COVID-19 Coronavirus **coding updates**

UPDATED INFO

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Coding update: March 16, 2020

The Centers for Medicare and Medicaid Services (CMS) took action to create two new HCPCS codes in response to the current World Health Organization (WHO) public health emergency of international concern for the COVID-19 Coronavirus which was declared on January 30, 2020 and subsequent actions from both the Center for Disease Control (CDC) and the US Food and Drug Administration (FDA).

Effective February 4, 2020 the codes below can be utilized by health care providers to report laboratory services related to COVID-19 Coronavirus diagnostic testing. Medicare claims processing systems will be able to accept these new HCPCS codes April 1, 2020 retroactively back to its effective date.

- ✓ **U0001**, *CDC 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel,* for use with CDC developed testing
- ✓ **U0002**, *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets),* for non-CDC developed testing (e.g., Hospital specific in-house developed testing)

It is important to remind providers that services must be reasonable and necessary for diagnosis and treatment in order to be covered by Medicare. [Social Security Act, Section 1862(a)(1)(A).] For a laboratory service to be reasonable and necessary, it must not only be ordered by the physician, but the ordering physician must also use the result in the management of the beneficiary's specific medical problem. Implicitly, the laboratory result must be reported to the physician promptly so that the physician can use the result and instruct continuation or modification of patient care; this includes the physician order for another laboratory service. [42 CFR, §410.32 and §411.15.]

Besides diagnostic testing, patients are likely to be quarantined in isolation accommodations which may not be adequately priced to cover additional costs related to the Coronavirus. These include, but may not be limited to, costs associated with increased staffing, security, decontamination (including disposal of contaminated items), and/or additional protective equipment required by caregivers. Hospitals should review their current isolation accommodation structure and costs to determine if current rates are appropriate. The Medicare Provider Reimbursement Manual indicates,

> "Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the service and uniformly applied to all patients whether inpatient or outpatient." [CMS Provider Reimbursement Manual, Chapter 22, Section 2202.4.]. If the Hospital determines that current rates are not appropriate, they should consider adding a second level tiered isolation charge to ensure additional costs are appropriately integrated into the charge for nursing care and supplies represented by the accommodation charge as related to the Coronavirus and other high-risk infectious disease management needs in their total patient population.

Medicare has acknowledged in their FAQs (link provided below) that there may be times when such quarantine services are required and, if provided for medically necessary care, that Medicare will pay hospitals a DRG rate.

A new diagnosis code for COVID-19 Coronavirus has been created in the International Classification of Diseases, Tenth Revision (ICD-10) as an emergency code (U07.1, 2019-nCoV acute respiratory disease) by the World Health Organization (WHO). The new code will be added to the ICD-10-CM for reporting, effective with the next update, October 1, 2020. Until then, the CDC has provided guidance which is available on their website for coding related to pneumonia, acute bronchitis, lower respiratory infection, acute respiratory distress syndrome (ARDS), exposure, and signs and symptoms related to the Coronavirus. Hospitals should review the link provided in the additional information below for this diagnosis coding guidance.

Additionally, on March 6, 2020 H.R.6074 - Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 was signed into law by the President (Public Law 116-123) which provides $8.3B in emergency funding for federal agencies to respond to the Coronavirus outbreak. This includes provisions that allow for the temporarily waiver or modification of the Medicare requirements with respect to telehealth services during certain emergency periods. A link to the full text of Public Law 116-123 can be accessed from the list of resources below.

At this time, nThrive recommends that Hospitals

- ✓ Add HCPCS codes U0001 and U0002 to the CDM for diagnostic Coronavirus laboratory testing and develop a charge capture/order process for testing
- ✓ Hold claims with these HCPCS codes until April 1, 2020 for submission to Medicare
- ✓ Determine if HCPCS codes U0001 and U0002 will be accepted by other payers or if another alternative code should be reported for testing
- ✓ Review current isolation accommodation costs/charges and determine if a tiered isolation accommodation level is necessary to appropriately report costs based on current/anticipated isolation services
- ✓ Review with Hospital coding staff the CDC emergent coding advice from the link provided and standardize internal coding and diagnostic testing/admission coding elements or processes, including the provision of education to ordering providers as necessary
- ✓ Review the resources below related to the Coronavirus, testing, coding, and coverage at the following websites as it pertains to this reference document:

Reference documents

1. Public Law No: 116-123, signed 3/6/2020
2. CMS Public Health News Alert New Code for Coronavirus
3. CMS MLN Connects HCPS development
4. CMS Additional Code for Coronavirus Lab Tests
5. CMS Medicare Coverage Fact Sheet (Coronavirus)
6. CMS Medicaid and CHIP Coverage Fact Sheet (Coronavirus)
7. CMS Individual and Small Group Market Coverage Fact Sheet (Coronavirus)
8. CMS Notification to Surveyors for Emergency Use Authorization related to the Coronavirus
9. US FDA Emergency Use Authorization for diagnostic testing
10. CDC Situation Summary on the Coronavirus
11. CDC ICD-10 Code and Coding Guidance for the Coronavirus ■

Medicare waivers

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past Public Health Emergencies (PHE) declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.[1]

These waiver purposes are to ensure that:

Sufficient health care items and services are available to meet the needs of Medicare, Medicaid and SCHIP beneficiaries.

Health care providers (defined in this provision) that furnish such items and services in good faith, but are unable to comply with certain requirements (defined in this provision), may still be reimbursed for such items or services and exempted from sanction (absent fraud or abuse).

If a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, the waiver of that requirement would no longer apply to that hospital.[2]

The hospital does not need to apply for the following approved blanket waivers that impact acute care hospitals:

Skilled Nursing Facilities (SNFs). Waives the requirement for a 3-day prior hospitalization for coverage of a SNF stay. Provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency.

Providers that receive beneficiaries without a 3-day qualifying stay (and for whom the requirement was waived under section 1812(f)) should report condition code "DR" (disaster related) on their claim. Based on the presence of this code, Medicare systems will bypass the 3-day stay requirement and occurrence span code "70" (qualifying stay dates) need not be reported. In addition, providers should include remarks indicating "declared emergency/disaster" on their remarks page for tracking/ verification purposes.

Critical Access Hospitals. Waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.

CMS will not count any bed use that exceeds the 25 inpatient bed or 96-hour average length of stay (LOS) limits, if this result is clearly identified as relating to the disaster. CAHs must clearly indicate in the medical record where an admission is made, or length of stay extended to meet the demands of the crisis.

Housing Acute Care Patients in Excluded Distinct Part Units. It is appropriate to issue a blanket waiver to inpatient prospective payment system (IPPS) hospitals that, as a result of the emergency, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient.

The 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 emergency.

The hospital also must annotate all Medicare fee-for-service claims related to such admissions with the "DR" condition code or the "CR" modifier, as applicable, for the period that the hospital remains affected by the emergency. The IPPS hospital should submit the claim rather than the distinct part.

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital. It is appropriate to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit.

The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the emergency.

This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

The opposite is also true, according to the referenced CMS FAQ. Beds in a psychiatric unit may be used for acute care; however, it should be fully documented in hospital records. In addition, the acute portion of the hospital should bill for all Medicare covered services; the psychiatric unit should record the services/charges as non-Medicare.

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital. It is appropriate to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit.

The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility (IRF) prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the emergency.

This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients, and such patients continue to receive intensive rehabilitation services.

In the case of an acute admission to a rehabilitation bed that is made solely to meet the demands of the emergency, a facility should clearly identify in the inpatient's medical record that the patient is being admitted solely to meet the demands of the emergency.

If all the services on the claim are disaster/emergency related, the institutional provider with a § 1135 waiver would use the "DR" (disaster related) condition code to indicate that the entire claim is disaster/emergency related.

Guidance

Apply the following to claims for which Medicare payment is based on a "formal waiver" including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The "DR" (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
    a. The DR condition code should be used by institutional providers (but not by non-institutional providers such as physicians and other suppliers) in all billing situations related to a declared emergency/disaster.
    b. The DR condition code is mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver"
2. The "CR" (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.
    a. Non-institutional providers do not use the DR condition code. Instead, non-institutional providers must use the CR modifier for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned on the presence of a "formal waiver."
    b. At the Medicare claims processing contractor's discretion, or as directed by CMS in a disaster or emergency, the CR modifier also may be required for any individual HCPCS code.

Sources

1. MLN Matters SE20011, March 16, 2020.
2. https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Provider-Survey-and-Certification-Frequently-Asked-Questions.pdf
3. https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf ■

Quality reporting waiver

Background

CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The action comes as part of the Trump Administration's response to 2019 Novel Coronavirus (COVID-19).

In a bulletin released on March 22, 2020, CMS stated that "in granting these exceptions and extensions, CMS is supporting clinicians fighting Coronavirus on the front lines," said CMS Administrator Seema Verma. "The Trump Administration is cutting bureaucratic red tape so the healthcare delivery system can direct its time and resources toward caring for patients."[1]

CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for the following CMS programs:

Provider Programs	2019 Data Submission	2020 Data Submission
Quality Payment Program – Merit-based Incentive Payment System (MIPS)	Deadline extended from March 31, 2020 to April 30, 2020. MIPS eligible clinicians who have not submitted any MIPS data by April 30, 2020 will qualify for the automatic extreme and uncontrollable circumstances policy and will receive a neutral payment adjustment for the 2021 MIPS payment year.	CMS is evaluating options for providing relief around participation and data submission for 2020.
Medicare Shared Savings Program Accountable Care Organizations (ACOs)		

Hospital Programs	2019 Data Submission	2020 Data Submission
Ambulatory Surgical Center Quality Reporting Program	Deadlines for October 1, 2019 – December 31, 2019 (Q4) data submission optional. If Q4 is submitted, it will be used to calculate the 2019 performance and payment (where appropriate). If data for Q4 is unable to be submitted, the 2019 performance will be calculated based on data from January 1, 2019 – September 30, 2019 (Q1-Q3) and available data.	CMS will not count data from January 1, 2020 through June 30, 2020 (Q1-Q2) for performance or payment programs. Data **does not** need to be submitted to CMS for this time period. * For the *Hospital-Acquired Condition Reduction Program and the Hospital Value-Based Purchasing Program,* if data from January 1, 2020 – March 31, 2020 (Q1) is submitted, it will be used for scoring in the program (where appropriate).
CrownWeb National ESRD Patient Registry and Quality Measure Reporting System		
End-Stage Renal Disease (ESRD) Quality Incentive Program		
Hospital-Acquired Condition Reduction Program		
Hospital Inpatient Quality Reporting Program		
Hospital Outpatient Quality Reporting Program		
Hospital Readmissions Reduction Program		
Hospital Value-Based Purchasing Program		
Inpatient Psychiatric Facility Quality Reporting Program		
PPS-Exempt Cancer Hospital Quality Reporting Program		
Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals		

Post-Acute Care (PAC) Programs	2019 Data Submission	2020 Data Submission
Home Health Quality Reporting Program	Deadlines for October 1, 2019 – December 31, 2019 (Q4) data submission optional. If Q4 is submitted, it will be used to calculate the 2019 performance and payment (where appropriate).	Data from January 1, 2020 through June 30, 2020 (Q1-Q2) **does not** need to be submitted to CMS for purposes of complying with quality reporting program requirements. **Home Health and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS)* survey data from January 1, 2020 through September 30, 2020 (Q1-Q3) does not need to be submitted to CMS. *For the *Skilled Nursing Facility (SNF) Value-Based Purchasing Program,* qualifying claims will be excluded from the claims-based SNF 30-Day All-Cause Readmission Measure (SNFRM; NQF #2510) calculation for Q1-Q2.
Hospice Quality Reporting Program		
Inpatient Rehabilitation Facility Quality Reporting Program		
Long Term Care Hospital Quality Reporting Program		
Skilled Nursing Facility Quality Reporting Program		
Skilled Nursing Facility Value-Based Purchasing Program		

For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report. In addition, no data reflecting services provided January 1, 2020 through June 30, 2020 will be used in CMS's calculations for the Medicare quality reporting and value-based purchasing programs. This is being done to reduce the data collection and reporting burden on providers responding to the COVID-19 pandemic.

CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period.

Guidance

- ✓ Review the guidelines above for each applicable program.
- ✓ Determine if optional data will be collected and submitted.
- ✓ Identify impact on reimbursement, if applicable.
- ✓ Re-task staff as needed if optional data submission is elected.

Sources

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

Medicare provider enrollment relief

Background

To help hospitals onboard additional Medicare eligible providers, CMS has released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19, including the toll-free hotlines available to provide expedited enrollment and answer questions related to COVID-19 enrollment requirements.

The FAQs can be found here: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

The waivers being implemented apply as follows:

Physicians and Non-Physician Practitioners

- ✓ Establish toll-free hotlines to enroll and receive temporary Medicare billing privileges
- ✓ Waive the following screening requirements:
  - Criminal background checks associated with fingerprint-based criminal background checks (FCBC) - 42 C.F.R 424.518 (to the extent applicable)
  - Site visits - 42 C.F.R 424.517
  - Postpone all revalidation actions

All Other Providers and Suppliers (including DMEPOS)

- ✓ Expedite any pending or new applications
- ✓ All clean web applications will be processed within 7 business days and all clean paper applications in 14 business days
- ✓ Waive the following screening requirements for all enrollment applications received on or after March 1, 2020:
  - Application Fee – 42 C.F.R. 424.514
  - Criminal background checks associated with the FCBC – 42 C.F.R. 424.518 (to the extent applicable)
  - Site-visits – 42 C.F.R. 424.517
  - Postpone all revalidation actions

CMS has established toll-free hotlines at each of the Medicare Administrative Contractors (MACs) to allow physicians and non-physician practitioners to initiate temporary Medicare billing privileges. The hotlines should also be used if providers/suppliers have questions regarding the other provider enrollment flexibilities afforded by the 1135 waiver.

The hotlines can also be used for physicians and non-physician practitioners to report a change in practice location. **For instance, CMS answered this question:**

Q. Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

A. There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. The practitioner is required to **update their Medicare enrollment with the home location**. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction **through the provider enrollment hotline**. It would be effective immediately so practitioners could continue providing care without a disruption. More details about this enrollment requirement can be found at 42 CFR 424.516. If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

The hotline numbers are as follows:

	TOLL-FREE HOTLINE	HOURS OF OPERATION
CGS Administrators, LLC (CGS)	1-855-769-9920	7:00 am–4:00 pm CT
First Coast Service Options Inc. (FCSO)	1-855-247-8428	8:30 am–4:00 pm ET
National Government Services (NGS)	1-888-802-3898	8:00 am–4:00 pm CT
National Supplier Clearinghouse (NSC)	1-866-238-9652	9:00 am–5:00 PM ET
Novitas Solutions, Inc.	1-855-247-8428	8:30 am–4:00 pm ET
Noridian Healthcare Solutions	1-866-575-4067	8:00 am–6:00 pm CT
Palmetto GBA	1-833-820-6138	8:30 am–5:00 pm ET
Wisconsin Physician Services (WPS)	1-844-209-2567	7:00 am–4:00 pm CT

A portion of the waiver addresses the need for State licensure:

The HHS Secretary has authorized 1135 waivers that allow CMS to waive, on an individual basis, the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which she/he is practicing. However, the 1135 waiver is not available unless all of the following four conditions are met:

1) the physician or non-physician practitioner must be enrolled as such in the Medicare program,
2) the physician or non-physician practitioner must possess a valid license to practice in the State which relates to his or her Medicare enrollment,
3) the physician or non-physician practitioner is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and
4) the physician or non-physician practitioner is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.

