## Priorities for Testing Patients with Suspected COVID-19 Infection

### Priority 1
Ensures optimal care options for all hospitalized patients, lessen the risk of healthcare-associated infections, and maintain the integrity of the U.S. healthcare system

- Hospitalized patients
- Healthcare facility workers with symptoms

### Priority 2
Ensures those at highest risk of complication of infection are rapidly identified and appropriately triaged

- Patients in long-term care facilities with symptoms
- Patients 65 years of age and older with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

### Priority 3
As resources allow, test individuals in the surrounding community of rapidly increasing hospital cases to decrease community spread, and ensure health of essential workers

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

### Non-Priority
- Individuals without symptoms

For more information visit: coronavirus.gov
Covid-19: remote consultations
A quick guide to assessing patients by video or voice call

This graphic, intended for use in a primary care setting, is based on data available in March 2020, much of which is from hospital settings in China. It will be revised as more relevant data emerges.

1. Set up
   Prepare yourself and decide how to connect
   - Have current ‘stay at home’ covid-19 guidance on hand
   - Video is useful for severe illness
   - Scan medical record for risk factors such as:
     - Diabetes
     - Pregnancy
     - Smoking
     - Chronic kidney or liver disease
     - COPD
     - Steroids or other immunosuppressants
     - Cardiovascular disease
     - Asthma

2. Connect
   Make video link if possible, otherwise call on the phone
   - Check video and audio
   - Confirm the patient’s identity
   - Check where patient is
   - Note patient’s phone number in case connection fails

3. Get started
   Quickly assess whether sick or less sick
   - Rapid assessment
     - If they sound or look very sick, such as too breathless to talk, go direct to key clinical questions
   - Establish what the patient wants out of the consultation, such as:
     - Clinical assessment
     - Reassurance
     - Advice on self isolation

4. History
   Adapt questions to patient’s own medical history
   - Contacts
     - Close contact with known covid-19 case
     - Immediate family member unwell
     - Occupational risk group
   - History of current illness
   - Date of first symptoms

5. Examination
   Assess physical and mental function as best as you can
   - Over phone, ask carer or patient to describe:
     - State of breathing
     - Colour of face and lips
   - Over video, look for:
     - General demeanour
     - Skin colour
   - Check respiratory function - inability to talk in full sentences is common in severe illness
   - Patient may be able to take their own measurements if they have instruments at home
   - Interpret self monitoring results with caution and in the context of your wider assessment
   - Temperature
   - Pulse
   - Peak flow
   - Blood pressure
   - Oxygen saturation

6. Decision and action
   Advise and arrange follow-up, taking account of local capacity
   - Likely covid-19 but well, with mild symptoms
     - Self management: fluids, paracetamol
   - Likely covid-19, unwell, deteriorating
     - Arrange follow up by video. Monitor closely if you suspect pneumonia
     - Reduce spread of virus - follow current government ‘stay at home’ advice
     - Safety netting
       - If living alone, someone to check on them
       - Maintain fluid intake - 6 to 8 glasses per day
     - Seek immediate medical help for red flag symptoms
   - Relevant comorbidities
   - Proactive, whole patient care
   - Ambulance protocol (999)
   - Unwell and needs admission

- Clinical concern, such as:
  - Temperature > 38°C
  - Respiratory rate > 20*
  - Heart rate > 100†
  - New confusion
  - Oxygen saturation ≤ 94%

- Likely current illness
  - Pneumonia

- Red flags
  - Severe shortness of breath at rest
  - Difficulty breathing
  - Pain or pressure in the chest
  - Cold, clammy, or pale and mottled skin
  - New confusion
  - Becoming difficult to rouse
  - Blue lips or face
  - Little or no urine output
  - Coughing up blood
  - Other conditions, such as:
    - Neck stiffness
    - Non-blanching rash

* Breaths per minute  † Beats per minute  ‡ If oximetry available for self monitoring

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The OCR is allowing the short-term use of certain applications for telehealth visits that do not meet HIPAA security standards. This is for a limited time in order to support response to COVID-19.

Patients should be notified that these third-party applications potentially introduce privacy risks, similar to when a patient requests PHI via email. All available encryption and privacy modes should be enabled when using such applications.

