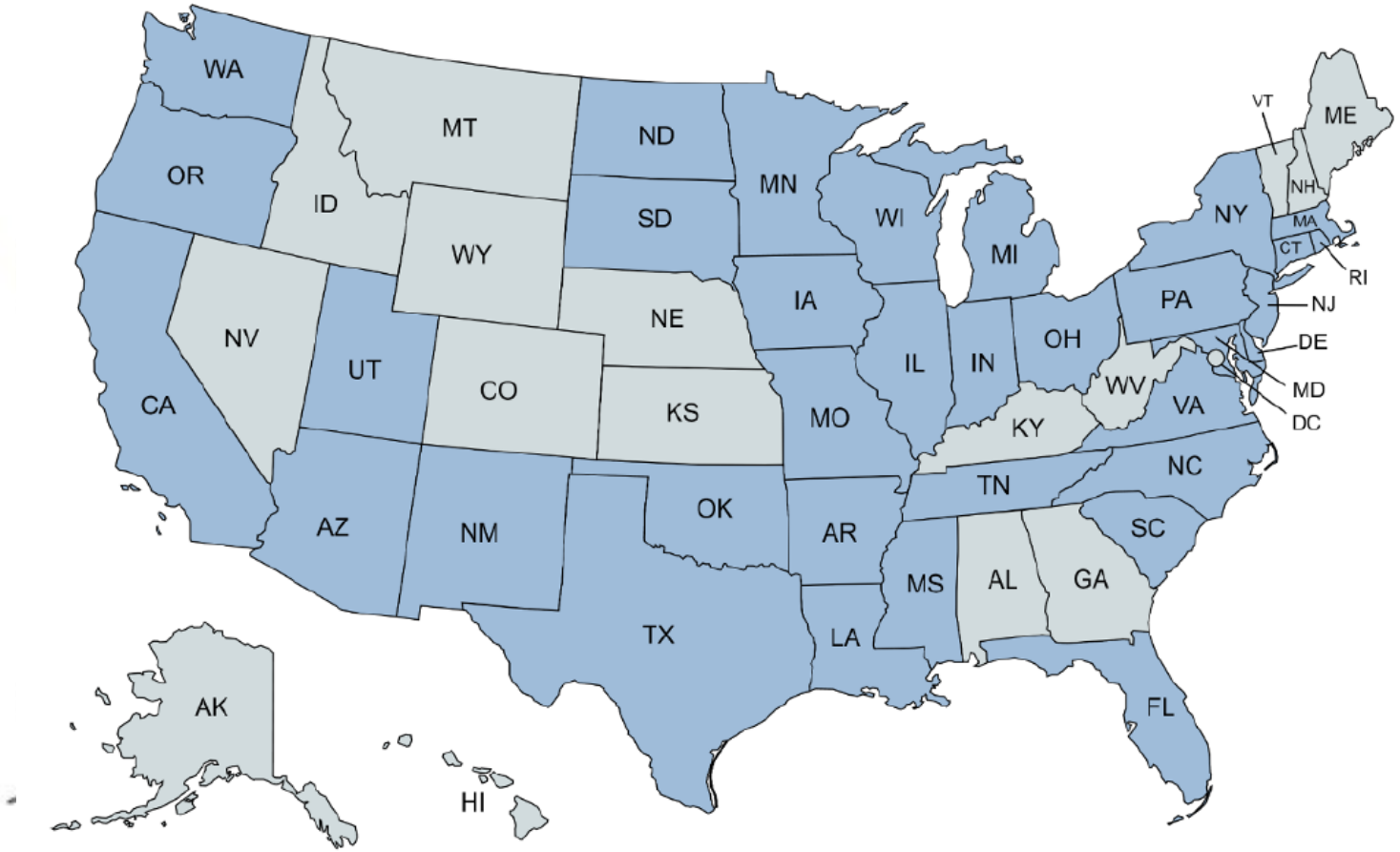
Geographic Distribution of Waiver Uptake



https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0338

- A total of 187 waivers approved Hospitals
- Waivers across 83 health systems
- Approved waivers in a total of 34 states

As of November 15, 2021

https://qualitynet.cms.gov/acute-hospital-care-at-home/resources

Questions, inquiries and information requests can be emailed directly to the waiver review team at AcuteHospitalCareAtHome@cms.hhs.gov