In addition to the statutory limitations that apply to 1135-based licensure waivers, an 1135 waiver, when granted by CMS, does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirements.

Those requirements would continue to apply unless waived by the State. Therefore, in order for the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the State also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home State.[1]

See additional waivers introduced in the CARES Act Waiver section.

Guidance

- ✓ Identify physician and non-physician practitioners that need billing privileges assigned by Medicare.
- ✓ Contact your MACs hotline to acquire new approval or to modify a current provider's information to allow submission of claims to Medicare.
- ✓ Review State guidelines regarding any waiver applicable to State licensure.
- ✓ Review the CMS FAQ document related to these issues.

Sources

1. https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf ■

Diagnostic testing

UPDATED INFO

Since previous publication, this content has been updated and also extends to the next page.

Background

The American Medical Association (AMA) has expedited approval of CPT© codes for reporting laboratory testing related to the novel coronavirus. The first to be released was:

> **87635** – *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique.*

The AMA indicated that "the pathology and laboratory section of the CPT code set already contains codes for coronavirus testing. But those are for nucleic acid assays that detect multiple respiratory viruses in a multiplex reaction, while CPT 87635 is for the detection of SARS-CoV-2 (COVID-19) and any pan-coronavirus types or subtypes", using an amplified probe technique.[1]

In response to the release of this code CPT Assistant© (CPTA) published a Fact Sheet to help providers accurately report these testing services by creating a series of Q&A.

The Q&A addresses reporting this new code versus one of two recently released HCPCS that CMS created:

> **U0001** – *CDC 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel, for use with CDC developed testing,* and
>
> **U0002** – *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets), for non-CDC developed testing (e.g., Hospital specific in-house developed testing).*

According to the CPTA: "the appropriate code to be reported is dependent upon the payer to which the claim is being submitted… CPT and HCPCS codes should not both be reported on the same claim."[2]

CPT© code 87635 was available for use as of April 1, 2020 which required providers to hold claims after February 4th before releasing them on April 1.

Reimbursement rates may be found at https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf.

On April 15, 2020 CMS also released a bulletin indicating payment under Medicare Supplementary Medical Insurance (Part B) for clinical diagnostic laboratory tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 making use of high throughput technologies.[3]

In order to identify these high throughput test methodologies two additional HCPCS codes to test for the virus were also released:

- ✓ **U0003** – *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.*
- ✓ **U0004** – *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.*

CMS has instructed providers to take note that "U0003 should identify tests that would otherwise be identified by CPT code 87635 but for being performed with these high throughput technologies. It is further noted that U0004 should identify tests that would otherwise be identified by U0002 but for being performed with these high throughput technologies. Finally, it is noted that neither U0003 nor U0004 should be used for tests that detect COVID-19 antibodies."

Making use of high throughput technologies beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, are new and involve high throughput machines (which are highly sophisticated equipment) which require more intensive technician training (to ensure the role of extremely skilled personnel) and more time intensive processes (to assure quality). A high throughput technology uses a platform that employs automated processing of more than two hundred specimens a day.

This training and these processes represent an increase in resources, bringing the total resources required for these tests to $100 (a more accurate payment than the one currently in use via contractor pricing).

Compared to an average payment of $51 for the standard test the CMS press release indicated that Medicare will pay the higher payment of $100 for COVID-19 clinical diagnostic lab tests making use of high-throughput technologies.[4]

As indicated these new codes are not meant to be reported for antibody testing. However, in response to the need for CPT© codes specific for antibodies the AMA also expedited the release of two additional codes on April 14, 2020:

- ✓ **86328** – *Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).*
- ✓ **86769** – *Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).*

Prior to this date an antibody test specific to COVID-19 was not available and providers could only report 82784, *Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each methodology.*

Guidance

- ✓ Determine test methodologies used by the Lab.
- ✓ Ensure all applicable codes are added to the CDM for testing reported by the hospital.
- ✓ Link CDM charge codes to Laboratory testing orders.
- ✓ Appropriately code and release claims held since February 4, 2020.

Sources

1. https://www.ama-assn.org/delivering-care/public-health/new-cpt-code-covid-19-testing-what-you-should-know
2. CPT Assistant, Special Edition: April Update, Volume 30, 2020.
3. https://www.cms.gov/files/document/cms-2020-01-r.pdf
4. CMS Increases Medicare Payment for High-Production Coronavirus Lab Tests, cms.gov/newsroom, April 15, 2020. ■

Diagnostic testing coverage

Background

On March 18, 2020 President Trump signed the Families First Coronavirus Response Act which provides for free testing for the COVID-19 coronavirus.[1]

Section G

Section 101. Coverage of Testing for COVID-19. This section requires private health plans to provide coverage for COVID-19 diagnostic testing, including the cost of a provider, urgent care center and emergency room visits in order to receive testing. Coverage must be provided at no cost to the consumer.

Section 102. Waiving Cost Sharing Under the Medicare Program For Certain Visits Relating To Testing For COVID-19. This section requires Medicare Part B to cover beneficiary cost-sharing for provider visits during which a COVID-19 diagnostic test is administered or ordered. Medicare Part B currently covers the COVID-19 diagnostic test with no beneficiary cost-sharing.

Section 103. Waiving Cost Sharing Under the Medicare Advantage Program for Certain Visits Relating to Testing for COVID-19. This section requires Medicare Advantage to provide coverage for COVID-19 diagnostic testing, including the associated cost of the visit in order to receive testing. Coverage must be provided at no cost to the beneficiary.

Section 104. Coverage at No Cost Sharing of COVID-19 Testing Under Medicaid and CHIP. This section requires Medicaid to provide coverage for COVID-19 diagnostic testing, including the cost of a provider visit in order to receive testing. Coverage must be provided at no cost to the beneficiary. It would also provide states with the option to extend Medicaid eligibility to uninsured populations for the purposes of COVID-19 diagnostic testing. State expenditures for medical and administrative costs would be matched by the federal government at 100 percent.

Section 105. Laboratory Reimbursement for Diagnostic Testing for COVID-19 in Uninsured Individuals. This section requires the National Disaster Medical System to reimburse the costs of COVID-19 diagnostic testing provided to individuals without insurance.

Section 107. Application with Respect to TRICARE, Coverage for Veterans, and Coverage for Federal Civilians. This section ensures that individuals enrolled in TRICARE, covered veterans, and federal workers have coverage for COVID-19 diagnostic testing without cost sharing.

Section 108. Coverage of Testing for COVID-19 At No Cost Sharing for Indians Receiving Contract Health Services. This section ensures that American Indians and Alaskan Natives do not experience cost sharing for COVID-19 testing, including those referred for care away from an Indian Health Service or tribal health care facility.

A bulletin containing FAQs addressing coverage of the test under Medicaid was also released yesterday:

Q. Is the test for the detection of COVID-19 coverable under Medicaid's mandatory laboratory benefit?

A. Yes, the test meets the criteria for a mandatory laboratory service as described at 1905(a)(3) and 42 C.F.R. § 440.30. The test must be ordered and provided by or under the direction of a physician or other licensed practitioner within the appropriate scope of practice as defined by the state, or ordered by a physician, but provided by referral laboratory. To meet this definition, the test must be provided in an office or similar facility other than a hospital outpatient department or clinic and furnished by a laboratory that meets Clinical Laboratory Improvement Amendments (CLIA) requirements at Part 493 of the Code of Federal Regulations. Tests that do not meet these criteria may still be covered under the optional diagnostic benefit described at 1905(a)(13) of the Act and 42 C.F.R. § 440.130(a).[2]

Q. Are Medicaid home health agencies able to collect the samples necessary for the diagnostic testing for COVID-19?

A. If a physician orders the diagnostic test and the sample collection needed is within the scope of practice for the home health nurse or can be delegated to other practitioners, based on the state's nurse practice act, Medicaid may cover the collection under the home health benefit. If it is not within the scope of practice, CMS encourages states to explore state emergency or other authorities to remove these restrictions during this public health emergency. CMS is available for technical assistance.

Pursuant to 42 C.F.R. §440.70(f), if the sample collection is a beneficiary's first utilization of the home health benefit, a face-to-face encounter must have occurred no longer than 90 days before or 30 days after the start of services and must be related to the primary reason the beneficiary requires home health services.

Although the test may be free, there may still be limitations on who needs to be tested. The American Medical Association in a FAQ for physicians provides the following guidance:

Q. When should I test patients for COVID-19?

A. The CDC is regularly updating guidance on who physicians should test for COVID-19. In general, physicians should watch for patients presenting with fever or signs of lower respiratory illness — especially in those who may have been exposed to the virus. Decisions on testing may be made based on local epidemiology of COVID-19. Clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.[3]

The CDC also maintains criteria for testing:

Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever[1] and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). Priorities for testing may include:

1. Hospitalized patients who exhibit signs and symptoms compatible with COVID-19 in order to inform decisions related to infection control.
2. Other symptomatic individuals, such as older adults and individuals with chronic medical conditions and/or an immunocompromised state that may put them at higher risk for poor outcomes (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).
3. Any persons including health care personnel[2], who within 14 days of symptom onset had close contact[3] with a suspect or laboratory-confirmed[4] COVID-19 patient, or who have a history of travel from affected geographic areas (see below) within 14 days of their symptom onset.

There are epidemiologic factors that may also help guide decisions about COVID-19 testing. Documented COVID-19 infections in a jurisdiction and known community transmission may contribute to an epidemiologic risk assessment to inform testing decisions. Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).[4]

NBC News reached out to the health departments for all 50 states, the District of Columbia and the five U.S. territories for information on how they are handling testing and what recommendations they have for people seeking tests.

Their findings are published in an article found at: https://www.nbcnews.com/health/health-news/coronavirus-testing-information-covid-19-tests-according-state-health-departments-n1158041#anchor-Alabama

> "The general advice is the same nationwide: Call ahead to your doctor or a health care facility if you are concerned you may need to be tested. Based on your symptoms and exposure, they will decide if you need to be evaluated in person and may confer with state authorities about where and how to do the testing."

By using a link at this site, providers can review their State's specific guidelines. However, providers should be reminded to check frequently as guidelines are updated frequently.

Guidance

- ✓ Review State specific guidelines for who should be tested.
- ✓ Implement strategies across the health system to test patients consistently and according to guidelines.
- ✓ Create charges in the CDM based on the test methodology employed.
- ✓ Educate billing and collection staff to ensure patients are not balance billed for this testing.
- ✓ See the Laboratory Waiver Update regarding collection fees and add to CDM as appropriate.
- ✓ See the Laboratory Waiver Update for further information on data collection.

Sources

1. https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/Families%20First%20summary.pdf
2. https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
3. https://www.ama-assn.org/delivering-care/public-health/covid-19-frequently-asked-questions
4. https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html ■

Telehealth/virtual services

Background

The Centers for Medicare & Medicaid Services (CMS) issued a fact sheet with additional guidance for health care providers and patients about the telehealth benefits in the agency's Medicare program. According to CMS "the fact sheet is part of a broader effort by CMS and the White House Task Force to ensure that all Americans – particularly those at high risk of complications from the COVID-19 virus – are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the community spread of this disease.

CMS' historic effort made virtual check-ins and other services that use telecommunications possible with new policies implemented in 2019 and 2020. These services are available right now to patients and their physicians and now certain other clinicians, as a result of the CARES Act,
providing a great deal of flexibility and an easy way for patients who are concerned about illness to remain in their homes avoiding exposure to others. With the COVID-19 virus, there is an urgency to expand the use of virtual care to keep the beneficiaries with mild symptoms in their homes while increasing access to their provider's office."[1]

The fact sheet goes on to explain:
"For the beneficiary, these benefits can be very helpful. For example, a Medicare beneficiary who is looking for advice about symptoms they are experiencing, can call their doctor and receive medical advice about whether he or she needs to see their doctor in person for a physical exam. If they start to feel more ill, a virtual check-in allows a healthcare provider to offer recommendations about next steps and even take precautions for someone they are concerned may have the COVID-19 virus or flu before they step in the office or hospital putting others at risk. These check-ins are billable services and the Medicare coinsurance and deductible would apply to these services.

Medicare Advantage plans may also provide enrollees access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries' homes, as part of their benefit packages for a plan year. Therefore, enrollees in Medicare Advantage plans that include coverage of such services may be available to receive clinically appropriate services for treatment of COVID-19 via telehealth from many sites, including their home."

In another bulletin, CMS explains:
"Since 2018, Medicare pays for "virtual check-ins" for patients to connect with their doctors without going to the doctor's office. These brief, virtual check-in services were for patients with an established relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The CARES Act has expanded the use of this service to new patients as well. The patient must verbally consent to using virtual check-ins and the consent must be documented in the medical record prior to the patient using the service. The Medicare coinsurance and deductible would apply to these services.

Initially, only doctors and certain practitioners were permitted to bill professionally for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010). These services are not covered under OPPS. The CARES Act has expanded these services to additional clinicians as outlined in the new Telehealth Expansion section.

Medicare also pays for patients to communicate with their doctors and others without going to the doctor's office, using online patient portals. The individual communications, like the virtual check in, must be initiated by the patient; however, practitioners may educate beneficiaries on the availability of this kind of service prior to patient initiation. The communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The Medicare coinsurance and deductible would apply to these services."[2]

CMS stated "these services will not be subject to the limitations on Medicare telehealth services in section 1834(m) of the Act because, as we have explained, we do not consider them to be Medicare telehealth services; instead, they will be paid under the PFS like other physicians' services."[3]

CPT© codes 99441-99443 were not reported under OPPS, as they were excluded from coverage by Medicare, but may have been recognized and paid by other insurers. Under the new telehealth expansion resulting from the CARES Act, these are listed as being reported by the hospital. nThrive anticipates that CMS may change the Status Indicator (SI) from E1 to a payable status, however, at this time, information is not available. See the new Telehealth Expansion section for the most current updates regarding these codes as well as many others that might be more appropriate.

This bulletin also makes the following statement regarding rural telehealth services:

> "In addition, Medicare beneficiaries living in rural areas may use communication technology to have full visits with their physicians. The law requires that these visits take place at specified sites of service, known as telehealth originating sites, and receive services using a real-time audio and video communication system at the site to communicate with a remotely located doctor or certain other types of practitioners. Medicare pays for many medical visits through this telehealth benefit."

The traditional guidance from CMS regarding telehealth services requires that these services are available in rural areas, under certain conditions, but only if you're located at one of these places:

- ✓ A doctor's office
- ✓ A hospital
- ✓ A critical access hospital (CAH)
- ✓ A rural health clinic
- ✓ A federally qualified health center
- ✓ A hospital-based dialysis facility
- ✓ A skilled nursing facility
- ✓ A community mental health center[4]

A new MLN article released the evening of Tuesday March 17, 2020 includes additional information regarding the waiver of these requirements.