Here are examples of what you can use:

- Applications like these can be used for a limited time only and are not to be used as a long-term solution as they do not meet all HIPAA security requirements.
  - FaceTime
  - Facebook Messenger video chat
  - Google Hangouts video
  - Skype

- The best long-term solutions require a BAA, and include applications like:
  - Skype for Business (Microsoft Teams)
  - Updox
  - VSee
  - Zoom for Healthcare
  - Doxy.me
  - Google G Suite Hangouts Meet
  - TigerConnect

Some applications are providing services at no cost to providers for COVID-19 response. Methods of communication like Facebook Live, TikTok, and Twich should never be used because those communications are not direct or person to person.

Providers should conduct telehealth sessions in a private area away from others just as any other patient encounter.

Medicare has expanded its coverage of telehealth visits during the COVID-19 response. Providers should refer to billing guidelines for telehealth visit requirements.
Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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CMS Alert!

Medicare Beneficiaries Expanded Telehealth Benefits During COVID-19 Outbreak

Under the Coronavirus Preparedness and Response Supplemental Appropriations Act and Section 1135 waiver authority, the Centers for Medicare & Medicaid Services (CMS) broadened access to Medicare telehealth services, so beneficiaries can get a wider range of services from their doctors and other clinicians without traveling to a health care facility. On March 6, 2020, Medicare began temporarily paying clinicians to furnish beneficiary telehealth services residing across the entire country.

Before this announcement, Medicare could only pay clinicians for telehealth services, such as routine visits in certain circumstances. For example, the beneficiary getting the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location. In addition, the beneficiary generally could not get telehealth services in their home.

Under this Section 1135 waiver expansion, a range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, can offer a specific set of telehealth services. The specific set of services beneficiaries can get include evaluation and management visits (common office visits), mental health counseling, and preventive health screenings. Beneficiaries can get telehealth services in any health care facility including a physician’s office, hospital, nursing home or rural health clinic, as well as from their homes. This change broadens telehealth flexibility without regard to the beneficiary’s diagnosis, because at this critical point it is important to ensure beneficiaries follow CDC guidance including practicing social distancing to reduce the risk of COVID-19 transmission. This change will help prevent vulnerable beneficiaries from unnecessarily entering a health care facility when clinicians can meet their needs remotely.

To read the Fact Sheet on this announcement visit: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Learn about these Medicare telehealth services topics:

- Originating sites
- Distant site practitioners
- Telehealth services
- Telehealth services billing and payment
- Telehealth originating sites billing and payment
- Resources
- Helpful websites and Regional Office Rural Health Coordinators

Medicare pays for specific (Part B) physician or practitioner services furnished through a telecommunications system. Telehealth services substitute for an in-person encounter.

**ORIGINATING SITES**

An originating site is the location where a Medicare beneficiary gets physician or practitioner medical services through a telecommunications system. The beneficiary must go to the originating site for the services located in either:

- A county outside a Metropolitan Statistical Area (MSA)
- A rural Health Professional Shortage Area (HPSA) in a rural census tract

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see a potential Medicare telehealth originating site’s payment eligibility, go to HRSA’s [Medicare Telehealth Payment Eligibility Analyzer](#).

Providers qualify as originating sites, regardless of location, if they were participating in a Federal telemedicine demonstration project approved by (or getting funding from) the U.S. Department of Health & Human Services as of December 31, 2000.

Beginning July 1, 2019, the [Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act](#) removes the originating site geographic conditions and adds an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.
Each December 31 of the prior calendar year (CY), an originating site’s geographic eligibility is based on the area’s status. This eligibility continues for a full CY. Authorized originating sites include:

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units

**Note:** Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites.

Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke. Go to MLN Matters® article, [New Modifier for Expanding the Use of Telehealth for Individuals with Stroke](#) to learn how to use the new modifier for billing.
DISTANT SITE PRACTITIONERS

Distant site practitioners who can furnish and get payment for covered telehealth services (subject to State law) are:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)
  - CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professional
TELEHEALTH SERVICES

You must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site.

Transmitting medical information to a physician or practitioner who reviews it later is permitted only in Alaska or Hawaii Federal telemedicine demonstration programs.

