

2023 State of Hawaii Wildfires Available Waivers for Health Care Providers

CMS is empowered to take proactive steps to help providers through waivers issued pursuant to section 1135 of the Social Security Act (the Act). In addition, the statute provides for discretionary SNF coverage authority under section 1812(f) of the Act, and extended coverage until December 2024 for certain telehealth services. The following blanket waivers and other flexibilities are in effect through the end of the Hawaii wildfires public health emergency declaration of August 11, 2023, or when no longer needed. Despite the availability of blanket waivers, suppliers and providers should strive to return to their normal practice as soon as possible.

Blanket waivers DO NOT need to be submitted via the CMS 1135 Waiver Portal (https://cmsqualitysupport.servicenowservices.com/cms_1135) or via notification to the CMS Survey & Operations Group and are applied automatically by surveyors.

Flexibility for Medicare Telehealth Services

- **Originating Sites.** Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(C) of the Act and 42 CFR § 410.78 (a)(4) which specify eligible originating sites. The waiver of these requirements eliminates the limitations for telehealth services as well as the general requirement that beneficiaries be located in rural areas and in health care settings to receive telehealth services.
- **Expanded List of Services.** CMS will maintain an expanded list of Telehealth services on the CMS website that can be furnished through the end CY 2024, aligning with authority granted by section 4113(b) of CAA, 2023, which temporarily expands the types of health care professionals that may provide covered telehealth services and which specifies eligible originating sites.
- **Eligible Practitioners.** Pursuant to authority granted by section 4113(b) of CAA, 2023, the Secretary has authorized additional telehealth flexibilities. Section 1834(m)(4)(E) of the Act temporarily expands the types of health care professionals that may provide covered telehealth services to include physical therapists, occupational therapists, speech language pathologists, and audiologists.

- **Audio-Only Telehealth for Certain Services.** Pursuant to authority granted under section 4113(e) of CAA 2023, CMS has extended until the end of 2024 coverage under section 1834(m)(9) of the ACT for use of interactive telecommunications systems to furnish services via audio-only equipment described by the codes for audio only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes <https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes>). Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs), including Cancer Centers and Long-Term Care Hospitals (LTCHs)

- **Emergency Medical Treatment & Labor Act (EMTALA).** CMS is waiving the enforcement of section 1867(a) of the Act. This will allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan.
- **Medical Staff.** CMS is waiving requirements under 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges will expire to continue practicing at the hospital and for new physicians to be able to practice before full medical staff/governing body review and approval to address workforce concerns. CMS is waiving §482.22(a) (1)-(4) regarding details of the credentialing and privileging process.
- **Physical Environment.** CMS is waiving **certain** physical environment requirements under the hospital, psychiatric hospital, and critical access hospital conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow increased flexibilities for surge capacity. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. States are still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation ¹.

¹ Please note that consistent with the integration mandate of Title II of the ADA and the *Olmstead vs LC* decision, States are obligated to offer/ provide discharge planning and/or case management/ transition services, as appropriate, to individuals who are removed from their Medicaid home and community based services under these authorities during the course of the public health emergency as well as to individuals with disabilities who may require these services in order to avoid unjustified institutionalization or segregation. Transition services/ case management and/or discharge planning would be provided to facilitate these individuals in their return to the community when their condition and public health circumstances permit.