This new MLN states:

> "A range of health care providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to Medicare beneficiaries.
>
> Beneficiaries will be able to receive 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."

Bulletins released on Monday, March 30, 2020, as a result of the CARES Act, expands telehealth services to certain other clinicians. See the new Telehealth Expansion section for further details.

A FAQ provided with this article also answers questions regarding the waiving of both the "prior relationship with the provider" and the "HIPAA" requirements associated with telehealth services.

CMS responded to a question regarding the requirement that the patient have a previously established relationship with the provider:

> "To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency."

The CARES Act also resulted in lifting the limitation regarding telehealth for established patients to allow providers to use telehealth technology to render services for new patients, as well.

A similar response was issued regarding maintaining HIPAA requirements:

> "The new waiver in Section 1135(b) of the Social Security Act explicitly allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency."

Providers can find more information at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Guidance

Report the appropriate telehealth or virtual service code for the service provided and the insurer paying the claims.

Medicare Virtual Services

1. G2012, *Brief Communication Technology-Based Service, e.g. Virtual Check-In,* is defined and payable as described in the FR with the following guidance:
    a. When performed by a physician or other qualified health care professional who can report evaluation and management services, provided to either a new or established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion).
    b. Verbal consent is required that is noted in the medical record for each billed service.
    c. This service can only be furnished for established patients because Medicare believes that the practitioner needs to have an existing relationship with the patient, and therefore, basic knowledge of the patient's medical condition and needs, in order to perform this service.
    d. Use of this code is appropriate for circumstances when a patient needs a brief non-face-to-face check-in to assess whether an office visit is necessary.
2. G2010, *Remote Evaluation of Pre-Recorded Patient Information,* is defined and payable as described in the FR with the following guidance which has been expanded by the CARES Act:
    a. This service describes the remote professional evaluation of patient transmitted information conducted via pre-recorded "store and forward" video or image technology and includes;
    b. Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
    c. Like the virtual check-in service, this service would be used to determine whether an office visit or other service is warranted.
    d. Verbal consent is required that is noted in the medical record for each billed service.

Medicare Telehealth Services G0406-G0408 and G0425-G0427

1. Qualifying professional services provided at a distant site are billed on a 1500 claim form.
    a. Professional Billing
        i. Submit the claim to the contractor for physician/practitioner's service area (where the practitioner providing the service is located).[7]
        ii. Report the appropriate CPT/HCPCS for Telehealth services.[8]
        iii. Report the Place of Service the same as if it took place face-to-face.[9]
        iv. Apply Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System.*
        v. Do not apply Modifier CR, *Catastrophe/disaster related.*[10]
2. Qualifying services provided by a hospital as the distant site provider report Modifier 95 to identify services rendered by Telehealth.[11]
3. Method II Critical Access Hospitals (CAH), where the practitioner has reassigned their benefits to the CAH, submit the appropriate HCPCS code for the covered telehealth service with Modifier GT, *Via interactive audio and video telecommunication systems.*[12]
4. Under the CARES Act, RHC and FQHP may act as a distant site provider as well.

Third-party Payers

1. Review all insurance plans to determine whether services are covered, and which codes are recognized.

Sources

1. https://www.cms.gov/newsroom/press-releases/telehealth-benefits-medicare-are-lifeline-patients-during-coronavirus-outbreak
2. https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf
3. Federal Register /Vol. 83, No. 226 / Friday, November 23, 2018 /Rules and Regulations.
4. https://www.medicare.gov/coverage/telehealth
5. MLN, Special Edition, President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak, March 17, 2020.
6. https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
7. CMS Fact Sheet FAQ for Telehealth, page 2, Distant Site Providers.
8. CMS Fact Sheet FAQ for Telehealth, pages 3-5, Table of Medicare Telehealth Services.
9. CMS Special Edition Bulletin, April 3, 2020.
10. CMS Special Edition Bulletin, April 3, 2020.
11. CMS Open Door Forum Q&A, April 7, 2020.
12. Medicare Claims Manual, Pub 100-04, Chapter 12, 190.6.1. ■

Telehealth HIPAA waiver update

Background

The general principles of telehealth remain intact and the waivers only eliminate certain limitations of the service during the COVID-19 pandemic. Providers may find the Telehealth Start Up Guide helpful in implementing new telehealth services. This document can be accessed at:

https://www.healthit.gov/sites/default/files/telehealthguide_final_0.pdf

The American Medical Association (AMA) has designed a quick guide to support physicians and practices in expediting the implementation of telemedicine which can be found at:

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

Health and Human Services (HHS) released a bulletin that further discusses the HIPAA issues associated with telehealth services.[1] We have shared key paragraphs from this bulletin below, however providers may access the full document at the referenced website.

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients.

OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth, using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

Under this Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers.

The list below includes vendors that state they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA.

Skype for Business

Updox

VSee

Zoom for Healthcare

Doxy.me

Google G Suite Hangouts Meet

Guidance

- ✓ Share guidelines with physician practices within the health system.
- ✓ Confirm only non-public facing remote communication products are in use.
- ✓ Notify patients that these third-party applications potentially introduce privacy risks.
- ✓ Review guidelines with the Compliance Department and determine if Business Associate Agreements will be required and execute as appropriate.

Source

1. CPT Assistant, Special Edition, Volume 30, 2020. ■

ICD-10-CM diagnosis coding

Background

On January 30, 2020, the World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern. As a result of the declaration, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) convened an emergency meeting on January 31, 2020 to discuss the creation of a specific code for this new coronavirus. A new International Classification of Diseases, Tenth Revision (ICD-10) emergency code (U07.1, 2019-nCoV acute respiratory disease) was established by WHO.[1]

On February 11, 2020 the WHO announced the official name of the virus: COVID-19. Consistent with this WHO update to the ICD-10, the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC/NCHS) announced they will implement the new diagnosis code into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for reporting, effective with the next update, October 1, 2020.

In the interim, the CDC released a bulletin to provide official diagnosis coding guidance for health care encounters and deaths related to the 2019 novel coronavirus (COVID-19) previously named 2019-nCoV. The guidance was approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services.

The guidance utilizes existing ICD-10 code B97.29, *Other coronavirus as the cause of diseases classified elsewhere*, which is a supplementary or additional code to identify the infectious agent(s) in diseases classified elsewhere.[2]

The CDC guidance notes that Diagnosis code B34.2, *Coronavirus infection, unspecified,* would in generally not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be "unspecified."

As a secondary code, the following example was given to demonstrate reporting the underlying disease first:

> For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes J12.89, *Other viral pneumonia,* and B97.29, *Other coronavirus as the cause of diseases classified elsewhere.*

Additional examples for coding acute bronchitis, lower respiratory infection and ARDS are also given.[3]

The following scenarios are also outlined for reporting suspected cases:

> For cases where there is a concern about a possible exposure to COVID-19, but it is ruled out after evaluation, it would be appropriate to assign the code Z03.818, *Encounter for observation for suspected exposure to other biological agents ruled out.*
>
> For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases.*
>
> If the provider documents "suspected," "possible" or "probable" COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).

On March 18, 2020 AHIMA cited the CDC bulletin stating that due to the "urgent need to capture the reporting of [COVID-19] in our nation's claims and surveillance data," the agency has changed the effective date of **new diagnosis code U07.1, *COVID-19,*** from October 1 to April 1, 2020.[4]

Going forward, U07.1 would be reported as the most specific code available, rather than the "other coronavirus" code B97.29 **and sequence it as the primary code**.

Guidance

- ✓ Review coding guidelines with both hospital and physician practice staff to ensure the appropriate diagnosis codes are both reported and sequenced correctly.
- ✓ Assign other codes for conditions unrelated to coronavirus if required to fully code the scenario in accordance with the ICD-10-CM Official Guidelines for Coding and Reporting.

Sources

1. https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-3-18-2020.pdf
2. ICD-10 CM, 2020.
3. https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf
4. AHIMA Weekly E-Alert, March 19, 2020. ■

Implementing virtual and telehealth services

Background

To help providers implement new virtual and telehealth programming, CMS released on March 23, 2020 two comprehensive toolkits on telehealth that are specific to general practitioners, as well as providers treating patients with End-Stage Renal Disease (ESRD). (See new telehealth expansion section.)

According to the CMS bulletin, each toolkit contains electronic links to reliable sources of information on telehealth and telemedicine, which will reduce the amount of time providers spend searching for answers and increase their time with patients. Many of these links will help providers learn about the general concept of telehealth, choose telemedicine vendors, initiate a telemedicine program, monitor patients remotely and develop documentation tools. Additionally, the information contained within each toolkit will also outline temporary virtual services that could be used to treat patients during this specific period of time.[1]

These two tool kits can be accessed at:

https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

https://www.cms.gov/files/document/esrd-provider-telehealth-telemedicine-toolkit.pdf

CMS maintains a Telehealth web page that includes several tools to help providers implement these services as well. The page can be accessed at: https://www.healthit.gov/topic/health-it-initiatives/telemedicine-and-telehealth.

Some of the resources available at this site include:

- ✓ The Federal Telehealth Compendium, which contains telehealth activities and resources available across the federal arena.
- ✓ Designing The Consumer-Centered Telehealth & eVisit Experience: Considerations for the Future of Consumer Healthcare
- ✓ Health IT Playbook: Telehealth
- ✓ The Telehealth Start-Up and Resource Guide, which provides a background and introduction to telehealth and telemedicine concepts, benefits, and resources.

Guidance

1. Identify areas within the health system that currently do not have virtual and/or telehealth services and would be able to serve patients more safely and effectively if implemented.
2. Review all applicable guidelines including current waivers to ensure services are implemented appropriately.
3. In addition to waivers designed to improve access during the COVID-19 emergency, be certain to note limitations that are being enforced to protect patient privacy.
4. Identify and make available appropriate equipment.
5. Implement charges for each service available.
6. Educate providers and staff to ensure:
   a. Identification of payers that allow virtual and telehealth services
   b. Services available are correctly identified and billed
   c. Appropriate documentation is maintained
   d. That emergency specific waivers are only implemented and maintained during this period
   e. Educate patients

Sources

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

Telehealth non-physician services

Background

A Medicare Telemedicine Health Care Provider Fact Sheet was published on March 17, 2020, addressing expansions to telehealth services during the COVID-19 Public Health Emergency (PHE).[1]

This led to many providers asking if e-visits or virtual services could be reported for Therapy services or other non-physician services offered in a variety of hospital outpatient settings and clinics. Initially, these services were not available for hospital outpatient billing. Implementation of the CARES Act on March 30, 2020 changed this.

The CARES Act did not provide a mechanism to split bill professional and technical services. However, it did expand the virtual and telehealth services to such an extent that services the hospital itself provides via these mechanisms can now be reported.

nThrive is guiding hospitals to the new Telehealth Expansion section of this booklet for additional information on the new codes that have been temporarily added to the list of services that may be provided via virtual or telehealth mechanisms.

A complete list of telehealth services can be found at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Medical Nutritional Therapy (MNT) and Diabetes Self-Management Training (DSMT) may be provided using telehealth services. These are commonly provided in a hospital provider-based clinic and were on the list of Telehealth services prior to COVID-19 Coronavirus. Many certified DSMT programs are hospital-based, which allows the hospital to transition to telehealth mechanisms in order to continue the treatment of patients eligible for these programs.

List of Medicare Telehealh Services / CY 2020

Code	Short Descriptor
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
97804	Medical nutrition group
G0108	Diab manage trn per indiv
G0109	Diab manage trn ind/group
G0270	Mnt subs tx for change dx

Therapeutic rehabilitation and speech evaluation and therapy codes are now found on the list of available services by telehealth.

While the waiver and addition of the therapy service codes to the list of telehealth codes seems straightforward, language in a pending Interim Final Rule (IFR) introduces a potential issue. The IFR indicates that Therapy Associations have been petitioning CMS to add therapy services since 2018. CMS pointed to the fact that the providers eligible to render these services were not on the list of providers approved to render telehealth services.

> "Since the majority of the codes are furnished over 90 percent of the time by therapy professionals, who are not included on the statutory list of eligible distant site practitioners, we stated that we believed that adding therapy services to the telehealth list could result in confusion about who is authorized to furnish and bill for these services when furnished via telehealth.
>
> In light of the PHE for the COVID-19 pandemic, we believe that the risks associated with confusion are outweighed by the potential benefits for circumstances when these services might be furnished via telehealth by eligible distant site practitioners. We believe this is sufficient clinical evidence to support the addition of therapy services to the Medicare telehealth list on a category 2 basis.
>
> However, we note that the statutory definition of distant site practitioners under section 1834(m) of the Act does not include physical therapists, occupational therapists, or speech-language pathologists, meaning that it does not provide for payment for these services as Medicare telehealth services when furnished by physical therapists, occupational therapists, or speech-language pathologists."[2]

Though there is not a current provision for payment regarding PT, OT, and Speech via Telehealth, the CARES Act would suggest CMS' intent was "to increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home."[5]

On one hand, CMS has limited access to therapy services by continuing to exclude therapists from the distant site provider list. At the same time saying if the practitioners on the list are "under quarantine or at home, it could unintentionally limit the number of licensed practitioners available to furnish services to Medicare patients and could have the unintended consequence of limiting access to services paid under the PFS."

Guidance

1. Identify eligible telehealth services that may be offered.
2. Ensure clinicians continuing to provide services via a telehealth mechanism:
    a. Confirm anticipated services are within the scope of practice of the designated practitioner or clinician.
    b. Ensure documentation is consistent with requirements prior to the PHE
    c. Document the telehealth mechanism by which the service was provided
3. Confirm CPT codes used to report these services are on the CMS list of approved telehealth services.
    a. If the clinician is on the distant site provider list and the service is on the approved list of telehealth services, submit a claim with:
        i. Condition code DR
        ii. Modifier CR
        iii. Revise the revenue code to Revenue code 0780

b. If the clinician is NOT on the distant site provider list but the service is on the approved list of telehealth services determine whether the provider will capture the charges and hold the claim until further direction is available. **Without revised CMS guidance reimbursement will NOT be available.**

Sources

1. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
2. CMS-1744-IFC, https://www.cms.gov/files/document/covid-final-ifc.pdf
3. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf ■

Interim CDC recommendations for inpatient OB care

Background

The Center for Disease Control (CDC) has published infection control recommendations for inpatient hospital providers to consider in providing obstetric (OB) services.[1]

According to the CDC, "these infection prevention and control considerations are for healthcare facilities providing obstetric care for pregnant patients with confirmed coronavirus disease (COVID-19) or pregnant persons under investigation (PUI) in inpatient obstetric healthcare settings, including obstetrical triage, labor and delivery, recovery and inpatient postpartum settings."

Considerations include:

- ✓ Appropriate isolation of pregnant patients who have confirmed COVID-19 or are PUIs.
- ✓ Basic and refresher training for all healthcare personnel on those units to include correct adherence to infection control practices and personal protective equipment (PPE) use and handling.
- ✓ Enough and appropriate PPE supplies positioned at all points of care.
- ✓ Processes to protect newborns from risk of COVID-19.