CY 2019 Medicare Telehealth Services

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>G0425–G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>G0406–G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>99231–99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>99307–99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>G0420–G0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training</td>
<td>G0108–G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>96150–96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90832–90838</td>
</tr>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>90791–90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
<td>90963</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
<td>90964</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
<td>90965</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older</td>
<td>90966</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age</td>
<td>90967</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2–11 years of age</td>
<td>90968</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12–19 years of age</td>
<td>90969</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older</td>
<td>90970</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>G0270, 97802–97804</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>96116</td>
</tr>
<tr>
<td>Smoking cessation services</td>
<td>G0436, G0437, 99406, 99407</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
<td>G0396, G0397</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>G0442</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>G0443</td>
</tr>
<tr>
<td>Annual depression screening, 15 minutes</td>
<td>G0444</td>
</tr>
<tr>
<td>Service</td>
<td>HCPCS/CPT Code</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>High-intensity behavioral counseling to prevent sexually transmitted</td>
<td>G0445</td>
</tr>
<tr>
<td>infection; face-to-face, individual, includes: education, skills</td>
<td></td>
</tr>
<tr>
<td>training and guidance on how to change sexual behavior; performed</td>
<td></td>
</tr>
<tr>
<td>semi-annually, 30 minutes</td>
<td></td>
</tr>
<tr>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular</td>
<td>G0446</td>
</tr>
<tr>
<td>disease, individual, 15 minutes</td>
<td></td>
</tr>
<tr>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>G0447</td>
</tr>
<tr>
<td>Transitional care management services with moderate medical decision</td>
<td>99495</td>
</tr>
<tr>
<td>complexity (face-to-face visit within 14 days of discharge)</td>
<td></td>
</tr>
<tr>
<td>Transitional care management services with high medical decision</td>
<td>99496</td>
</tr>
<tr>
<td>complexity (face-to-face visit within 7 days of discharge)</td>
<td></td>
</tr>
<tr>
<td>Advance Care Planning, 30 minutes</td>
<td>99497</td>
</tr>
<tr>
<td>Advance Care Planning, additional 30 minutes</td>
<td>99498</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>90845</td>
</tr>
<tr>
<td>Family psychotherapy (without the patient present)</td>
<td>90846</td>
</tr>
<tr>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
<td>90847</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring</td>
<td>99354</td>
</tr>
<tr>
<td>direct patient contact beyond the usual service; first hour</td>
<td></td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring</td>
<td>99355</td>
</tr>
<tr>
<td>direct patient contact beyond the usual service; each additional 30</td>
<td></td>
</tr>
<tr>
<td>minutes</td>
<td></td>
</tr>
<tr>
<td>Prolonged service in the inpatient or observation setting requiring</td>
<td>99356</td>
</tr>
<tr>
<td>unit/floor time beyond the usual service; first hour (list separately</td>
<td></td>
</tr>
<tr>
<td>in addition to code for inpatient evaluation and management service)</td>
<td></td>
</tr>
<tr>
<td>Prolonged service in the inpatient or observation setting requiring</td>
<td>99357</td>
</tr>
<tr>
<td>unit/floor time beyond the usual service; each additional 30 minutes</td>
<td></td>
</tr>
<tr>
<td>(list separately in addition to code for prolonged service)</td>
<td></td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of</td>
<td>G0438</td>
</tr>
<tr>
<td>service (PPPS) first visit</td>
<td></td>
</tr>
</tbody>
</table>
### CY 2019 Medicare Telehealth Services (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit</td>
<td>G0439</td>
</tr>
<tr>
<td>Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth</td>
<td>G0508</td>
</tr>
<tr>
<td>Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth</td>
<td>G0509</td>
</tr>
<tr>
<td>Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)</td>
<td>G0296</td>
</tr>
<tr>
<td>Interactive Complexity Psychiatry Services and Procedures</td>
<td>90785</td>
</tr>
<tr>
<td>Health Risk Assessment</td>
<td>96160, 96161</td>
</tr>
<tr>
<td>Comprehensive assessment of and care planning for patients requiring chronic care management</td>
<td>G0506</td>
</tr>
<tr>
<td>Psychotherapy for crisis</td>
<td>90839, 90840</td>
</tr>
<tr>
<td>Prolonged preventive services</td>
<td>G0513, G0514</td>
</tr>
</tbody>
</table>

A physician, NP, PA, or CNS must furnish at least one ESRD-related “hands on visit” (not telehealth) each month to examine the beneficiary’s vascular access site.
TELEHEALTH SERVICES BILLING AND PAYMENT

Submit professional telehealth service claims using the appropriate CPT or HCPCS code.