- **Telemedicine.** CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a) (8)– (9) for hospitals and §485.616(c) for CAHs, making it easier for telemedicine services to be furnished to the hospital’s patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.
- **Medical Records.** CMS is waiving requirements under 42 CFR §482.24(a) through (c), which cover the subjects of the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements, and these flexibilities may be implemented so long as they are not inconsistent with a state’s emergency preparedness or pandemic plan. CMS is waiving §482.24(c)(4)(viii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge from a hospital. This flexibility will allow clinicians to focus on the patient care at the bedside during the pandemic.
- **Written Policies and Procedures for Appraisal of Emergencies at Off-Campus Hospital Departments.** CMS is waiving 42 CFR §482.12(f)(3), emergency services, with respect to surge facilities only. For these facilities, staff need not utilize written policies and procedures when evaluating emergencies during the PHE. This removes the burden on facilities to develop and establish additional policies and procedures at their surge facilities or surge sites related to the assessment, initial treatment, and referral of patients. These flexibilities may be implemented so long as they are not inconsistent with a state’s emergency preparedness or pandemic plan.
- **Emergency Preparedness Policies and Procedures.** CMS is waiving 42 CFR §482.15(b) and §485.625(b), which requires hospitals and CAHs to develop and implement emergency preparedness policies and procedures, and §482.15(c)(1)– (5) and §485.625(c)(1)–(5) which requires that the emergency preparedness communication plans for hospitals and CAHs to contain specified elements. The requirement under the communication plan requires hospitals and CAHs to have specific contact information for staff, entities providing services under arrangement, patients’ physicians, other hospitals and CAHs, and volunteers, but would not be enforced for surge hospitals during the PHE. This waiver applies to both hospitals and CAHs, and removes the burden on facilities to establish these policies and procedures for their surge facilities or surge sites.
- **CAH Staff Licensure.** CMS is deferring staff licensure, certification, or registration to state law by waiving 42 CFR §485.608(d) regarding the requirement that staff of the CAH be licensed, certified, or registered in accordance with applicable federal, state, and local laws and regulations.

This waiver will provide maximum flexibility for CAHs to use all available clinicians. These flexibilities may be implemented so long as they are not inconsistent with a state’s emergency preparedness or pandemic plan.

Temporary Expansion Locations. CMS will waive certain physical environment requirements under 42 CFR §482.41 and §485.623 (as noted elsewhere in this waiver document) and the provider-based department location requirements at §413.65(e)(3) to allow hospitals to establish and operate as part of the hospital any location meeting those conditions of participation for hospitals, including any existing provider-based departments of the hospital. . This extends to any entity operating as a hospital so long as the relevant location meets the conditions of participation and other requirements not waived by CMS.

Expanded Ability for Hospitals to Offer Long-term Care Services (“Swing-Beds”) for Patients Who do not Require Acute Care but do Meet the Skilled Nursing Facility (SNF) Level of Care Criteria as Set Forth at 42 CFR 409.31. Under section 1135(b)(1) of the Act, CMS is waiving the eligibility requirements at 42 CFR 482.58(a), *“Special Requirements for hospital providers of long-term care services (“swing-beds”)”* to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF.

In order to qualify for this waiver, hospitals must:

- Not use SNF swing beds for acute level care.
- Comply with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
- Be consistent with the state’s emergency preparedness or pandemic plan.

Hospitals must call the CMS Medicare Administrative Contractor (MAC) enrollment hotline to add swing bed services. The hospital must attest to CMS that:

- They have made a good faith effort to exhaust all other options;
- There are no skilled nursing facilities within the hospital’s catchment area that under normal circumstances would have accepted SNF transfers, but are currently not willing to accept or able to take patients because of the PHE;
- The hospital meets all waiver eligibility requirements; and
- They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

This waiver is available to all Medicare enrolled hospitals (except psychiatric and long-term care hospitals) that wish to provide post-hospital SNF level swing-bed services for non-acute care patients in hospitals. As noted, the waiver must be consistent with the

state's emergency preparedness or pandemic plan. The hospital shall not bill for SNF PPS payment using swing beds when swing-bed patients require acute level care or continued acute care at any time while this waiver is in effect. The hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

- **CAH Status and Location.** CMS is waiving the requirement at 42 CFR §485.610(b) that the CAH be located in a rural area or an area being treated as being rural, allowing the CAH flexibility in the establishment of surge site locations. CMS is also waiving the requirement at §485.610(e) regarding the CAH's off-campus and co-location requirements, allowing the CAH flexibility in establishing temporary off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers will also suspend restrictions on CAHs regarding their location relative to other hospitals and CAHs. consistent with a state's emergency preparedness or pandemic plan.
- **CAH Length of Stay.** CMS is waiving the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours (per patient, on an annual average basis) under the Medicare conditions of participation for number of beds and length of stay at 42 CFR § 485.620.
- **Responsibilities of Physicians in Critical Access Hospitals (CAHs).** 42 CFR § 485.631(b)(2). CMS is waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § 485.631(b)(2) that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS policy and related longstanding sub-regulatory guidance that further described communication between CAHs and physicians will ensure an appropriate level of physician direction and supervision for the services provided by the CAH. This will allow the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to temporarily expand service locations to meet

the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements at 42 CFR §491.5(a)(1) and (2). When the PHE ends, if a clinic elects to continue providing services in at the temporary location, it must independently enroll the location in the RHC Medicare program.