Because of the limited information regarding transmission of this virus, the CDC states the approaches outlined below are intentionally cautious until additional data become available to refine recommendations for prevention of person-to-person transmission in inpatient obstetric care settings.

The approaches the CDC has outlined are divided into the various OB points of care:

Prehospital Considerations

- ✓ Pregnant patients who have confirmed COVID-19 or who are PUIs should notify the obstetric unit prior to arrival so the facility can make appropriate infection control preparations before the patient's arrival.
  - – Identifying the most appropriate room for labor and delivery.
  - – Ensuring infection prevention, control supplies and PPE are correctly positioned.
  - – Informing all healthcare personnel who will be involved in the patient's care of infection control expectations.
- ✓ If a pregnant patient who has confirmed COVID-19 or is a PUI arrives transport by emergency medical services, the driver should contact the receiving emergency department or healthcare facility and follow previously agreed-upon local or regional transport protocols.

During Hospitalization

- ✓ Healthcare facilities should ensure recommended infection control practices for hospitalized pregnant patients who have confirmed COVID-19 or are PUIs are consistent with Interim Infection Prevention and Control Recommendations.
- ✓ All healthcare facilities that provide obstetric care must ensure that their personnel are correctly trained and capable of implementing recommended infection control interventions.
  - – Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- ✓ Healthcare facilities should follow the interim infection control guidance on managing visitor access, including essential support persons for women in labor (e.g., spouse, partner).
- ✓ Infants born to mothers with confirmed COVID-19 should be considered PUIs. As such, infants should be isolated according to the Infection Prevention and Control Guidance for PUIs.

Mother/Baby Contact

It is unknown whether newborns with COVID-19 are at increased risk for severe complications. Transmission after birth via contact with infectious respiratory secretions is a concern. To reduce the risk of transmission of the virus that causes COVID-19 from the mother to the newborn, facilities should consider temporarily separating (e.g., separate rooms) the mother, who has confirmed COVID-19 or is a PUI, from her baby until the mother's transmission-based precautions are discontinued, as described in the Interim Considerations for Disposition of Hospitalized Patients with COVID-19. See the considerations below for temporary separation:

- ✓ The risks and benefits of temporary separation of the mother from her baby should be discussed with the mother by the healthcare team.
- ✓ A separate isolation room should be available for the infant while they remain a PUI.
  - – Healthcare facilities should consider limiting visitors, except for a healthy parent or caregiver.
  - – Visitors should be instructed to wear appropriate PPE, including gown, gloves, face mask, and eye protection.
  - – If another healthy family or staff member is present to provide care (e.g., diapering, bathing) and feeding for the newborn, they should use appropriate PPE.
  - – For healthy family members, appropriate PPE includes gown, gloves, face mask, and eye protection.
  - – For healthcare personnel, recommendations for appropriate PPE are outlined in the Infection Prevention and Control Recommendations.

- ✓ The decision to discontinue temporary separation of the mother from her baby should be made on a case-by-case basis in consultation with:
  - Clinicians.
  - Infection prevention and control specialists.
  - Public health officials.
- ✓ The decision should consider:
  - Disease severity.
  - Illness signs and symptoms.
  - Results of laboratory testing for the virus that causes COVID-19, SARS-CoV-2.
- ✓ Considerations to discontinue temporary separation are the same as those to discontinue transmission-based precautions for hospitalized patients with COVID-19. (Please see Interim Considerations for Disposition of Hospitalized Patients with COVID-19.)
- ✓ If colocation (sometimes referred to as "rooming in") of the newborn with his/her ill mother in the same hospital room occurs in accordance with the mother's wishes or is unavoidable due to facility limitations, facilities should consider implementing measures to reduce exposure of the newborn to the virus that causes COVID-19.
- ✓ Consider using engineering controls like physical barriers (e.g., a curtain between the mother and newborn) and keeping the newborn ≥6 feet away from the ill mother.
- ✓ If no other healthy adult is present in the room to care for the newborn, a mother who has confirmed COVID-19 or is a PUI should:
  - Put on a facemask and practice hand hygiene before each feeding or other close contact with her newborn.
  - The facemask should remain in place during contact with the newborn.
  - These practices should continue while the mother is on transmission-based precautions in a healthcare facility.

Breastfeeding

- ✓ During temporary separation, mothers who intend to breastfeed should be encouraged to express their breast milk to establish and maintain milk supply.
  - If possible, a dedicated breast pump should be provided.
  - Prior to expressing breast milk, mothers should:
  - Practice hand hygiene.
  - After each pumping session, all parts that came into contact with breast milk should be thoroughly washed and the entire pump should be appropriately disinfected per the manufacturer's instructions.
  - This expressed breast milk should be fed to the newborn by a healthy caregiver.
- ✓ If a mother and newborn do room-in and the mother wishes to feed at the breast, she should put on a facemask and practice hand hygiene before each feeding.

Hospital Discharge

- ✓ Discharge for postpartum women should follow recommendations described in the Interim Considerations for Disposition of Hospitalized Patients with COVID-19.
- ✓ For infants with pending testing results or who test negative for the virus that causes COVID-19 – 4 upon hospital discharge, caretakers should take steps to reduce the risk of transmission to the infant, including following the Interim Guidance for Preventing Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities.

The CDC considers proper hand hygiene to include use of alcohol-based hand sanitizer that contains 60% to 95% alcohol before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene can also be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to alcohol-based hand sanitizer.

Guidance

1. Review recommendations for each point of care with responsible staff.
2. Formalize decisions, policies and procedures in a written guide shared with all applicable staff.
3. Reference additional resources and guidance found on the CDC web page:

   Persons Under Investigation:
   https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

   CDC interim guidance on infection control:
   https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

   Interim guidance for Emergency Medical Services (EMS):
   https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html

   Disposition of Hospitalized Patients:
   https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

   Preventing Spread in Homes and Residential Communities:
   https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html

Sources

1. https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html ■

Medicare beneficiary notice delivery guidance

Background

On Thursday, March 26, 2020 CMS released an MLN Connects bulletin that included guidance for delivery of beneficiary notices to patients who may have COVID-19.[1]

In this bulletin CMS encourages providers that are treating a patient with suspected or confirmed COVID-19, to be diligent and safe while issuing the following beneficiary notices to beneficiaries receiving institutional care:

- ✓ Important Message from Medicare (IM)_CMS-10065
- ✓ Detailed Notices of Discharge (DND)_CMS-10066
- ✓ Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
- ✓ Detailed Explanation of Non-Coverage (DENC)_CMS-10124
- ✓ Medicare Outpatient Observation Notice (MOON)_CMS-10611
- ✓ Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
- ✓ Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)_CMS-10055
- ✓ Hospital Issued Notices of Non-Coverage (HINN)

Current notice delivery instructions provide flexibilities for delivering notices to beneficiaries in isolation:

- ✓ Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely.
  - – A contact phone number should be provided for a beneficiary to ask questions about the notice, if the individual delivering the notice is unable to do so.
- ✓ If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also be delivered via email, if a beneficiary has access in the isolation room.
  - – The notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent.
- ✓ Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite.
  - – The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

Guidance

1. Review revised instructions for delivery of beneficiary notices in isolation with all staff responsible for this task.
2. Implement strategies for complying with guidelines to ensure notices are appropriately delivered and that patients can respond appropriately.
3. Guidance allows for modification in delivery of notices only. Providers should reference standing guidelines for content and other issues related to notices that may be found at: https://www.cms.gov/media/137111

Sources

1. CMS MLN Connects, Special Edition, Thursday, March 26, 2020. ■

State Medicaid waivers and telehealth

Background

"States have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use. Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services."[1]

Like the Medicare waiver, the available telehealth flexibility allows Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a health care facility so that risk of exposure and spread of the virus can be limited.

According to an outline of telehealth benefits "States may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services."[2]

CMS also released a bulletin to assist states in understanding policy options for telehealth services. The overview and sample state plan language apply to Medicaid fee-for-service payments and additional considerations may be warranted for states interested in offering telehealth within other delivery systems. CMS encourages states to consider telehealth options as a flexibility in combating the COVID-19 pandemic and increasing access to care.[3]

Some of the key take-aways from this bulletin include:

- ✓ States are not required to submit a State Plan Amendment (SPA) to pay for telehealth services if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting.
- ✓ States may pay a qualified physician or other licensed practitioner at the distant site (the billing provider) and the state's payment methodology may include costs associated with the time and resources spent facilitating care at the originating site. The billing provider may distribute the payment to the distant and originating sites.
- ✓ States may also pay for appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for the delivery of telehealth services. A state would need an approved state plan payment methodology that specifies the ancillary costs and circumstances when those costs are payable.
- ✓ Ancillary costs associated with the originating site for telehealth may be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state when a Medicaid service is delivered. The ancillary costs must be directly related to a covered Medicaid service provided via telehealth and properly allocated to the Medicaid program.
- ✓ States are encouraged to reach out to their state lead as soon as possible, if they are interested in submitting a state plan amendment.

Despite this general guidance, states often have varied and unique services and benefit requirements. Therefore, in lieu of attempting to list the varied details of each plan and their corresponding waivers, nThrive has located two resources that enables our clients to link to plan details based on each state:[4]

https://www.cchpca.org/resources/covid-19-related-state-actions

https://mtelehealth.com/home/reimbursement-policies/TX-state-telehealth-laws-and-reimbursement-policies/

The links address several Medicaid issues and waivers for each state in addition to those that address telehealth services. Many of the waivers address flexibility in the plans themselves versus the benefits.

Appendix K Waivers may be found at:

https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/appendix-k/index.html

Waivers to state governed insurance rules and guidelines are granted on a state-by-state basis Unlike Medicare, where the federal government issued blanket waivers, the Medicaid programs must apply individually for waivers. nThrive has endeavored to compile a list of the 1135 waivers, current as of March 26, 2020, in the table below. This table may be updated as additional plan waivers are approved.[5]

STATE	Prior Auth	Prior Auth Extension	PASRR Waiver	Hearing & Appeals	Provider Enrollment	Alternate Settings	SPA Flexibilities	Tribal Consults
Alabama			✓					
Arizona		✓			✓			
California		✓		✓	✓	✓		
Florida		✓	✓	✓	✓	✓		
Illinois		✓	✓	✓	✓	✓		
Indiana		✓	✓	✓	✓	✓		
Iowa			✓					
Kentucky			✓	✓	✓	✓		
Kansas		✓	✓	✓				
Louisiana			✓	✓	✓	✓		
Mississippi		✓	✓	✓	✓	✓		
Missouri		✓	✓	✓	✓	✓	✓	
New Hampshire		✓	✓	✓	✓	✓		
New Mexico		✓	✓	✓	✓			
New Jersey		✓	✓	✓	✓	✓		
N Carolina			✓	✓	✓	✓		
N Dakota		✓	✓	✓	✓			✓
Oklahoma			✓	✓	✓	✓		
Puerto Rico					✓			
Rhode Island		✓		✓	✓			
S Dakota			✓	✓	✓	✓		
Virginia		✓		✓				
Washington	✓		✓	✓	✓	✓	✓	✓

Definitions

Prior Authorization: CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services provided on or after March 1, 2020 through the termination of the emergency declaration for at least 90 days and up to 180 days (up to the last day of the emergency period under section 1135(e) of the Act). This pertains to beneficiaries with a permanent residence in the geographic area of the public health emergency declared by the Secretary.

Prior Authorization Extension: CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services approved to be provided on or after March 1, 2020, to continue to be provided without a requirement for a new or renewed prior authorization, through the termination of the public health emergency, including any extensions (up to the last day of the emergency period under section 1135(e) of the Act).

PASRR: Section 1919I (7) of the Act allows Level I and Level II assessments to be waived for 30 days. All new admissions can be treated like exempted hospital discharges. After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available.

Fair Hearing and Appeals: CMS approves a waiver under section 1135 that allows enrollees to have more than 90 days, up to an additional 120 days for an eligibility or fee for service appeal to request a fair hearing. Modification of the timeframe for managed care entities to resolve

appeals under 42 C.F.R. §438.408(f)(1) before an enrollee may request a State Fair Hearing to no less than one day in accordance with the requirements specified below; this allows managed care enrollees to proceed almost immediately to a state fair hearing without having a managed care plan resolve the appeal first; it permits the state to modify the timeline for managed care plans to resolve appeals to one day so the impacted appeals satisfy the exhaustion requirements.

Modification of the timeframe under 42 C.F.R. §438.408(f)(2) for enrollees to exercise their appeal rights to allow an additional 120 days to request a fair hearing when the initial 120th day deadline for an enrollee occurred during the period of this section 1135 waiver.

CMS approves a modification of the timeframe, under 42 C.F.R. §438.408(f)(2), for managed care enrollees to exercise their appeal rights. Specifically, any managed care enrollees for whom the 120-day deadline described in 42 C.F.R. §438.408(f)(2) would have occurred between March 1, 2020 through the end of the public health emergency, are allowed up to an additional 120 days to request a State Fair Hearing.

Provider Enrollment: Relaxation of some criteria, but not all criteria related to:

- ✓ Payable claims from out-of-state providers.
- ✓ Provisionally, temporarily enroll the out-of-state provider for the duration of the public health emergency to accommodate participants who were displaced by the emergency.
- ✓ Provisionally, temporarily enroll the providers for the duration of the public health emergency.
- ✓ Temporarily cease revalidation of providers who are otherwise directly impacted by the emergency.

Alternate Setting: CMS approves a waiver under section 1135(b)(1) of the Act to allow facilities, including NFs, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs), and hospital NFs, to be fully reimbursed for services rendered to an unlicensed facility (during an emergency evacuation or due to other need to relocate residents where the placing facility continues to render services) provided that the State makes a reasonable assessment that the facility meets minimum standards, consistent with reasonable expectations in the context of the current public health emergency, to ensure the health, safety and comfort of beneficiaries and staff. The placing facility would be responsible for determining how to reimburse the unlicensed facility.

State Plan Amendment Flexibility: SPAs related to the COVID-19 emergency by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 C.F.R. §430.20. CMS is approving this request pursuant to section 1135(b)(5) of the Act. This approval applies only with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to alternative benefit plans (ABPs) to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof).

Public notice for SPAs is required under 42 C.F.R §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to ABPs. These requirements help to ensure that the affected public has reasonable opportunity to comment on these SPAs. CMS is approving the state's request to waive these notice requirements applicable to SPA submissions. Even though CMS is approving this waiver, we encourage the state to make all relevant information available to the public, so they are aware of the changes.

- ✓ Tribal Consults: The state has flexibility in modifying their tribal consultation timeframe, including shortening the number of days before submission or conducting consultation after submission of the SPA.

Guidance

- ✓ Review Medicaid plan waivers applicable to your State.
- ✓ Implement strategies as appropriate.
- ✓ Utilize the link provided to review telehealth and other program benefit changes resulting from the COVID-19 health emergency.

Sources

1. https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
2. https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html
3. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf
4. © Public Health Institute/ Center for Connected Health Policy 2019: http://cchpca.org
5. https://www.cms.gov/newsroom/press-releases/cms-approves-medicaid-section-1135-waivers-11-additional-states-response-covid-19 ■

Compliance topics

Background

CMS has released waivers that address topics that otherwise might be considered compliance issues. Full discussions of these and other waivers may be found at the following:

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

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Waivers have an issue date of March 30, 2020, but will be **retroactive to March 1, 2020**, nationwide, and shall terminate as set forth in section 1135(e) of the Act. Parties may not use the blanket waivers after the expiration of the Secretary's authority to grant waivers for the COVID-19 outbreak in the United States.[1]

Compliance topics impacted by recently released waivers include the following.

