

March 16, 2020

CMS, OSHA and Others Release Waivers and Other New Information on COVID-19

Information on emergency declaration waivers, nursing homes, respirators, public charge determinations and new testing codes

The Centers for Medicare & Medicaid Services (CMS) and Occupational Health and Safety Administration (OSHA), as well as other organizations, have released a number of new documents and other information related to COVID-19. This includes:

- Emergency declaration waivers;
- Revised guidance for nursing homes on visitor limitations;
- Guidance for flexibility with respirator fit-testing;
- Clarifications regarding public charge determinations; and
- A new CPT code for coronavirus testing.

What You Can Do: Please share this advisory with your executive management team, hospital epidemiologist, infection control leadership, emergency department (ED) director, emergency preparedness staff, employee health staff and heads of services (e.g., environmental services, resources and materials managers, hospital engineers pediatrics and critical care), billing department, as well as your clinical leadership team.

The following are select highlights from the documents that are important to hospitals and health systems.

Key Takeaways

New information related to COVID-19 includes:

- Waivers granting flexibility to hospitals, critical access hospitals, long-term care hospitals, inpatient rehabilitation facilities, and other providers to enable them to better treat their patients and communities.
- New guidance that restricts visitors to nursing homes in almost all circumstances, including family members, volunteers and nonessential health care and other personnel.
- Guidance to OSHA field offices that they may exercise discretion in not citing annual fit testing requirement violations, so long as a series of efforts have been taken on the part of the employer.
- Clarifications that seeking treatment or preventive services for COVID-19 will not negatively affect any immigrants' future public charge determination, even if provided or paid for by one or more public benefits.
- A new CPT code to report testing for COVID-19.

HIGHLIGHTS OF THE RESOURCES

Emergency Declaration Waivers. As [urged by the AHA](#), President Trump Friday [declared a national emergency](#) in response to COVID-19. **The AHA is very pleased that the President and the Administration took this urgent and necessary step.**

The declaration paves the way for the Department of Health and Human Services Secretary to take critical actions, such as providing Section 1135 waivers, to ensure that health care services and sufficient health care items are available to respond to the COVID-19 outbreak. **Indeed, shortly after the announcement, CMS [issued a number of waivers](#) that will help health care providers and patients. However, many more are needed and the AHA is working with CMS to obtain those and help ensure that hospitals and health systems are able to most effectively respond to the emergency.** The waivers that CMS issued including those that:

- Waive requirements, for Medicare and Medicaid purposes, that out-of-state providers be licensed in the state where they are providing services, if they are licensed in another state;
- Waive the critical access hospital 25-bed limitation and 96-hour average length of stay limitation;
- Allow acute care hospitals to house inpatients in excluded units, and be paid under the inpatient prospective payment system, with the patient's medical record properly identifying such;
- Allow acute care hospitals with inpatient psychiatric and inpatient rehabilitation units to, as a result of the emergency, relocate inpatients from the unit to an acute care bed, and continue to be paid under the inpatient psychiatric and inpatient rehabilitation payment systems;
- Allow long-term care hospitals to exclude from the 25-day average length of stay calculation those patient stays that were made to meet the demands of the emergency;
- Allow inpatient rehabilitation facilities (IRFs) to exclude from the 60% Rule calculation those patients admitted solely to respond to the emergency, with the patient's medical record properly identifying such;
- Waive the skilled-nursing facility (SNF) 3-day Rule for patients who need to be transferred as a result of the effect of the emergency;
- Authorize renewed SNF coverage for certain beneficiaries who recently exhausted their benefits, without first having to start a new benefit period;
- Establish a hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges;
- Waive certain enrollment screening requirements, including the application fee and site visits; and
- Provide flexibility in Medicare appeals for fee-for-service, Medicare Advantage and Part D, including extensions to file an appeal and waived timeliness for requests for additional information to adjudicate the appeal.

