a specific professional service, but do not individually report that professional service.

(5) The number of visits that are furnished to the beneficiary during—

(i) An AMI episode, is up to 13 post-discharge home visits;

(ii) A CABG episode, is up to 9 post-discharge home visits; and

(iii) A SHFFT episode, is up to 9 post-discharge home visits.

(c) *Payment.* Up to the maximum post-discharge home visits for a specific EPM episode, as described in paragraph (b)(5) of this section, may be billed under Part B by the physician or non-physician practitioner or by the participant hospital to which the supervising physician has reassigned his or her billing rights.

(d) *Other requirements.* All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

§ 512.605 Waiver of certain telehealth requirements.

(a) *Waiver of the geographic site requirements.* Except for the geographic site requirements for a face-to-face encounter for home health certification, CMS waives the geographic site requirements of section 1834(m)(4)(C)(i)(I) through (III) of the Act for episodes being tested in an EPM, but only for services that—

(1) May be furnished via telehealth under existing requirements; and

(2) Are included in the episode in accordance with § 512.210.

(b) *Waiver of the originating site requirements.* Except for the originating site requirements for a face-to-face encounter for home health certification, CMS waives the originating site requirements under section 1834(m)(4)(C)(ii)(I) through (VIII) of the Act for episodes being tested in an EPM to permit a telehealth visit to originate in the beneficiary's home or place of residence, but only for services that—

(1) May be furnished via telehealth under existing requirements; and

(2) Are included in an EPM episode in accordance with § 512.210.

(c) *Waiver of selected payment provisions.* (1) CMS waives the payment requirements under section 1834(m)(2)(A) so that the facility fee normally paid by Medicare to an originating site for a telehealth service is not paid if the service is originated in the beneficiary's home or place of residence.

(2) CMS waives the payment requirements under section 1834(m)(2)(B) to allow the distant site payment for telehealth home visit HCPCS codes unique to this model to more accurately reflect the resources involved in furnishing these services in the home by basing payment upon the comparable office visit relative value units for work and malpractice under the Physician Fee Schedule.

(d) *Other requirements.* All other requirements for Medicare coverage and payment of telehealth services continue to apply, including the list of specific services approved to be furnished by telehealth.

§ 512.610 Waiver of SNF 3-day rule.

(a) *Applicability of the SNF 3-day rule waiver.* CMS determines that the SNF 3-day rule is—

(1) Waived for the AMI model;

(2) Not waived for the CABG model; and

(3) Not waived for the SHFFT model.

(b) *Waiver of the SNF 3-day rule.* For episodes being tested in those EPMs where the SNF 3-day rule is waived under paragraph (a) of this section, CMS waives the SNF 3-day rule for coverage of a SNF stay for a beneficiary who is an EPM beneficiary on the date of discharge from the anchor hospitalization on or after October 4, 2018, but only if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of EPM beneficiary admission to the SNF.

(1) CMS determines the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare Web site. Qualified SNFs are rated an overall of 3 stars or better for at least 7 of the 12 months.

(2) CMS posts to the CMS Web site the list of qualified SNFs in advance of the calendar quarter and the waiver only applies for a beneficiary who has been discharged from an anchor hospitalization if the SNF is included on

the applicable calendar quarter list for the date of the beneficiary's admission to the SNF.

(c) *Financial liability for uncovered SNF services.* CMS will determine the financial liability for uncovered SNF services if, subsequent to an EPM hospital applying the SNF 3-day rule waiver under this section, an EPM hospital incorrectly applies the SNF 3-day rule waiver.

(1) If the EPM hospital discharges a beneficiary to a SNF that is not a qualified SNF under paragraph (b) of this section and provides the beneficiary with a discharge planning notice, as described at §512.450(b)(3), to the beneficiary at the time of discharge to a SNF then the SNF coverage requirements apply and the beneficiary may be financially liable for uncovered SNF services.

(2) The EPM hospital will be financially liable for the SNF stay and the SNF must not bill the beneficiary for the costs of the uncovered SNF services furnished during the SNF stay if, subsequent to an EPM hospital applying the SNF 3-day rule waiver under this section, CMS determines the EPM hospital discharges a beneficiary—

(i) To a SNF that is not a qualified SNF under paragraph (b) of this section and the EPM hospital does not provide the beneficiary with a discharge planning notice, as described at §512.450(b)(3)

(ii) That is in an EPM where the SNF 3-day rule waiver is not applicable under paragraph (a) of this section; or

(iii) Prior to October 4, 2018, where the SNF 3-day rule waiver is not applicable under paragraph (b) of this section.

(d) *Other requirements.* All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

§512.615 Waiver of certain post-operative billing restrictions.

(a) *Waiver to permit certain services to be billed separately during the 90-day post-operative global surgical period.* CMS waives the billing requirements for global surgeries to allow the separate billing of certain post-discharge home visits described under §512.600, including those related to recovery from the surgery, as described in paragraph (b) of this section, for episodes being tested in an EPM.

(b) *Services to which the waiver applies.* Up to the maximum post-discharge home visits for a specific EPM episode, as described in §512.600(b)(5), including those related to recovery from the surgery, per EPM episode may be billed separately under Medicare Part B by the physician or non-physician practitioner, or by the participant hospital to which the physician or non-physician practitioner has reassigned his or her billing rights.

(c) *Other requirements.* All other Medicare rules for global surgery billing during the 90-day post-operative period continue to apply.

§512.620 Waiver of deductible and coinsurance that otherwise apply to reconciliation payments or repayments.

(a) *Waiver of deductible and coinsurance.* CMS waives the requirements of sections 1813 and 1833(a) of the Act for Medicare Part A and Part B payment systems only to the extent necessary to make reconciliation payments or receive repayments based on the NPRA that reflect the episode payment methodology under the final payment model for EPM participant hospitals.

(b) *Reconciliation payments or repayments.* Reconciliation payments or repayments do not affect the beneficiary cost-sharing amounts for the Medicare Part A and Part B services provided under an EPM.

§512.630 Waiver of physician definition for furnishing cardiac rehabilitation and intensive cardiac rehabilitation services to an EPM beneficiary.

(a) *General.* Section 410.49 of this chapter requires cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) services to be furnished under the direction of a physician as defined in §410.49(a) of this chapter.

(b) *Waiver of the physician definition.* For a provider or supplier of CR and ICR services to an EPM beneficiary during an AMI and CABG episode, as defined in §512.2, CMS waives the physician definition to allow the functions of supervising physician, prescribing exercise, and establishing, reviewing,