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** to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. Greater detail regarding the following may be found at:

https://www.cms.gov/files/document/qso-20-15-emtala-requirements-and-coronavirus-0311-updated-003pdf.pdf-1

- ✓ Hospitals may set up alternative screening sites on campus.
  - The medical screening examination (MSE) does not have to take place in the ED.
  - A hospital may set up alternative sites on its campus to perform the MSE.
- ✓ Hospitals may set up screening at off-campus, hospital-controlled sites.
  - Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for influenza-like illness (ILI).
  - A hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE. Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.
- ✓ Communities may set up screening clinics at sites not under the control of a hospital.
  - There is no EMTALA obligation at these sites.

Every hospital or CAH with a dedicated emergency department (ED) is required to conduct an appropriate MSE of all individuals who come to the ED, including individuals who are suspected of having COVID-19, regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate COVID-19 screening criteria when applicable, to immediately identify and isolate individuals who meet the screening criteria to be a potential COVID-19 patient and to contact their state or local public health officials to determine next steps when an individual meeting the screening criteria is found.[2]

In the case of individuals with suspected or confirmed COVID-19, hospitals and CAHs are expected to consider the current guidance of CDC and public health officials in determining whether they have the capability to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers. In the event of any EMTALA complaints alleging inappropriate transfers or refusal to accept appropriate transfers, CMS will take into consideration the public health guidance in effect at the time.

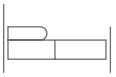
Additional details and scenarios are discussed at: https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf

Verbal Orders

CMS is waiving the requirements of 42 CFR §482.23, §482.24 and §485.635(d)(3) to provide additional flexibility related to verbal orders where readback verification is required, but authentication may occur later than 48 hours.

- ✓ If verbal orders are used for the use of drugs and biologicals (except immunizations), they are to be used infrequently.

- ✓ All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient.
- ✓ Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders.
- ✓ Although the regulation requires that medication administration be based on a written, signed order, this does not preclude the CAH from using verbal orders. A practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact.



Restraint Reporting Requirements

CMS is waiving the requirements which require that hospitals report patients in an intensive care unit whose death is caused by their disease, but who required soft wrist restraints to prevent pulling tubes/IVs, no later than the close of business on the next business day.

Due to current hospital surge, CMS is waiving this requirement to ensure that hospitals are focusing on increased patient care demands and increased patient census, provided any death where the restraint may have contributed is still reported within standard time limits (i.e., close of business on the next business day following knowledge of the patient's death).

Patient Rights

CMS is waiving requirements only for hospitals that are impacted by a widespread outbreak of COVID-19. Hospitals that are in a state which has widespread confirmed cases (i.e., 51 or more confirmed cases*) as updated on the CDC website, CDC States Reporting Cases of COVID-19, would not be required to meet the following requirements.

- ✓ With respect to timeframes in providing a copy of a medical record.
- ✓ Related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes.
- ✓ Regarding seclusion.

Medicare Physician Supervision

The physician can enter a contractual arrangement that meets the definition of auxiliary personnel at 42 CFR 410.26.

- ✓ Including with staff of another provider/supplier type, such as a home health agency or a qualified home infusion therapy supplier, or entities that furnish ambulance services, that can provide the staff and technology necessary to provide care that would ordinarily be provided incident to a physicians' service (including services that can be performed via telehealth).
- ✓ In such instances, the provider/supplier would seek payment for any services provided by auxiliary personnel from the billing practitioner and would not submit claims to Medicare for such services.

Direct physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.

CMS is waiving 482.12(c)(1-2) and (4), which requires that Medicare patients in the hospital be under the care of a physician. This allows hospitals to use other practitioners, such as physician's assistant and nurse practitioners, fully possible. This waiver should be implemented in accordance with a state's emergency preparedness or pandemic plan.

Under current rules, Medicare payment is made for services by a teaching physician involving residents only if the physician is physically present for the service or procedure.

- ✓ Teaching physicians can provide services with medical residents virtually through audio/video real-time communications technology.
- ✓ This does not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.
- ✓ This allows teaching hospitals to maximize their workforce to safely take care of patients.[3]

Provider Enrollment

CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met.

- ✓ Must be enrolled as such in the Medicare program.
- ✓ Must possess a valid license to practice in the state which relates to his or her Medicare enrollment.
- ✓ Is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring to contribute to relief efforts in his or her professional capacity.
- ✓ Is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area.

For the physician or non-physician practitioner to avail him or herself of the 1135 waiver under the conditions described above, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.

CMS has established toll-free hotlines for physicians, non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges. CMS is providing the following flexibilities for provider enrollment.

- ✓ Waive certain screening requirements.
- ✓ Postpone all revalidation actions.
- ✓ Allow licensed physicians and other practitioners to bill Medicare for services provided outside of their state of enrollment.
- ✓ Expedite any pending or new applications from providers.
- ✓ Allow practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from your currently enrolled location.
- ✓ Allow opted-out practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.

"Stark Law" Waivers

The physician self-referral law (also known as the "Stark Law") prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in short, a physician cannot refer a patient to any entity with which he or she has a financial relationship.

CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. The following is a summary of issues addressed however **numerous details** surrounding these waivers may be found at: https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf.

- ✓ Hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians (or vice versa).
  - For example, a physician practice may be willing to rent or sell needed equipment to a hospital at a price that is below what the practice could charge another party; or,
  - A hospital may provide space on hospital grounds at no charge to a physician who is willing to treat patients who seek care at the hospital but are not appropriate for emergency department or inpatient care.
- ✓ Health care providers can support each other financially to ensure continuity of health care operations.
  - For example, a physician owner of a hospital may make a personal loan to the hospital without charging interest at a fair market rate so that the hospital can make payroll or pay its vendors.
- ✓ Hospitals can provide benefits to their medical staffs, such as multiple daily meals, laundry service to launder soiled personal clothing, or childcare services while the physicians are at the hospital and engaging in activities that benefit the hospital and its patients.
- ✓ Allowing the provision of certain items and services that are solely related to COVID-19 purposes (as defined in the waivers), even when the provision of the items or services would exceed the annual non-monetary compensation cap.
  - For example, a home health agency may provide continuing medical education to physicians in the community on the latest care protocols for homebound patients with COVID-19, or a hospital may provide isolation shelter or meals to the family of a physician who was exposed to the novel coronavirus while working in the hospital's emergency department.

- ✓ Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms, even though such expansion would otherwise be prohibited under the Stark Law.
  - For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the COVID-19 pandemic in the United States.
- ✓ Loosen some of the restrictions when a group practice can furnish medically necessary designated health services (DHS) in a patient's home.
  - For example, any physician in the group may order medically necessary DHS that is furnished to a patient by a technician or nurse in the patient's home contemporaneously with a physician service that is furnished via telehealth by the physician who ordered the DHS.
- ✓ Group practices can furnish medically necessary MRIs, CT scans or clinical laboratory services from locations like mobile vans in parking lots that the group practice rents on a part-time basis.

Signature Requirements

CMS is waiving signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.

Guidance

- ✓ Review, implement and monitor revised EMTALA guidelines to ensure compliance in all settings.
- ✓ Review waiver for delayed signature and use of verbal orders. Determine if terms of the waiver will be implemented and educate all applicable staff.
- ✓ Review guidelines regarding deaths related to restraint use and ensure compliance with reporting guidelines.
- ✓ Ensure patient rights are waived only in the circumstances outlined and monitor for compliance.
- ✓ Review guidelines for physician supervision and use of alternative providers. Determine the elements that will be implemented at the hospital and ensure the medical staff and other key staff are involved and conversant with the provisions put in place.
- ✓ Allow waiver of Stark guidelines in conjunction with the hospital's Compliance Officer and committee when appropriate to facilitate care and safety of patient and staff.
- ✓ In those settings where it is applicable educate staff impacted by the signature requirement changes for delivery of Part B or DME.

Sources

1. https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf
2. https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf
3. https://www.cms.gov/files/document/covid-teaching-hospitals.pdf ■

Financial updates

Background

Accelerated/Advance Payments

Accelerated and Advance Medicare payments provide emergency funding and addresses cash flow issues based on historical payments when there is disruption in claims submission and/or claims processing. These expedited payments are typically offered in natural disasters to accelerate cash flow to the impacted health care providers and suppliers. In this situation, CMS is expanding the program for all Medicare providers throughout the country during the public health emergency related to COVID-19. The payments can be requested by hospitals, doctors, durable medical equipment suppliers and other Medicare Part A and Part B providers and suppliers.

To qualify for Accelerated or Advance Medicare payments, the provider or supplier must:

1. Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form,
2. Not be in bankruptcy,
3. Not be under active medical review or program integrity investigation, and
4. Not have any outstanding delinquent Medicare overpayments.

Medicare will start accepting and processing the Accelerated/Advance payment requests immediately.

Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these Accelerated/Advance payments begins at 90 days; however, for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these Accelerated/Advance payments to begin 120 days after the date of issuance of the payment.[1]

Providers can get more information on this process here: www.cms.gov/files/document/Acceleratedand-Advanced-Payments-Fact-Sheet.pdf

Medicare Appeals in Fee for Service, Medicare Advantage (MA) and Part D

1. CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), to allow extensions to file an appeal.
2. CMS is allowing MACs and QICs in the FFS program and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if:
    a. The enrollee requests the extension;
    b. The extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or
    c. The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest.
3. CMS is allowing MACs and QICs in the FFS program and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even with incomplete Appointment of Representation forms. However, any communications will only be sent to the beneficiary.
4. CMS is allowing MACs and QICs in the FFS program and MA and Part D plans, as well as the Part C and Part D IREs to process requests for appeal that don't meet the required elements using information that is available.
5. CMS is allowing MACs and QICs in the FFS program and MA and Part D plans, as well as the Part C and Part D IREs, to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Medical Review

CMS has suspended most Medicare Fee-For-Service (FFS) medical review during the emergency period due to the COVID-19 pandemic. This includes pre-payment medical reviews conducted by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate program, and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC).

No additional documentation requests will be issued for the duration of the PHE for the COVID-19 pandemic. Targeted Probe and Educate reviews that are in process will be suspended and claims will be released and paid. Current post payment MAC, SMRC, and RAC reviews will be suspended and released from review. This suspension of medical review activities is for the duration of the PHE. However, CMS may conduct medical reviews during or after the PHE if there is an indication of potential fraud.

Changes to MIPS

CMS is making two updates to the Merit-based Incentive Payment System (MIPS) in the Quality Payment Program. CMS is modifying the MIPS Extreme and Uncontrollable Circumstances policy to allow clinicians who have been adversely affected by the COVID-19 public health emergency to apply and request reweighting of the MIPS performance categories for the 2019 performance year. This is an important change that allows clinicians who have been impacted by the COVID-19 outbreak and may be unable to submit their MIPS data during the current submission period, to request reweighting and potentially receive a neutral MIPS payment adjustment for the 2021 payment year.

Additionally, CMS is adding one new Improvement Activity for the CY 2020 performance year that, if selected, would provide high-weighted credit for clinicians within the MIPS Improvement Activities performance category. Clinicians will receive credit for this Improvement Activity by participating in a clinical trial utilizing a drug or biological product to treat a patient with COVID-19 and then reporting their findings to a clinical data repository or clinical data registry. This would help contribute to a clinicians overall MIPS final score, while providing important data to help treat patients and address the current COVID-19 pandemic.

Resident Time at Alternate Locations

Existing regulations have specific rules on when a hospital may count a resident for purposes of Medicare direct graduate medical education (DGME) payments or indirect medical education (IME) payments. Currently, if the resident is performing activities with the scope of his/her approved program in his/her own home, or a patient's home, the hospital may not count the resident.

A hospital that is paying the resident's salary and fringe benefits for the time that the resident is at home or in a patient's home, but performing duties within the scope of the approved residency program and meets appropriate physician supervision requirements can claim that resident for IME and DGME purposes. This allows medical residents to perform their duties in alternate locations, including their home or a patient's home so long as it meets appropriate physician supervision requirements.[2]

Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission

CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. CMS is currently granting an extension for data submission for hospitals nationwide affected by COVID-19 until August 3, 2020. If hospitals encounter difficulty meeting this extended deadline date, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Cost Reporting

CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. CMS is currently authorizing delay for the following fiscal year end (FYE) dates.

1. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020.
2. The extended cost report due dates for these October and November FYEs will be June 30, 2020.
3. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020.
4. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020.

Guidance

1. Determine if the provider is eligible for Accelerated/Advance payments and apply if applicable to CMS as directed.
2. Review guidelines and waivers for appeals and pending medical reviews and modify or suspend activities as needed.
3. Anticipate release of claims currently held due to medical review.
4. Assess impact of changes to MIPS and Resident time calculations.
5. Note delayed dates for submission of Wage Index Occupational Mix and Cost Reporting data.

Sources

1. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
2. https://www.cms.gov/files/document/covid-teaching-hospitals.pdf ■

Laboratory waiver update

Background

New laboratory waivers released on March 30, 2020 introduce additional flexibilities and further expansion of previous waivers. These waivers are **retroactive back to March 1, 2020**.

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A summary of these provisions can be found at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Additional links related to Coronavirus waivers and flexibilities can be found at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Clinical Laboratory Improvement Act (CLIA) Guidance

Health plans are directed to pay providers of laboratory services the full negotiated rate or, if the provider and plan do not have a contract in place, they must reimburse the provider the cash price for the service. Each provider of such laboratory services will be required to post a cash price for COVID-19 testing on a public website and failure to comply could result in civil monetary penalties.[1]

CMS is allowing laboratories within a hospital/University Hospital Campus to hold a single certificate for the laboratory sites within the same physical location or street address to expand testing capacity in these shared locations. CMS has clarified that alternate specimen collection devices and media may be used to collect and transport COVID-19 samples.

CMS guidelines state that a CLIA program is unable to approve section 1135 waiver requests with respect to waivers of CLIA program requirements. The section 1135 waiver authority is only applicable to specified programs (or penalties) authorized by the Social Security Act (SSA). The CLIA program does not fall into this category of programs. CMS does not have the authority to grant waivers or exceptions that are not established in statute or regulation. However, "CMS is willing to explore flexibilities, as we have, under our current authorities."[2]

- ✓ CMS will allow laboratories to utilize temporary testing sites for remote review and reporting of laboratory data/slides/images if specific criteria are met. See QSOG memo at: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/clinical-laboratory-improvement-amendments-clia-laboratory-guidance-during-covid-19-public-health.
- ✓ If the laboratory is performing proficiency testing (PT) and providing patient results, PT is still required and must be performed, as required by the CLIA regulations. Details for actions required if PT activities are suspended may be found at: https://www.cms.gov/files/document/clia-laboratory-covid-19-emergency-frequently-asked-questions.pdf.
- ✓ To perform COVID-19 testing labs must be a CLIA-certified laboratory that meets applicable regulatory requirements. To apply for a CLIA certificate, submit the application form (CMS-116, CLIA Application Form) to the state (SA Contacts) where the laboratory is located.
- ✓ Almost all current Emergency Use Authorization (EUA)-authorized tests for COVID-19 are FDA-authorized for use by laboratories that meet the CLIA requirements for either moderate or high complexity testing. Therefore, testing personnel must meet the appropriate moderate or high complexity CLIA testing personnel qualification requirements depending on which EUA authorized tests are being used by the laboratory
- ✓ If the facility has the appropriate CLIA certificates and follows applicable CLIA regulations, state regulations and guidelines, the laboratory may perform testing in the parking lot or any other designated overflow location in its facility.
- ✓ Laboratories with questions related to biosafety levels should consult CDC biosafety guidance found at: https://www.cdc.gov/coronavirus/2019-nCoV/lab/lab-biosafety-guidelines.html. The Lab may also email the CDC at DLSinquires@cdc.gov.