Housing Acute Care Patients in the Inpatient Rehabilitation Facility (IRF) Excluded Distinct Part Units

Flexibility for Inpatient Rehabilitation Facilities Regarding the “60 Percent Rule”

- CMS is allowing IRFs to exclude patients from the freestanding hospital’s or excluded distinct part unit’s inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the “60 percent rule”) if an IRF admits a patient solely to respond to the emergency and the patient’s medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

Housing Acute Care Patients in the Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units

Housing Acute Care Patients In Excluded Distinct Part Units

- CMS is allowing acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

- **Reporting Minimum Data Set (MDS).** CMS is waiving the requirements at 42 CFR §483.20, subsection (b)(2) to provide relief to SNFs on the timeframes in which they must conduct a comprehensive assessment and collect MDS data. CMS is not waiving the requirements for facilities to conduct the assessment and collect MDS data at 42 CFR 483.20(b)(1).
- **Waive Pre-Admission Screening and Annual Resident Review (PASARR).** CMS is waiving 42 CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes

with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review.

Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs)

- CMS has determined it is appropriate to issue a blanket waiver to long-term care hospitals (LTCHs) where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement at § 412.23(e)(2), which allows these hospitals to participate in the LTCH PPS.

Skilled Nursing Facilities (SNFs)

- **3-Day Prior Hospitalization.** Using the authority under Section 1812(f) of the Act, CMS may cover SNF stays without a 3-day prior inpatient hospitalization. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes a one-time renewal of SNF coverage without first having to start a new benefit period (this portion of the waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).
- **Physician Visits in Skilled Nursing Facilities/Nursing Facilities.** CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.
- **Physical Environment.** CMS is waiving requirements under 42 CFR 483.90 to temporarily allow for rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity. Rooms that may be used for this purpose include activity rooms, meeting/conference rooms, dining rooms, or other rooms, as long as residents can be kept safe, comfortable, and other applicable requirements for participation are met. This can be done so long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department.

Hospice

- **Comprehensive Assessments.** CMS is waiving certain requirements at 42 CFR §418.54 related to updating comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment found at §418.54(d). Hospices

must continue to complete other required assessments (i.e., initial and ad-hoc assessments based on a change in the patient's condition); however, the timeframes for updating the comprehensive assessment may be extended from 15 to 21 days.

- **Waive Non-Core Services.** CMS is waiving the requirement for hospices to provide certain noncore hospice services during an emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.

Home Health Agencies (HHAs)

- **Reporting.** CMS is providing relief to HHAs on the timeframes related to OASIS Transmission through the following actions below:
 - Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
 - Waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.
- **Initial Assessments.** CMS is waiving the requirements at 42 CFR §484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment for them while reducing the impact on acute care and long-term care facilities. This will allow for maximizing coverage by already scarce physician, and advanced practice clinicians, and allow those clinicians to focus on caring for patients with the greatest acuity.

End-Stage Renal Dialysis (ESRD) Facilities

- **Ability to Delay Some Patient Assessments.** CMS is not waiving subsections (a) or (c) of 42 CFR §494.80 but is waiving the following requirements at 42 CFR §494.80(b) related to the frequency of assessments for patients admitted to the dialysis facility. CMS is waiving the "on-time" requirements for the initial and follow up comprehensive assessments within the specified timeframes as noted below. This waiver applies to assessments conducted by members of the interdisciplinary team, including: a registered nurse, a physician treating the patient for ESRD a social worker, and a dietitian. These waivers are intended to ensure that dialysis facilities are able to focus on the operations related to the Public Health Emergency. Specifically, CMS is waiving:
 - §494.80(b)(1): An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.

- §494.80(b)(2): A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient’s plan of care specified in §494.90.
- **Time Period for Initiation of Care Planning and Monthly Physician Visits.** CMS is modifying two requirements related to care planning, specifically:
 - 42 CFR §494.90(b)(2): CMS is modifying the requirement that requires the dialysis facility to implement the initial plan of care within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This modification will also apply to the requirement for monthly or annual updates of the plan of care within 15 days of the completion of the additional patient assessments.
 - §494.90(b)(4): CMS is modifying the requirement that requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician’s assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.
- **Special Purpose Renal Dialysis Facilities (SPRDF) Designation Expanded.** CMS authorizes the establishment of SPRDFs under 42 CFR §494.120 to address access to care issues and the need to mitigate transmission among this vulnerable population. This will not include the normal determination regarding lack of access to care at §494.120(b) as this standard has been met during the period of the national emergency. Approval as a Special Purpose Renal Dialysis Facility related to does not require Federal survey prior to providing services.