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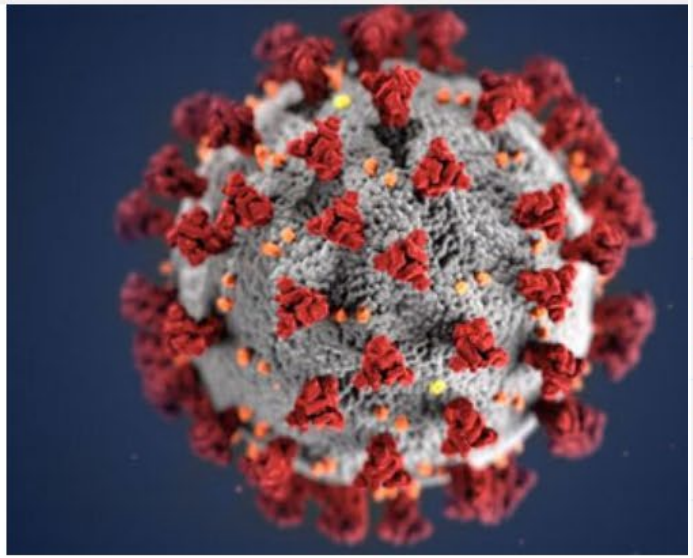
COVID-19 Vaccine and Therapeutics Toolkits

COVID-19 Vaccine Policies & Guidance

We're giving you the information you need to be ready for the COVID-19 vaccine when it's available. If we can prepare a wide pool of providers to administer the COVID-19 vaccine, then we can ensure the vaccine is covered and available free of charge for every American.

Read IFC 4 (PDF)



COVID-19

- Enrollment for Administering COVID-19 Vaccine Shots
- Coding for COVID-19 Vaccine Shots
- Medicare COVID-19 Vaccine Shot Payment
- Medicare Billing for COVID-19 Vaccine Shot Administration
- SNF: Enforcement Discretion Relating to Certain Pharmacy Billing
- Beneficiary Incentives for COVID-19 Vaccine Shots
- CMS Quality Reporting for COVID-19 Vaccine Shots
- *New* Monoclonal Antibody COVID-19 Infusion

Vaccine guidance: https://www.cms.gov/covidvax

Clinician/provider toolkit: https://www.cms.gov/covidvax-provider

FAQs on billing therapeutics: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Current COVID-19 Vaccine Recommendations

CDC recommends **everyone ages 5 and older get a COVID-19 vaccine** to help protect against COVID-19.

Authorized For	Pfizer-BioNTech	Moderna	J&J / Janssen
4 years and under	No	No	No
5–11 years old	**Yes**	No	No
12–17 years old	**Yes**	No	No
18 years and older	**Yes**	**Yes**	**Yes**

Widespread vaccination for COVID-19 is a critical tool to best protect everyone from COVID-19 and COVID-19 related complications. Children and teens who are fully vaccinated can safely resume many activities that they did prior to the pandemic.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html

Everyone Ages 16 and Older Should Get a Booster Shot

IF YOU RECEIVED	Who can get a booster: / Who should get a booster:	When to get a booster:	Which booster can you get:
Pfizer-BioNTech	• Teens 16-17 years old • Adults 18 years and older	At least 6 months after completing your primary COVID-19 vaccination series	• Teens 16–17 years old can get a Pfizer-BioNTech COVID-19 vaccine booster • Adults 18 years and older can get any of the COVID-19 vaccines authorized in the United States
IF YOU RECEIVED **Moderna**	**Who should get a booster:** Adults 18 years and older	**When to get a booster:** At least 6 months after completing your primary COVID-19 vaccination series	**Which booster can you get:** Any of the COVID-19 vaccines authorized in the United States
IF YOU RECEIVED **Johnson & Johnson's Janssen**	**Who should get a booster:** Adults 18 years and older	**When to get a booster:** At least 2 months after completing your primary COVID-19 vaccination	**Which booster can you get:** Any of the COVID-19 vaccines authorized in the United States

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html

https://www.cms.gov/covidvax-provider

https://vaccines.gov

CMS will continue to provide coverage for this critical protection from the virus, including booster doses, without cost sharing

Coadministration of Flu & COVID-19 Vaccines

- COVID-19 vaccines **may be administered without regard to timing of other vaccines**. This includes simultaneous administration of COVID-19 vaccine and other vaccines on the same day.
- **If multiple vaccines are administered at a single visit, administer each injection in a different injection site.** For people ≥11 years, the deltoid muscle can be used for more than one intramuscular injection administered at different sites in the muscle. For children (5–10 years), if more than two vaccines are injected in a single limb, the vastus lateralis muscle of the anterolateral thigh is the preferred site because of greater muscle mass.
- Best practices for multiple injections include:
  - Label each syringe with the name and the dosage (amount) of the vaccine, lot number, the initials of the preparer, and the exact beyond-use time, if applicable.
  - Separate injection sites by 1 inch or more, if possible.
  - **Administer the COVID-19 vaccines and vaccines that may be more likely to cause a local reaction in different limbs, if possible.**