CMS COVID-19 Specimen Collection

To identify and reimburse specimen collection for COVID-19 testing, CMS established two HCPCS codes, effective with line item date of service on or after March 1, 2020. The following codes are billable by clinical diagnostic laboratories.

- ✓ **G2023** – *Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source*
- ✓ **G2024** – *Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source*

Medicare will pay when laboratories can send trained technicians to a beneficiary's home, including a nursing home, to collect a sample for COVID-19 diagnostic testing.

- ✓ Medicare will pay a collection fee and the travel cost.
- ✓ The nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally is $23.46 and for individuals in a SNF or whose samples are collected by a laboratory on behalf of an HHA is $25.46.

If a patient is already receiving Medicare home health services, the home health nurse, during an otherwise covered visit, could obtain the sample to send to the laboratory for COVID-19 diagnostic testing.

If a visiting nurse has an otherwise covered RHC or FQHC visit, they can obtain a sample to send to the laboratory for COVID-19 diagnostic testing.

- ✓ Any RHC/FQHC visiting nurse service solely to obtain a nasal or throat culture would not be considered a nursing service because it would not require the skills of a nurse to obtain the culture as the specimen could be obtained by an appropriately-trained medical assistant or laboratory technician.[3]

Data Collection

In a bulletin released on Sunday, March 29th CMS indicated the White House Coronavirus Task Force is already collecting data from public health labs and private laboratory companies but does not have data from hospital labs that conduct laboratory testing in their hospital. According to CMS this hospital data is needed at the federal level to support the Federal Emergency Management Agency (FEMA) and CDC in their efforts to support states and localities in addressing and responding to the virus.

CMS further indicated that Academic, University and Hospital "in-house" labs are performing thousands of COVID-19 tests each day, but unlike private laboratories, the full results are not shared with government agencies working to track and analyze the virus.[4]

The bulletin refers to a letter sent by Vice President Pence to hospital Administrators with a request for data from these "in-house" labs along with instruction for reporting the data to HHS each day and to the CDC's NHSN.[5] A spreadsheet template was attached to the letter to facilitate the data collection.

- ✓ Hospitals that submit all their COVID-19 testing to a private lab on the list below will not need to submit results data.
  - Arup Laboratories
  - Mayo Clinic Laboratories
  - Quest Diagnostics
  - LabCorp
  - BioReference Laboratories
- ✓ Hospitals where testing is done through a Lab not on this list should send the completed spreadsheet, due every day at 5pm ET via email to fema-hhs-covid-diagnostics-tf@fema.dhs.gov.
- ✓ All hospitals should be submitting data daily through the National Healthcare Safety Network (NHSN) Covid-19 Patient Impact and Hospital Capacity Module which has been made available as of March 27, 2020.
  - Although most hospitals already submit data to NHSN on healthcare associated infections for purposes of CMS reporting the data that is now being requested is to monitor the spread of severe COVID-19 illness and death as well as the impact to hospitals.
  - Current users of NHSN received an email from the CDC with instructions on how to report to this new module.
  - For questions on this module email NHSN@CDC.gov and place COVID-19 Module in the subject line.

Guidance

- ✓ Review guidelines prior to implementing in-house COVID-19 testing.
- ✓ Add specimen collection codes/charges to the chargemaster (CDM) and implement charge capture strategies.
- ✓ Utilize all alternative options to collect specimens at home when possible.
- ✓ Based on where COVID-19 testing is being performed determine if the hospital needs to engage in data submission activities.
- ✓ Educate applicable staff to submit required data through NHSN.

Sources

1. https://www.aha.org/special-bulletin/2020-03-26-senate-passes-coronavirus-aid-relief-and-economic-security-cares-act
2. https://www.cms.gov/files/document/clia-laboratory-covid-19-emergency-frequently-asked-questions.pdf
3. https://www.cms.gov/files/document/covid-rural-health-clinics.pdf
4. CMS Bulletin, Special Edition, March 29, 2020.
5. https://www.cms.gov/files/document/32920-hospital-letter-vice-president-pence.pdf ■

CARES Act waivers

Background

New waivers released by CMS on March 30, 2020 introduce new flexibilities and further expansion of previous waivers. These waivers are **retroactive back to March 1, 2020**.

A summary of these provisions can be found at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Additional links related to Coronavirus waivers and flexibilities can be found at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Following are some of the key issues.

Hospital Services

Temporary Expansion Sites. As part of the CMS Hospital Without Walls initiative, hospitals can provide hospital services in other healthcare facilities and sites not currently considered to be part of a healthcare facility or set up temporary expansion sites to help address the urgent need to increase capacity to care for patients. Previously, hospitals were required to provide services to patients within their hospital departments and have shared concerns about capacity for treating patients during the COVID-19 Public Health Emergency, especially those requiring ventilator and intensive care services.

CMS is providing additional flexibilities for hospitals to create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations or sites not considered part of a healthcare facility such as hotels or community facilities. CMS is allowing hospitals to screen patients at offsite locations, furnish inpatient and outpatient services at temporary expansion sites. Hospitals would still be expected to control and oversee the services provided at an alternative location.

Written policies and procedures for appraisal of emergencies at off campus hospital departments specify that CMS is waiving 482.12(f)(3) related to Emergency services, with respect to the surge facility(ies) only, such that written policies and procedures for staff to use when evaluating emergencies are not required for surge facilities. 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 should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

Emergency preparedness policies and procedures specify that CMS is waiving 482.15(b) and 485.625(b), which requires the hospital and CAH 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 with respect to the surge site. 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. This would not be an expectation for temporary expansion site.

Pharmacy Sterile Compounding. CMS is waiving requirements in order to allow used face masks to be removed and retained in the compounding area to be redonned and reused during the same work shift in the compounding area only. This will conserve scarce face mask supplies. CMS will not review the use and storage of face masks under these requirements.

Medical Staff. CMS is waiving requirements which requires that Medicare patients be under the care of a physician. This waiver may be implemented so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. This allows hospitals to use other practitioners to the extent possible.

For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.

CMS is waiving requirements 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 related to COVID-19. CMS is waiving §482.22(a) (1)-(4) regarding details of the credentialing and privileging process.

CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following five conditions are met:

1. Must be enrolled as such in the Medicare program.
2. Must possess a valid license to practice in the state which relates to his or her Medicare enrollment.
3. Is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring to contribute to relief efforts in his or her professional capacity.
4. Is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area.
5. For the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.

Anesthesia Services. CMS is waiving requirements that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician. CRNA supervision will be at the discretion of the hospital and state law. This waiver applies to hospitals, CAHs, and Ambulatory Surgical Centers (ASCs). These waivers will allow CRNAs to fully function to the extent of their licensure and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

Nursing Services. CMS is waiving the requirements which require the following.

- ✓ The nursing staff to develop and keep current a nursing care plan for each patient.
- ✓ The hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present.
- ✓ Hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely of lower priority. These flexibilities apply to both hospitals and CAHs and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

Organ Procurement. Ensuring that individuals have continued access to life-saving organs is critical. CMS understands that hospitals are preparing for a surge in COVID-19 patients and makes the following statement: "we would ask that donor hospitals continue with normal operations regarding allowing organ procurement coordinators into hospitals to discuss organ donation with families wherever possible. Hospital and Organ Procurement Organization (OPO) leadership should communicate on risk assessments in their communities and any potential impacts for organ recovery operations."[1]

Respiratory care services. CMS is waiving the requirement that requires hospitals to designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures.

These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/ emergency plan. Not being required to designate these professionals in writing will allow qualified professionals to fully operate to the extent of their licensure and training in providing patient care for respiratory illnesses.

National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) on Respiratory Related Devices, Oxygen and Oxygen Equipment, Home Infusion Pumps and Home Anticoagulation Therapy now allow clinicians to have maximum flexibility in determining patient needs for respiratory related devices and equipment and the flexibility for more patients to manage their treatments at the home. The current NCDs and LCDs that restrict coverage of these devices and services to patients with certain clinical characteristics do not apply during the public health emergency. For example, Medicare will cover non-invasive ventilators, respiratory assist devices and continuous positive airway pressure devices based on the clinician's assessment of the patient.

Medical Records. CMS is waiving requirements which cover the following subjects and these flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- ✓ Organization and staffing of the medical records department.
- ✓ Requirements for the form and content of the medical record.
- ✓ Record retention requirements.
- ✓ Flexibility with completion of medical records within 30 days following discharge from a hospital.

Critical Access Hospitals. CMS is waiving specific personnel qualifications and staff licensure requirements.

- ✓ **Personnel qualifications**. CMS is waiving the minimum personnel qualifications for clinical nurse specialist, nurse practitioners, and physician assistants described in federal guidelines. Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants will still have to meet state requirements for licensure and scope of practice, but not additional Federal requirements that may exceed State requirements. This will give States and facilities more flexibility in using clinicians in these roles to meet increased demand. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.
- ✓ **Staff licensure**: CMS is deferring to staff licensure, certification, or registration to State law by waiving the requirement that staff of the CAH be licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations. The CAH and its staff must still follow applicable Federal, State and Local laws and regulations, and all patient care must be furnished in compliance with State and local laws and regulations. This waiver would defer all licensure, certification, and registration requirements for CAH staff to the state, which would add flexibility where Federal requirements are more stringent. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.

RHCs and FQHCs

RHCs and FQHCs can provide visiting nursing services to a beneficiary's home with fewer requirements, making it easier for beneficiaries to get care from their home.

- ✓ Any area typically served by the RHC, and any area that is included in the FQHCs service area plan, is determined to have a shortage of home health agencies, and no request for this determination is required.
- ✓ Any RHC/FQHC visiting nurse service solely to obtain a nasal or throat culture would not be considered a nursing service because it would not require the skills of a nurse to obtain the culture as the specimen could be obtained by an appropriately-trained medical assistant or laboratory technician.[2]
- ✓ The revised definition of "homebound" will apply to RHCs and FQHCs.

Home Health

A variety of waivers addressing assessments, oversight, signatures, etc. have been issued and further details can be found at: https://www.cms.gov/files/document/covid-home-health-agencies.pdf.

- ✓ Medicaid home health regulations now allow non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, and physical therapy, occupational therapy or speech pathology and audiology services, in accordance with state scope of practice laws.
- ✓ CMS is waiving the requirements which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period. This waiver is temporarily suspending the 2-week aide supervision requirement by a registered nurse for home health agencies, but virtual supervision is encouraged during the period of the waiver.

Hospice

Like Home Health several waivers have been issued related to hospice volunteers and oversight. These waivers may be viewed at: https://www.cms.gov/files/document/covid-hospices.pdf.

Guidance

- ✓ Review guidance related to alternative/surge sites and ensure all criteria is adhered to.
- ✓ Utilize waiver to conserve masks in Pharmacy sterile compounding area.
- ✓ Review medical staff waivers with the Medical Executive Committee/Chief of Staff and determine elements to be implemented. Convey strategies to all applicable staff.
- ✓ Compare CMS waiver for CRNA supervision to state requirements and implement as appropriate.
- ✓ Determine if the hospital will suspend nursing care plans and if so, educate all applicable staff.
- ✓ Review waivers for Respiratory Therapy and compare to state requirements before implementing any change in staffing.
- ✓ Review medical waivers with the Director of Medical Records and implement accordingly.
- ✓ Review waivers for non-acute care settings that are part of the Health System and implement as appropriate.

Sources

1. https://www.cms.gov/files/document/qso-20-13-hospitals-cahs-revised.pdf
2. https://www.cms.gov/files/document/covid-rural-health-clinics.pdf ■

Utilization review/case management updates

Background

Utilization Review

CMS is waiving certain requirements which address the statutory basis for hospitals and includes the requirement that hospitals participating in Medicare and Medicaid must have a utilization review plan that meets specified requirements.

- ✓ CMS is waiving the entire Utilization Review (UR) condition of participation which requires that a hospital must have a UR plan with a UR committee that provides for a review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

The intent of removing these administrative requirements is to allow hospitals to focus more resources on providing direct patient care.

Detailed Discharge Planning for Hospitals and CAHs

CMS is waiving the requirement to provide detailed information regarding discharge planning, described below:

- ✓ The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. The hospital must ensure that the post-acute care data on quality measures and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
- ✓ Medicare's Discharge Planning Regulations (which were updated in November 2019) requires that hospitals assess the patient's needs for post-hospital services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.[1]

During the Public Health Emergency (PHE), assisting patients in utilizing publicly reported quality data to select a post-acute provider will not be enforced, but hospitals must still work with patients and families to ensure the patient discharge is to post-acute care that is able to meet the patient's needs.

Limiting Detailed Discharge Planning for Hospitals

CMS is waiving all the requirements related to post-acute care services to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS is waiving the more detailed requirement that hospitals ensure those patients are discharged home and referred for HHA services, or transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, must:

- ✓ Include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient.
- ✓ Inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services.
- ✓ Identify in the discharge plan any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

These waivers acknowledge that due to the PHE a patient may not be able to receive a comprehensive list of nursing homes in the discharge area and make a choice of their ideal provider. However, the patient must still be discharged only to a post-acute provider able to meet the patient's specific care needs.

3-Day Stay

SNF care without a 3-day inpatient hospital stay will be covered for beneficiaries who experience dislocations or are otherwise affected by the emergency, such as those who are (1) evacuated from a nursing home in the emergency area, (2) discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients, or (3) need SNF care as a result of the emergency, regardless of whether that individual was in a hospital or nursing home prior to the emergency.

CMS will also provide renewed coverage for extended care services which will not first require starting a new spell of illness for such beneficiaries, who can then receive up to an additional 100 days of SNF Part A coverage for care needed as a result of the above-captioned emergency. This policy 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.

Home Bound

A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19. As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit.

Flexibility in Patient Self Determination Act Requirements (Advance Directives)

CMS is waiving the requirements which require hospitals and CAHs to provide information about their advance directive policies to patients.

Guidance

- ✓ Review waiver guidelines with Utilization Review/Case Management staff.
- ✓ Ensure patients receive sufficient information and discharge planning activities to meet the requirements outlined.
- ✓ Communicate revisions to the 3-day rule and homebound definition to key partners in the hospital's community to ensure patients can be transferred to another level of care efficiently.