If you performed telehealth services “through an asynchronous telecommunications system”, add the telehealth GQ modifier with the professional service CPT or HCPCS code (for example, 99201 GQ). You are certifying the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

Submit telehealth services claims, using Place of Service (POS) 02-Telehealth, to indicate you furnished the billed service as a professional telehealth service from a distant site. As of January 1, 2018, distant site practitioners billing telehealth services under the CAH Optional Payment Method II must submit institutional claims using the GT modifier.

Bill covered telehealth services to your Medicare Administrative Contractor (MAC). They pay you the appropriate telehealth services amount under the Medicare Physician Fee Schedule (PFS). If you are located in, and you reassigned your billing rights to, a CAH and elected the Optional Payment Method II for outpatients, the CAH bills the telehealth services to the MAC. The payment is 80 percent of the Medicare PFS facility amount for the distant site service.

TELEHEALTH ORIGINATING SITES BILLING AND PAYMENT

HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee. Bill your MAC for the separately billable Part B originating site facility fee.

Note: The originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services when a CMHC serves as an originating site.
# RESOURCES

## Telehealth Services Resources

<table>
<thead>
<tr>
<th>For More Information About…</th>
<th>Resource</th>
</tr>
</thead>
</table>
| Telehealth Services | CMS.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html  
CMS.gov/Medicare/Medicare-General-Information/Telehealth  
| Physician Bonuses | CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses  
CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246598.html |

## Hyperlink Table

<table>
<thead>
<tr>
<th>Embedded Hyperlink</th>
<th>Complete URL</th>
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<tbody>
<tr>
<td>Health Professional Shortage Area</td>
<td><a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses</a></td>
</tr>
<tr>
<td>Medicare Telehealth Payment Eligibility Analyzer</td>
<td><a href="https://data.hrsa.gov/tools/medicare/telehealth">https://data.hrsa.gov/tools/medicare/telehealth</a></td>
</tr>
<tr>
<td>New Modifier for Expanding the Use of Telehealth for Individuals with Stroke</td>
<td><a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10883.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10883.pdf</a></td>
</tr>
<tr>
<td>Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act</td>
<td><a href="https://www.congress.gov/bill/115th-congress/house-bill/6">https://www.congress.gov/bill/115th-congress/house-bill/6</a></td>
</tr>
</tbody>
</table>
HELPFUL WEBSITES

American Hospital Association Rural Health Care
https://www.aha.org/advocacy/small-or-rural

Critical Access Hospitals Center
https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospitals
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration
https://www.hrsa.gov

Hospital Center
https://www.cms.gov/Center/Provider-Type/Hospital-Center.html

Medicare Learning Network®
http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers
http://www.nachc.org

National Association of Rural Health Clinics
https://narhc.org

National Rural Health Association
https://www.ruralhealthweb.org

Rural Health Clinics Center
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Rural Health Information Hub
https://www.ruralhealthinfo.org

Swing Bed Providers
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

Telehealth Resource Centers
https://www.telehealthresourcecenter.org

U.S. Census Bureau
https://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf.

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EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

Put on a fit-tested N-95 or higher level respirator before room entry.

Remove respirator after exiting the room and closing the door.

Door to room must remain closed.
Understanding and Selecting Respiratory Protection Devices

While it is your employer’s responsibility to provide policies, programs, training, and guidance on respirator use, it is the healthcare workers who implement these procedures. Do you know when to use respiratory protection? If so, do you understand what type of protection to choose and how to use it properly?

Seasonal Influenza

- Patient with suspected or confirmed seasonal influenza.
  - Close contact: Surgical mask equivalent or higher
  - Aerosol-generating procedure: N95 Filtering Facepiece Respirator (FFR) equivalent or higher

Airborne Precautions

- Patient with suspected or confirmed infectious disease requiring airborne precautions (e.g., measles, tuberculosis)
  - Close contact: N95 FFR equivalent or higher
  - Aerosol-generating procedure: N95 FFR equivalent or higher

Droplet Precautions

- Patient with suspected or confirmed infectious disease requiring droplet precautions (e.g., pertussis)
  - Close contact: Surgical mask equivalent or higher
  - Aerosol-generating procedure: Surgical mask equivalent or higher
Respiratory Infection Control: Respirators Versus Surgical Masks

It is important that employers and workers understand the significant differences between these two types of personal protective equipment. The decision whether or not to require workers to use either surgical masks or respirators must be based upon a hazard analysis of the workers’ specific work environments and the different protective properties of each type of personal protective equipment.