Ambulatory Surgical Centers (ASCs)

- **Medical Staff.** 42 CFR 416.45(b). CMS is waiving the requirement at § 416.45(b) that medical staff privileges must be periodically reappraised, and the scope of procedures performed in the ASC must be periodically reviewed. This will allow for physicians whose privileges will expire to continue practicing at the ambulatory surgical center, without the need for reappraisal, and for ASCs to continue operations without performing these administrative tasks during the PHE. This waiver will improve the ability of ASCs to maintain their current workforce during the PHE.

Intermediate Care Facility for Individuals with Intellectual Disabilities

- **Staffing Flexibilities.** CMS is waiving the requirements at 42 CFR §483.430(c)(4), which requires the facility to provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that interfere with direct client care. DSS perform activities such as cleaning of the facility, cooking, and laundry services. DSC perform activities such as teaching clients appropriate hygiene, budgeting, or effective communication and socialization skills. During the time of this waiver, DCS may be needed to conduct some of the activities normally performed by the DSS. This will allow facilities to adjust staffing patterns, while maintaining the minimum staffing ratios required at §483.430(d)(3).
- **Physical Environment.** CMS is waiving **certain** physical environment requirements under the Intermediate Care Facilities for Individuals with Intellectual Disabilities conditions of participation at §42 CFR §483.470 to allow increased flexibilities for surge capacity. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. States are still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation ².

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

- When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.

This also allows CMS to temporarily extend the 10-business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period,

² Please note that consistent with the integration mandate of Title II of the ADA and the *Olmstead vs LC* decision, States are obligated to offer/ provide discharge planning and/or case management/ transition services, as appropriate, to individuals who are removed from their Medicaid home and community based services under these authorities during the course of the public health emergency as well as to individuals with disabilities who may require these services in order to avoid unjustified institutionalization or segregation. Transition services/ case management and/or discharge planning would be provided to facilitate these individuals in their return to the community when their condition and public health circumstances permit.

affected contract suppliers will have 30 business days to provide notice to the Competitive Bidding Implementation Contractor of any subcontracting arrangements. CMS will notify DMEPOS Competitive Bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. Note: CMS will provide notice of any changes to reporting timeframes for future events.

Provider Enrollment

- Postpone all revalidation actions.
- Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location (currently extended through December 31, 2023).
- Postpone provider enrollment site visits for moderate and high-risk providers/suppliers.
- Postpone fingerprint-based criminal background checks for 5% or greater owners of newly enrolling high-risk categories of providers and suppliers (e.g., newly enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs, Skilled Nursing Facilities).
- Waive the collection of application fees.

Replacement Prescription Fills

- Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the disaster or emergency.

Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)

CMS is modifying the 60-day limit in section 1842(b)(6)(D)(iii) of the Social Security Act to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services plus an additional period of no more than 60 continuous days after the public health emergency expires. On the 61st day after the public health emergency ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock. Without this flexibility, the regular physician or physical therapist generally could not use a single substitute for a continuous period of longer than 60 days, and would instead be required to secure a series of substitutes to cover sequential 60-day periods. The modified

timetable applies to both types of substitute billing arrangements under Medicare fee-for-service (i.e., reciprocal billing arrangements and fee-for-time compensation arrangements (formerly known as locum tenens)).

Notes: Under the Medicare statute, only 1) physicians and 2) physical therapists who furnish outpatient physical therapy services in a health professional shortage area (HPSA), a medically underserved area (MUA), or a rural area can receive Medicare fee-for-service payment for services furnished by a substitute under a substitute billing arrangement. In addition, Medicare can pay for services under a substitute billing arrangement only when the regular physician or physical therapist is unavailable to provide the services. Finally, as provided by law, a regular physician or physical therapist who has been called or ordered to active duty as a member of a reserve component of the Armed Forces may continue to use the same substitute for an unlimited time even after the emergency ends.