Sources

1. https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2
2. https://www.cms.gov/files/document/coronavirus-snf-1812f-waiver.pdf ■

Condition code DR and Modifier CR update

Background

While CMS has provided technical direction in the use of Condition code DR and related Modifier CR for use during disasters and emergencies, the availability of clear clinical examples is lacking. nThrive has compiled the information currently available and will continue to provide updates as more information becomes available.

As part of its response to the 2005 *Katrina* hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed Condition code DR and Modifier CR to facilitate the processing of claims affected by that emergency.

Condition code DR and Modifier CR were also authorized for use on claims for items and services affected by subsequent emergencies. Based on that experience, the Medicare fee-for-service program is refining the uses of both the code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/suppliers in emergency situations without adding undue administrative burden associated with claim submission.

The definition of the Condition code DR, disaster related, requires it to be "used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster."

Condition code DR is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I.

In previous emergencies, use of the Condition code DR was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned **directly or indirectly** on the presence of a "formal waiver."

Modifier CR, *catastrophe/disaster related,* is used in relation to Part B items and services for **both institutional and non-institutional billing**. Non-institutional billing, i.e., claims submitted by "physicians and other suppliers", are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format.

Modifier CR is historically considered no longer discretionary but is mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned **directly or indirectly** on the presence of a "formal waiver." However late Friday, April 3, 2020 CMS released a corrective bulletin indicating that Modifier CR is not to be used on 1500 professional claims for Telehealth services.[1] Rather CMS states, professional providers "should report the place of service equal to what it would have been had the service been furnished in-person; and Modifier 95, indicating that the service rendered was actually performed via telehealth."

A "formal waiver" is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers.

1. Waiver of a requirement specified in Section 1135(b) of the Social Security Act (Act). Although Medicare payment rules themselves are not "waivable" under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred.
2. Waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the "3-day qualifying hospital stay" requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Social Security Act.

The use of Condition Code DR and Modifier CR indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.[2]

According to the Medicare Claims Manual the "DR condition code is used at the claim level when all of the services/items billed on the claim are related to the emergency/disaster."[3]

The Manual also indicates that claims from institutional billers must be annotated with a **condition code when the entire claim** is so related or with a modifier for each relevant line item **when only certain line items** are so related.

Although a unique condition code and modifier were issued for Gulf Oil Spill the Claims Manual does use this example which provides some clarity to how these emergency or disaster related codes are to be used:

> "In order to facilitate tracking of items and services provided for treatment of illnesses, injuries, or conditions that are related (directly or indirectly) to the Gulf oil spill, a new modifier and condition code have been established for providers and suppliers to use on claims specific to the aforementioned disaster. The modifier to be used for 2010 Gulf oil spill-related line items is CS. The condition code to be used for institutional claims is BP.
>
> Effective for dates of service on or after April 20, 2010, all providers and suppliers must annotate their claims with the new modifier and/or condition code (where applicable) when submitting **claims for beneficiaries whose illness, injury, or condition is caused or exacerbated by** the Gulf oil spill or circumstances related to the Gulf oil spill, including but not limited to subsequent clean-up activities."

Applying this to the COVID-19 Coronavirus Public Health Emergency (PHE) it would be apparent that patients admitted or treated for the disease itself have been affected by the PHE and the Condition code DR and Modifier CR would be applicable.

For patients hospitalized or receiving care unrelated to the COVID-19 Coronavirus it is less clear whether the provider needs to convey this information.

Due to the wide spread nature of the PHE and the volume of waivers that have been issued addressing topics that impact non-COVID-19 patients such as the waiver of Utilization Review and Case Management activities, assignment of attending practitioners, provider enrollment, medical record management, use of telehealth services; nThrive is recommending that all inpatient claims be assigned Condition code DR.

For Emergency Room, Mobile "Drive-Up" or COVID-19 Assessment Centers all claims would receive the Condition code DR. However, Modifier CR would only be applied to services related to COVID-19 Coronavirus.

> Example: A patient arriving with an arm fracture may be triaged outside prior to a decision for treatment. This would substantiate application of Condition code DR. Once the patient is examined the decision is made to send to Radiology for an x-ray. Neither the E.R. exam nor the Radiology exam is related to the PHE therefore would not be assigned Modifier CR.
>
> Example: A patient arrives with a fever, cough and shortness of breath. They are triaged outside prior to decisions for treatment. This substantiates application of Condition code DR. After exam the patient is placed in isolation and receives a portable chest x-ray. In this instance Modifier CR would be applied to the E.R. exam code and the Radiology exam as it relates to the PHE.

For the provision of scheduled, ordered services NOT modified by the fact that the hospital is under a Public Health Emergency (PHE) declaration neither Condition code DR nor Modifier CR would need to be applied. However, providers should be aware of all waivers being implemented at their facility including those affecting medical record completion, timely signatures, verbal orders, etc. If any of these are implemented scheduled outpatient claims should also report Condition code DR.

Guidance

- ✓ Identify all PHE related waivers being implemented at the facility.
- ✓ Establish a process for HIM coders to review outpatient claims and assign Modifier CR as outlined above.
- ✓ Task Patient Registration or the Billing Department with assignment of Condition code DR as outlined above.

Sources

1. CMS Special Edition Bulletin, April 3, 2020.
2. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6451.pdf
3. CMS Claims Manual, Pub 100-04, Chapter 38, Section 10. ■

Telehealth expansion

Background

Additional temporary emergency rules further expand telehealth services.[1] One of the goals of these actions is to increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home.

Under the public health emergency, all beneficiaries across the country can receive Medicare telehealth and other communications technology-based services wherever they are located.

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. During the public health emergencies, individuals can use interactive apps with audio and video capabilities to visit with their clinician for an even broader range of services. Providers also can evaluate beneficiaries who have audio phones only.

Providers can bill for telehealth visits at the same rate as in-person visits. In addition, providers can waive Medicare copayments for these telehealth services for beneficiaries in original Medicare.

Telehealth visits include emergency department visits, inpatient and observation visits, initial nursing facility and discharge visits, home visits, and therapy services, **which must be provided by a clinician who is allowed to provide telehealth**. New as well as established patients now may stay at home and conduct a telehealth visit with their provider.

While there is abundant information concerning the CMS 1500 and professional fee services, there is minimal information about submitting institutional billing, except when referencing an FQHC or RHC. This is reasonable, considering telehealth services were allowed only within Health Professional Shortage Areas (HPSA) prior to the Public Health Emergency. CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health.[2]

During a CMS Open Door Forum call on April 7, 2020 the question was asked if Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* could be applied to a facility claim and the response was positive that this modifier may also be used on the facility claim to indicate use of a telehealth mechanism.

Telehealth

To enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:

- ✓ Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- ✓ Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217-99220; CPT codes 99224-99226; CPT codes 99234-99236)
- ✓ Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238-99239)
- ✓ Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- ✓ Critical Care Services (CPT codes 99291-99292)
- ✓ Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327-99328; CPT codes 99334-99337)
- ✓ Home Visits, New and Established Patient, All levels (CPT codes 99341-99345; CPT codes 99347-99350)
- ✓ Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; CPT codes 99475-99476)
- ✓ Initial and Continuing Intensive Care Services (CPT code 99477-99478)
- ✓ Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- ✓ Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136-96139)
- ✓ Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- ✓ Radiation Treatment Management Services (CPT codes 77427)
- ✓ Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

A complete list of all Medicare telehealth services can be found here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Virtual Check-Ins & E-Visits

- ✓ Additionally, clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients.
- ✓ Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).
- ✓ A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients (CPT codes 98966-98968; 99441-99443).

Remote Patient Monitoring

- ✓ Clinicians can provide remote patient monitoring services to both new and established patients.
- ✓ These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494)

Removal of Frequency Limitations

The following services are no longer limited on the number of times they can be provided by Medicare telehealth:

- ✓ A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
- ✓ A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310).
- ✓ Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (HCPCS codes G0508-G0509).

Other Telehealth Topics

- ✓ Beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.
- ✓ Medicare patients with End Stage Renal Disease (ESRD).
  - Clinicians no longer must have one "hands on" visit per month for the current required clinical examination of the vascular access site.
  - For Medicare patients with ESRD, CMS will exercise enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.
  - CMS is modifying the requirement which 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 recommend exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.[3]
- ✓ Home Health Agencies (HHAs) can provide more services to beneficiaries using telehealth within the 30-day episode of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. CMS acknowledges that the use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care.
- ✓ Hospice providers can provide services to a Medicare patient receiving routine home care through telehealth, if it is feasible and appropriate to do so. Face-to-face encounters for purposes of patient recertification for the Medicare hospice benefit can now be conducted via telehealth.
- ✓ Nursing Homes:
  - 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.
  - Additional information can be found at: https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf
- ✓ To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.
- ✓ According to a bulletin released by the American Hospital Association (AHA) "this legislation will waive the Section 1834(m) restriction on FQHCs and RHCs that prohibits them from serving as distant sites. Specifically, during the emergency period, FQHCs and RHCs will be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. The legislation will reimburse FQHCs and RHCs at a rate that is similar to payment for comparable telehealth services under the physician fee schedule."[4]

Guidance

- ✓ Implement strategies to utilize newly added telehealth services to minimize patient and staff exposure.
- ✓ Determine staff eligible to report virtual and telehealth services and create charge capture mechanisms for these new services.
- ✓ Release any claims that were held pending direction from CMS by appending Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* to indicate the service was provided by Telehealth.
- ✓ Ensure documentation supports services rendered and billed.
- ✓ Review guidelines for non-hospital settings and implement telehealth services as appropriate.

Sources

1. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
2. https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19
3. https://www.cms.gov/files/document/covid-19-esrd-facilities.pdf
4. https://www.aha.org/special-bulletin/2020-03-26-senate-passes-coronavirus-aid-relief-and-economic-security-cares-act ■

Inpatient hospital care update

Background

During the COVID-19 Coronavirus Public Health Emergency (PHE) regarding inpatient hospital care CMS as stated that:

> "There may be times when beneficiaries with the virus need to be quarantined in a hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the hospital for public health reasons.
>
> Patients who would have been otherwise discharged from the hospital after an inpatient stay, but are instead remaining in the hospital under quarantine, would not have to pay an additional deductible for quarantine in a hospital.
>
> If a Medicare beneficiary is a hospital inpatient for medically necessary care, Medicare will pay hospitals the diagnosis-related group (DRG) rate and any cost outliers for the entire stay, including any quarantine time when the patient does not meet the need for acute inpatient care, until the Medicare patient is discharged. The DRG rate (and cost outliers as applicable) includes the payments for when a patient needs to be isolated or quarantined in a private room."[1]

The new diagnosis code, U07.1, COVID-19, has been implemented, effective April 1, 2020.

As a result, CMS has released an updated ICD-10 MS-DRG GROUPER software package to accommodate the new ICD-10-CM diagnosis code effective with discharges on and after April 1, 2020. The new software package is available on the CMS MS-DRG Classifications and Software webpage.[2]

CMS further indicates that "this updated GROUPER software package (V37.1 R1) replaces the GROUPER software package V37.1 that was developed in response to the new ICD-10-CM diagnosis code U07.0, Vaping-related disorder, also effective with discharges on and after April 1, 2020, that is currently available on the MS-DRG Classifications and Software webpage. Providers should use this new code, U07.1, where appropriate, for discharges on or after April 1, 2020."

The American Hospital Association summarized the CARES Act provision to allow a 20% add-on to the DRG rate for patients with COVID-19. This add-on will apply to patients treated at rural and urban inpatient prospective payment system (IPPS) hospitals.[3]

> "For discharges occurring during the emergency period described in section 1135(g)(1)(B), in the case of a discharge of an individual diagnosed with COVID–19, the Secretary shall increase the weighting factor that would otherwise apply to the diagnosis-related group to which the discharge is assigned by 20 percent. The Secretary shall identify a discharge of such an individual through the use of diagnosis codes, condition codes, or other such means as may be necessary."[4]

Guidance

1. Review guidance with applicable staff, specifically Utilization Review and Case Management.
2. Ensure accurate coding of confirmed COVID-19 Coronavirus cases.
3. Install updated DRG software package.
4. Monitor reimbursement to ensure appropriate payment with increase is received.

Sources

1. https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf
2. CMS Special Bulletin, April 3, 2020.
3. https://www.aha.org/special-bulletin/2020-03-26-senate-passes-coronavirus-aid-relief-and-economic-security-cares-act
4. H.R. 478, CARES Act, Section 3710. ■

Modifier CS cost-sharing coding update

Background

If coding claims during this Public Health Emergency (PHE) wasn't complex enough, CMS has introduced a new twist as they too struggle to operationalize and implement all the provisions of the CARES Act.

As our coders and billers know, modifiers tell the payer something additional about how the service was rendered or how the claim should be processed or paid.

On April 7, 2020 CMS released an MLN Special Edition which included an article that, according to the title, addresses the waiving of copays and deductibles.

On the surface, this may not have captured the interest of those preparing claims data. However, the article directs providers to utilize an additional modifier to indicate that the line-item service was related to the assessment for, or diagnosis of, COVID-19 whether it results in testing or not.

This change is retroactive to March 18, 2020 and continues through the end of the PHE. These services might have been provided face-to-face, by telehealth or by the Lab. Regardless, Modifier CS, *Cost Sharing Waived,* must be applied.

Initially, the article indicates that the waiver of cost-sharing referred to medical visits for the HCPCS evaluation and management categories listed when an outpatient provider, physician, or other provider and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002 or 87635.

However, the article goes on to state, "services that result in an order for or administration of a COVID-19 test are related to furnishing or administering such a test **or to the evaluation of an individual for purposes of determining the need for such a test**" are subject to the waiver of cost-sharing.[1] This would seem to indicate that if the visit relates to the assessment of COVID-19 symptoms, regardless of whether the patient is ultimately tested, that cost-sharing would not be applicable.

Modifier CS was initially created in April 2010 to facilitate tracking of items and services provided for treatment of illnesses, injuries, or conditions that are related (directly or indirectly) to the Gulf oil spill. It is being repurposed to identify claims where cost-sharing is being waived in relation to the new COVID-19 emergency.

The special bulletin announces that providers that have already submitted claims on or after March 18, 2020 must take additional action:

- ✓ For professional claims, physicians and practitioners who did not initially submit claims with the Modifier CS must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the Modifier CS to get 100% payment.
- ✓ For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the Modifier CS must resubmit applicable claims submitted on or after 3/18/2020, with the Modifier CS to visit lines to get 100% payment.

Modifier CS is applicable to the following list of services, in addition to laboratory test codes U0001, U0002 and 87635.

- ✓ Office and other outpatient services
- ✓ Hospital observation services
- ✓ Emergency department services
- ✓ Nursing facility services
- ✓ Domiciliary, rest home, or custodial care services
- ✓ Home services
- ✓ Online digital evaluation and management services

Additionally, Modifier CS is applicable to the following provider types:

- ✓ Hospital outpatient departments paid under the Outpatient Prospective Payment System
- ✓ Physicians and other professionals under the Physician Fee Schedule
- ✓ Critical Access Hospitals (CAHs)
- ✓ Rural Health Clinics (RHCs)
- ✓ Federally Qualified Health Centers (FQHCs)

Modifier CS is to be applied in addition to any other modifiers or condition codes that may also be required. (See the Condition Code DR and Modifier CR coding update published by nThrive on April 3, 2020).