In addition, the HHS Secretary issued [waivers](#) related to sanctions under the Emergency Medical Treatment and Labor Act (EMTALA), Stark/self-referral law and HIPAA:

- EMTALA sanctions are waived for the direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan or for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared federal public health emergency for the COVID-19 pandemic. This waiver is not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.
- Sanctions are waived under the Stark/self-referral law under such conditions and in such circumstances as CMS determines appropriate.
- Sanctions and penalties arising from noncompliance with the following provisions of the HIPAA privacy regulations are waived as described below. These waivers are in effect for a period of time not to exceed 72 hours from implementation of a hospital disaster protocol but not beyond the period described in Section 1135(e). They are not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.
 - the requirements to obtain a patient’s agreement to speak with family members or friends or to honor a patient’s request to opt out of the facility directory (as set forth in 45 C.F.R. § 164.510);
 - the requirement to distribute a notice of privacy practices (as set forth in 45 C.F.R. § 164.520); and
 - the patient’s right to request privacy restrictions or confidential communications (as set forth in 45 C.F.R. § 164.522); but in each case, only with respect to hospitals in the designated geographic area that have hospital disaster protocols in operation during the time the waiver is in effect.

CMS also stated that it soon will be issuing additional waivers and flexibilities, including on telehealth.

In addition, the agency specified that it has the authority to approve state requests for waivers of certain Medicaid and Children’s Health Insurance Program (CHIP) requirements. Examples of the types of things state may request include waiving prior authorization requirements in fee-for-service programs, permitting out-of-state providers to provide care to a state’s enrollees impacted by the emergency, temporarily suspending certain provider enrollment and revalidation requirements, and temporarily suspending certain admission requirements for nursing home residents. There is no standard format for requests, but states should submit a request that includes the scope of the issue and potential impact to the Acting Director of the Medicaid & CHIP Operations Group with CMS’s Center for Medicaid & CHIP Services at Jackie.Glaze@cms.hhs.gov or by letter. More information is available as part of a [Medicaid and CHIP Disaster Response Toolkit](#).

Nursing Home Visitor Limitations. CMS on March 13 issued [revised guidance](#) on COVID-19 for nursing homes. It supersedes CMS’s prior guidance and seeks to mitigate the spread of COVID-19 by:

- Restricting all visitors to nursing homes, effective immediately, with exceptions for compassionate care, such as end-of-life situations;
- Restricting all volunteers and nonessential health care personnel and other personnel (i.e. barbers);
- Canceling all group activities and communal dining; and
- Implementing active screening of residents and health care personnel for fever and respiratory symptoms.

These new restrictions reflect Centers for Disease Control and Prevention (CDC) findings from Washington and California that visitors and health care personnel who are ill are the most likely source of introduction of COVID-19 into nursing homes. In lieu of visits, CMS encourages nursing homes to keep residents' loved ones informed about their care, including facilitating increased virtual communication between residents and families. CDC has made several additional COVID-19 mitigation recommendations for nursing homes, including placing alcohol-based hand sanitizer with 60%-95% alcohol in every resident room – both inside and outside the room if possible – and in every common area. A full list of CDC COVID-19 guidance to nursing homes can be found [here](#).

Respirator Fit Testing Flexibility. OSHA on March 14 released [guidance](#) notifying its field offices that they may exercise discretion in not citing annual fit testing requirement violations, so long as a series of efforts have been taken on the part of the employer. In addition, OSHA recommended that health care personnel who provide direct care to patients with known or suspected coronavirus use respirators that provide equal or higher protection than N95 respirator masks. These alternatives include N99 or N100 filtering facepieces, reusable elastomeric respirators or powered air purifying respirators. **However, this OSHA guidance concerning N95 masks contradicts current CDC guidance – the AHA is aware and taking steps to clarify this issue.**

USCIS Public Charge COVID-19 Alert. The U.S Citizenship and Naturalization Services (USCIS) issued a COVID-19-related [alert](#) regarding the implementation of new standards for immigration public charge decisions. It encourages all immigrants with symptoms that resemble COVID-19 (fever, cough, shortness of breath) to seek necessary medical treatment or preventive services. Importantly, it clarifies that such treatment or preventive services will not negatively affect any immigrants' future public charge determination, even if such treatment is provided or paid for by one or more public benefits, as defined in the rule (Medicaid, for example). In addition, the USCIS will take into consideration circumstances, such as social distancing and quarantine, that prevent the immigrant from working or attending school, and therefore results in the immigrant relying on public benefits for the duration of the COVID-19 outbreak and recovery phase.

CPT Code for Coronavirus Testing. CMS previously created two Healthcare Common Procedure Coding System (HCPCS) [codes](#) for coronavirus lab tests – one used for CDC-testing laboratories and one for non-CDC laboratory tests. However, at the request of private insurers that may not use HCPCS codes, the American Medical Association has now created a new (CPT) [code, which was](#) effective Friday, March 13 for use in reporting testing for COVID-19.