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Coadministration

Medicare payment for COVID-19 vaccination in the home

Effective June 8, 2021, in addition to the current payment amount, Medicare will pay an additional amount of $35 per dose for administering the Coronavirus disease 2019 (COVID-19) vaccine in the home for certain Medicare patients that have difficulties leaving their homes or are hard-to-reach.

Medicare will pay the $35 amount in addition to the standard administration amount (approximately $40 per dose), for a total payment of approximately $75 for a single-dose vaccine or $150 for both doses of a 2-dose vaccine. We also geographically adjust the additional amount and administration rate based on where you administer the vaccine.

Examples of Patient Situations for which the Additional Payment Amount Applies[1]:

- The patient has a condition that makes them more susceptible to contracting a pandemic disease such as COVID-19.
- The patient is generally unable to leave the home, and if they do leave home it requires a considerable and taxing effort.
- The patient has a disability or faces clinical, socioeconomic, or geographical barriers to getting a COVID-19 vaccine in settings other than their home.
- The patient faces challenges that significantly reduce their ability to get vaccinated outside the home, such as challenges with transportation, communication, or caregiving.

- More information on Medicare payment for COVID-19 vaccine administration – including a list of billing codes, payment allowances and effective dates – is available at https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment
- More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html

How to help your patients find a COVID-19 vaccine

- A person's ability to leave their home should not be an obstacle to getting the COVID-19 vaccine.

- Unvaccinated individuals and those looking to assist friends and family can:

  - Visit **vaccines.gov** (English) or **vacunas.gov** (Spanish) to search for vaccines nearby.

  - **Text GETVAX (438829)** for English or **VACUNA (822862)** for Spanish for near-instant access to details on three vaccine sites in the local area.

  - Call the National COVID-19 Vaccination Assistance Hotline at **1-800-232-0233** (TTY: 1-888-720-7489) for assistance in English and Spanish.

Myths, Facts and Questions about COVID-19 vaccination

FAQs: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

Myths & Facts: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/facts.html

Myths and Facts about COVID-19 Vaccines

Updated July 7, 2021 Languages Print

How do I know which COVID-19 vaccine information sources are accurate?

Accurate vaccine information is critical and can help stop common myths and rumors.

It can be difficult to know which sources of information you can trust. Before considering vaccine information on the Internet, check that the information comes from a credible source and is updated on a regular basis. Learn more about finding credible vaccine information.

Is it safe for me to get a COVID-19 vaccine if I would like to have a baby one day?

Yes. If you are trying to become pregnant now or want to get pregnant in the future, you may get a COVID-19 vaccine when one is available to you.

There is currently no evidence that COVID-19 vaccination causes any problems with pregnancy, including the development of the placenta. In addition, there is no evidence that female or male fertility problems are a side effect of any vaccine, including COVID-19 vaccines.

Can a COVID-19 vaccine make me sick with COVID-19?

No. None of the authorized COVID-19 vaccines in the United States contain the live virus that causes COVID-19. This means that a COVID-19 vaccine **cannot** make you sick with COVID-19.

COVID-19 vaccines teach our immune systems how to recognize and fight the virus that causes COVID-19. Sometimes this process can cause symptoms, such as fever. These symptoms are normal and are signs that the body is building protection against the virus that causes COVID-19. Learn more about how COVID-19 vaccines work.

https://cdc.gov/coronavirus/2019-ncov/vaccines/index.html

Updated CDC Guidance for those fully vaccinated

- Wear a mask indoors in public if they are in an area of substantial or high transmission.
  - Fully vaccinated people might choose to mask regardless of the level of community transmission, particularly if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is unvaccinated.
- Get tested if experiencing COVID-19 symptoms.
- Get tested 5-7 days after close contact with someone with suspected or confirmed COVID-19.
- Wear a mask indoors in public for 14 days after exposure or until a negative test result.
- Isolate if they have tested positive for COVID-19 in the prior 10 days or are experiencing COVID-19 symptoms.
- Follow any applicable federal, state, local, tribal, or territorial laws, rules, and regulations.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

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