Guidance

- ✓ Identify all areas where COVID-19 related services are provided.
- ✓ Develop an ongoing mechanism for sharing coding updates as they become available.
- ✓ Ensure print guidelines or coding tip sheets are replaced as new information is made available.
- ✓ Strategize mechanisms to identify claims related to the assessment and testing of patients related to COVID-19 and to apply Modifier CS and all other modifiers and condition codes as appropriate.

Sources

1. MLN Special Edition April 7, 2020. ■

CARES Act waivers part II

Background

During the emergency period, the CARES Act provides several waivers and flexibilities. nThrive has summarized some of the key provisions related to hospitals and health systems. A copy of H.R. 748 may be found at: https://www.majorityleader.gov/sites/democraticwhip.house.gov/files/Senate%20Amendment%20to%20H.R.%20748_0.pdf

A summary may also be found on the American Hospital Association site at: https://www.aha.org/special-bulletin/2020-03-26-senate-passes-coronavirus-aid-relief-and-economic-security-cares-act

nThrive has referenced both to provide a summary of some of the key provisions related to hospitals and health systems not otherwise covered in the specific coding updates.

Post-acute Care Flexibilities Waive (Section 3711)

Inpatient Rehabilitation Facility (IRF) 3-hour of therapy/day rule.

LTCH site-neutral payment policy.

LTCH "50% Rule".

Medicaid DSH Relief (Section 3813)

Eliminates the $4 billion in Medicaid DSH cuts in FY 2020.

Reduces the cut for FY 2021 to $4 billion from $8 billion.

Implementation of the FY 2021 cuts are delayed until December 1, 2020.

No additional cuts after the current end-date of FY 2025.

Home-based Services (Sections 3705-3708, 3715)

Reduces requirements that pertain to face-to-face evaluations for home dialysis patients.

Expands the ability of physician assistants, nurse practitioners and certified nurse specialists regarding the certification of home health services and document-related requirements.

Expands certain state and community-based services guidelines to include self-directed personal assistance services and attendant services and supports.

- ✓ Many of these policy changes also will apply to Medicaid home health services.

Nothing in this title, title XVIII, or title XI shall be construed as prohibiting receipt of any care or services specified in paragraph (1) in an acute care hospital that are:

- ✓ Identified in an individual's person-centered service plan (or comparable plan of care).
- ✓ Provided to meet needs of the individual that are not met through the provision of hospital services.
- ✓ Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law under another applicable requirement.
- ✓ Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

Supplies and Drugs (Section 3001)

Amends the Public Health Service Act to require that certain medical supplies and drugs be included in the strategic national stockpile. Specifically, it will require the inclusion of:

- ✓ Personal protective equipment.
- ✓ Ancillary medical supplies.
- ✓ Supplies necessary for the administration of drugs.
- ✓ Diagnostic tests.
- ✓ Vaccines.
- ✓ Other biologic products and medical devices.

Requires HHS to enter into an agreement with the National Academies to produce a report assessing and evaluating the medical device and pharmaceutical supply chain.

Includes the MEDS Act which:

- ✓ Requires additional manufacturer notification and reporting requirements in response to drug shortages.
- ✓ Requires Government Accountability Office to report on intra-agency coordination focused on drug manufacturing and application prioritization.
- ✓ Reports within two years of passage on encouraging the manufacturing of drugs in shortage or at risk of being in shortage.

Prevents device shortages.

- ✓ New requirements on device manufacturers to notify the HHS Secretary of potential or likely shortages due to discontinuance or interruption during or in advance of a public health emergency.
- ✓ Expedited inspection and review to curb any potential shortages.
- ✓ Specific devices that will be covered are those that are life-supporting, life-sustaining, used in emergency medical care or during surgery. The list will be made publicly available unless otherwise determined by the HHS Secretary and will include relevant information about the device and the reason for the shortage.

Coverage of COVID-19 Testing and Other Services (Sections 3201-3203, 3701)

Expands the types of diagnostic tests that will be covered to include laboratory tests that have not been approved by the FDA but meet certain conditions:

- ✓ Applicable state or territory has assumed responsibility for the validity of the tests.
- ✓ The legislation then directs certain commercial payers and public programs to cover this broader range of tests.

Directs health plans to pay providers of laboratory services the full negotiated rate or, if the provider and plan do not have a contract in place, they must reimburse the provider the cash price for the service.

- ✓ Each provider of such laboratory services will be required to post a cash price for COVID-19 testing on a public website and failure to comply could result in civil monetary penalties.

Requires Health plans to cover qualifying COVID-19 preventive services such as an item, service or immunization recommended by the US Preventive Services Task Force or CDC's Advisory Committee on Immunization Practices.

Requires High Deductible Health Plan (HDHP) with HSAs to cover telehealth services before a patient reaches his or her deductible amount.

Small Business Loans via the "Paycheck Protection Program" (Section 1102)

Makes available loan opportunities for organizations with less than 500 total employees (i.e., both full time and part time employees).

These loans may be up to $10 million and may be forgivable.

They could be used to pay:

- ✓ Salaries.
- ✓ Leave and health benefits.
- ✓ Rent.
- ✓ Retirement obligations.
- ✓ Other specific uses outlined in Section 1102.
- ✓ Both for-profit and non-profit hospitals will be eligible for these loans; however, affiliation rules will apply. The affiliation rules are intended to determine whether the organization, considering the "totality of circumstances," is operating as part of a larger organization and therefore not considered a small business, which will be evaluated on a case-by-case basis.

Blood Supply Awareness Campaign (Section 3226)

National campaign to improve awareness of, and support outreach to, public and health care providers about the importance and safety of blood donation and the need for donations for the blood supply during the public health emergency.

FMLA (Sections 3601-3602)

Amends changes to the family and medical leave and sick leave policies established by the Families First Coronavirus Response Act to limit the total amount employers may have to pay under each benefit, among other changes.

Substance Use Disorder Records (Section 3221)

Allows records pertaining to substance use disorder (SUD) treatment or other activities to be used or disclosed to covered entities for the purposes of treatment, payment or health care operations as permitted by HIPAA

- ✓ Requires patient's written consent

Allows disclosures of de-identified health information from these records to public health authorities as defined by HIPAA.

Prohibits the use of this information for use in any civil, criminal, administrative or legislative proceedings (except as otherwise authorized).

Inclusion of anti-discrimination clause ensuring that the information may not be used in decisions around treatment, employment, housing, access to courts or social services.

Patients will still have the right to request restrictions on the use or disclosure of their SUD treatment records.

HRSA Grants for Rural Entities (Sections 3211-3212)

Expands rural health care services.

- ✓ Outreach grants.
- ✓ Rural health network development grants.
- ✓ Small health care provider quality improvement grants.

Increases the time period of grants from three to five years.

Focuses the grants on assistance to rural underserved populations.

Removes the eligibility criterion of public or non-profit status for rural health care services outreach and rural health network development grants.

- ✓ Eligible entities must "be an entity with demonstrated experience serving, or the capacity to serve rural underserved populations"

Grants quality improvement activities related to:

- ✓ Increasing care coordination.
- ✓ Enhancing chronic disease management.
- ✓ Improving patient health outcomes.

Authorizes $79.5 million for each of fiscal years 2021 through 2025.

Requires a report on the activities and outcomes of these grant programs, including the impact of funded projects on the health status of rural residents with chronic conditions.

Guidance

- ✓ Share with appropriate staff.
- ✓ Review provisions of H.R. 478 to identify those that are applicable.
- ✓ Research additional information available prior to implementation. ■

Commercial cost sharing

Background

On Saturday, April 11, 2020 CMS, together with the Departments of Labor and the Treasury, issued guidance to ensure that Americans with private health insurance have coverage of COVID-19 diagnostic testing and certain other related services, including antibody testing, at no cost.

The **Families First Coronavirus Response Act (FFCRA)** was enacted on March 18, 2020. According to the FAQ released on April 11:

> "Section 6001 of the FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively in this document as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements."[1]

The **Coronavirus Aid, Relief, and Economic Security (CARES) Act** was enacted on March 27, 2020 and amended Section 6001 of the FFCRA:

> "Section 3201 of the CARES Act amended section 6001 of the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements or prior authorization or other medical management requirements.
>
> Additionally, section 3202 of the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price)."

The Acts apply to:

- ✓ Group health plans and health insurance issuers offering group or individual health insurance coverage including:
  - Grandfathered health plans as defined in section 1251(e) of the Patient Protection and Affordable Care Act.
  - Insured and self-insured group health plans.
  - Private employment-based group health plans (ERISA plans).
  - Non-federal governmental plans (such as plans sponsored by states and local governments).
  - Church plans.
- ✓ Individual health insurance coverage includes
  - Coverage offered in the individual market through or outside of an Exchange.
  - Student health insurance coverage (as defined in 45 CFR 147.145).

Section 6001 does not apply to:

- ✓ Short-term, limited-duration insurance (as defined in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103).
- ✓ Plan or coverage in relation to its provision of excepted benefits (as defined in 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), and 45 CFR 146.145(b) and 148.220).
- ✓ Group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate).

The Acts require plans and issuers to provide coverage for the following items and services provided on or after March 18, 2020.

- ✓ In vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of COVID-19 including administration of such a test that:
  - Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act.

- The developer has requested, or intends to request, emergency use authorization, unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe.
- Is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19.
- Includes other tests that the Secretary of HHS determines appropriate such as Serological tests for COVID-19 that are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19.

✓ Items and services furnished to an individual during health care provider visits that result in an order for or administration of an in vitro diagnostic product described above but only to the extent:

- Service was rendered during one of the following:
  - Office visits (which includes in-person visits and telehealth visits).
  - Urgent care center visits.
  - Emergency room visits.
  - COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing.

✓ Items and services relate to the furnishing or administration of the product

✓ Evaluation of the individual for purposes of determining the need of the individual for such product. If the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests.

Guidance

✓ Review guidelines with registration and collection staff to ensure the exemption to cost sharing is applied to all applicable groups.

✓ Refund out-of-pocket collections after March 18, 2020 related to these services.

✓ Follow specific commercial insurance instruction for use of Modifier CS, *Cost Sharing Waived,* or other guidance regarding claim submission.

Sources

1. https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf ■

FCC Telehealth Program

Background

According to a public bulletin released April 8, 2020 by the Federal Communications Commission (FCC) the "Wireline Competition Bureau (Bureau) provides guidance on actions applicants can begin to take to ready themselves for filing an application for COVID19 Telehealth Program funding. The COVID-19 Telehealth Program will provide $200 million in funding, appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID-19) pandemic.

The COVID-19 Telehealth Program will provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services until the program's funds have been expended or the COVID-19 pandemic has ended."[1]

The COVID-19 Telehealth Program will be open to receive applications effective upon publication of the Office of Management and Budget (OMB) approval in the Federal Register.

According to the bulletin there are three steps interested providers can take immediately to prepare to apply for the COVID-19 Telehealth Program.

1. Obtain an eligibility determination from the Universal Service Administrative Company (USAC);
2. Obtain an FCC Registration Number (FRN); and
3. Register with System for Award Management.

If providers do not already have these steps and accompanying components completed, the Bureau recommends that it gather the necessary information and begin to complete other necessary steps now, so it is prepared to submit applications for program funding as soon as applications can be accepted for filing.

Eligibility

The bulletin provides detailed instructions for health care providers seeking to participate in the COVID-19 Telehealth Program including the need to obtain an eligibility determination from the Universal Service Administrative Company (USAC) for each health care provider site that they include in their application.

The Telehealth Program is open to rural and non-rural providers and nonprofit and public eligible health care providers that fall within the following categories.

1. Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools.
2. Community health centers or health centers providing health care to migrants.
3. Local health departments or agencies.
4. Community mental health centers.
5. Not-for-profit hospitals.
6. Rural health clinics (Health care provider sites that USAC has already deemed eligible to participate in the Commission's existing Rural Health Care (RHC) Programs may rely on that eligibility determination for the COVID-19 Telehealth Program).
7. Skilled nursing facilities.
8. Consortia of health care providers consisting of one or more entities falling into the first seven categories (non-rural providers do not need to be part of a consortium to participate in the program).

The FCC directs interested health care providers that do not already have an eligibility determination to obtain one by filing an FCC Form 460 (Eligibility and Registration Form) with USAC. Providers may also file an application with Commission for the COVID-19 Telehealth Program while their FCC Form 460 is pending with USAC.

The FCC Form 460 can be found at: https://www.usac.org/rural-health-care/resources/forms/.

FCC Registration Number (FRN)

In addition to these steps for applying, and request for funding, the applicant must first obtain an FCC Registration Number (FRN). Additionally, to receive payment through the COVID-19 Telehealth Program, applicants must be registered with the federal System for Award Management.

While interested parties do not need to be registered with the System for Award Management in order to apply, the Bureau strongly encourages them to start that process early.

To obtain an FRN all applicants, like all other entities doing business with the Commission, must register for an FRN in the Commission Registration System (CORES). To register with CORES, providers are directed to use the following link: https://apps.fcc.gov/cores/userLogin.do.

Details for completing this step are outlined in the bulletin released by the FCC and referenced in this update. One piece of information needed is a DUNS number.

The Commission defines the DUNS number as a unique nine-character number used to identify the organization. The federal government uses the DUNS number to track how federal money is allocated. Most large organizations, libraries, colleges, and research universities already have a DUNS number.

If the provider is not certain if they have a DUNS number, they should contact their grant administrator, financial department, chief financial officer, or authorizing official to determine if one already exists for their organization. If your organization does not yet have a DUNS number, or no one knows it, providers are directed to the Dun & Bradstreet (D&B) website: https://fedgov.dnb.com/webform/displayHomePage.do.

Providers may also call 1-866-705-5711 to register or search for a DUNS number. Registering for a DUNS number is free of charge.

System for Award Management

The System for Award Management is a web-based, government-wide application that collects, validates, stores, and disseminates business information about the federal government's partners in support of federal awards, grants, and electronic payment processes.

Only applicants registered through the System for Award Management will be able to receive COVID-19 Telehealth Program funding.

Many applicants may already be registered with the System for Award Management and do not need to re-register with that system in order to receive payment through the COVID-19 Telehealth Program.

Health care providers not yet registered with the System for Award Management may still apply. However, the Bureau strongly recommends unregistered health care providers to start that registration process now because it may take up to 10 business days for the registration to become active and an additional 24 hours before that registration information is available in other government systems.

To register with the Award Management System, go to: https://www.sam.gov/SAM/. **Providers should be aware that they will need the DUNS number to complete this step.**

Guidance

1. Access the public bulletin available at the site provided and become familiar with the details of each of the three registration steps.
2. Gather all the necessary information needed to register and complete each step.
3. Confirm eligibility and obtain an FRN and DUNS number and complete registration with the Award Management System.
4. Prepare application for receiving funding.
5. Monitor the Federal Register site for the application open date published by the OMB and submit the prepared application.

Sources

1. https://docs.fcc.gov/public/attachments/DA-20-394A1.pdf ■