The use of surgical masks or respirators is one practice that may reduce the risk of infectious disease transmission between infected and noninfected persons. Since there is limited historical information on the effectiveness of surgical masks and respirators for the control of influenza during any previous pandemics, the effectiveness of surgical masks and respirators has been inferred on the basis of the mode of influenza transmission, particle size and professional judgment.

To offer protection, both surgical masks and respirators need to be worn correctly and consistently. If used properly, surgical masks and respirators both have a role in preventing different types of exposures. During an influenza pandemic, surgical masks and respirators need to be used in conjunction with interventions that are known to prevent the spread of infection, such as engineering and administrative controls (e.g., installing sneeze guards, teleworking) and work practices (e.g., cough etiquette, hand hygiene, and avoiding large gatherings).

Respirators

Respirators are designed to reduce a worker’s exposure to airborne contaminants. Respirators come in various sizes and must be individually selected to fit the wearer’s face and to provide a tight seal. A proper seal between the user’s face and the respirator forces inhaled air to be pulled through the respirator’s filter material and not through gaps between the face and respirator.

Respirators offer the best protection for workers who must work closely (either in contact with or within 6 feet) with people who have influenza-like symptoms. These generally include those workers who work in occupations classified as very high exposure risk or high exposure risk to pandemic influenza. For additional information on very high and high exposure risk occupations, please refer to OSHA Publication No. 3327, entitled Guidance on Preparing Workplaces for an Influenza Pandemic, which can be found at http://www.osha.gov/dsg/topics/pandemicflu/index.html.

Where workers are required by employers to wear respirators, they must be NIOSH-certified, selected, and used in the context of a comprehensive respiratory protection program, (see OSHA standard 29 CFR 1910.134, or www.osha.gov/SLTC/respiratoryprotection/index.html). It is important to medically evaluate workers to ensure that they can perform work tasks while wearing a respirator. For many workers, medical evaluation may be accomplished by having a physician or other licensed healthcare provider review a
respiratory questionnaire completed by the worker (found in Appendix C of OSHA’s Respiratory Protection standard, 29 CFR 1910.134) to determine if the worker can be medically cleared to use a respirator. Employers who have never before needed to consider a respiratory protection plan should note that it can take time to choose an appropriate respirator to provide to workers; arrange for a qualified trainer; and provide training, fit testing and medical evaluation for their workers. If employers wait until an influenza pandemic occurs, they may be unable to implement an adequate respiratory protection program in a timely manner.

Surgical Masks
Surgical masks are used as a physical barrier to protect the user from hazards, such as splashes of large droplets of blood or body fluids.

Surgical masks also protect other people against infection from the person wearing the surgical mask. Such masks trap large particles of body fluids that may contain bacteria or viruses expelled by the wearer.

Surgical masks are used for several different purposes, including the following:

- Placed on sick people to limit the spread of infectious respiratory secretions to others.
- Worn by healthcare providers to prevent accidental contamination of patients’ wounds by the organisms normally present in mucus and saliva.
- Worn by workers to protect themselves from splashes or sprays of blood or bodily fluids; they may also keep contaminated fingers/hands away from the mouth and nose.

Surgical masks are not designed or certified to prevent the inhalation of small airborne contaminants. These particles are not visible to the naked eye but may still be capable of causing infection. Surgical masks are not designed to seal tightly against the user’s face. During inhalation, much of the potentially contaminated air can pass through gaps between the face and the surgical mask and not be pulled through the filter material of the mask. Their ability to filter small particles varies significantly based upon the type of material used to make the surgical mask, so they cannot be relied upon to protect workers against airborne infectious agents. Only surgical masks that are cleared by the U.S. Food and Drug Administration to be legally marketed in the United States have been tested for their ability to resist blood and body fluids.