

## Article Detail

<b>Date:</b>	03/17/2020
<b>Title:</b>	COVID-19 Public Health Emergency: Blanket Waivers Issued for Medicare FFS
<b>Healthcare Type:</b>	All
<b>Source:</b>	COVID-19 Emergency Declaration Health Care Providers Fact Sheet ( <a href="https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf">https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf</a> ); Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) ( <a href="https://www.cms.gov/files/document/se20011.pdf">https://www.cms.gov/files/document/se20011.pdf</a> )
<b>Abstract:</b>	The Centers for Medicare and Medicaid Services (CMS) issued blanket waivers for certain payment requirements for Medicare fee-for-service care provided as result of the coronavirus pandemic public health emergency.

### Article Text

In response to the coronavirus pandemic, the Department of Health and Human Services has authorized waivers under and modifications to Medicare fee for service (FFS) requirements under section 1135 of the Social Security Act. The authorization is effective retroactive to March 1, 2020. The waivers will allow healthcare providers and facilities to be flexible in managing the anticipated needs of patients affected by the pandemic.

The Centers for Medicare and Medicaid Services (CMS) is issuing blanket waivers (not requiring individual applications) for Medicare FFS providers similar to those issued for past public health emergencies (PHE). They include:

#### Skilled nursing facilities (SNF)

- The 3-day prior hospitalization requirement for coverage has been waived so that SNFs can provide temporary emergency care as needed.
- SNF coverage can be renewed without starting a new benefit period for beneficiaries who have recently exhausted their SNF benefits.
- The timeframe requirements for Minimum Data Sets and transmission of data relating to assessments of residents' functional capacity (42 CFR 483.20) have been waived.

#### Critical access hospitals (CAH)

- CAHs do not have to limit the number of beds they have to 25 or keep the length of stay to 96 hours or less.

#### Durable medical equipment (DME)

- The requirement that a provider meet face to face, issue a new order for the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), or provide new documentation on medical necessity for a beneficiary who has lost DMEPOS, or whose DMEPOS has been destroyed, irreparably damaged, or otherwise made unusable, has been waived for contractors.

*Billing*—Suppliers must describe on the claim the reason for replacement and must maintain documentation of why the DMEPOS must be replaced.

#### Prescriptions

- Prescriptions for covered Part B drugs can be filled for up to the quantity originally dispensed when a patient's medications have been lost or made unusable because of the emergency.

#### Distinct part units

- Hospitals will be able to house acute care inpatients in distinct part units (DPU) excluded from the inpatient prospective payment system (IPPS) if needed and appropriate.

*Billing*—The medical record should include a note indicating that the beneficiary is an acute care inpatient being cared for in the excluded unit because of overcapacity issues elsewhere related to the PHE.

#### Excluded psychiatric DPUs

- Inpatients in excluded psychiatric DPUs can be moved to acute care beds and units if necessary to respond to the PHE. The acute care setting must be assessed as safe and not putting the patient at risk for harm to self or others.

*Billing*—Care for the inpatients can still be billed under the psychiatric IPPS as long as the medical record notes that they are being treated in an acute care bed because of capacity or other issues related to the PHE.

#### Excluded inpatient rehab DPUs

- As with patients in the psychiatric DPUs, inpatient rehab patients in DPUs may be moved to acute care beds and units as part of a response to the PHE. The patients must continue to receive appropriate intensive rehabilitation care.

- If an independent rehabilitation facility (IRF) or facility trying to obtain classification as an IRF admits a patient solely because of the virus emergency and the medical record reflects this fact, the facility will be able to exclude that patient from its inpatient population when calculating the applicable thresholds for qualifying for payment as an IRF (the 60 percent rule).  
*Billing*—Inpatient rehabilitation services should continue to be billed under the rehabilitation facility IPPS as long as the medical record notes that the patient is being cared for in an acute care bed because of capacity or other issues related to the PHE.

#### **Long-term care acute hospitals**

- Long-term care hospitals (LTCHs) will be able to exclude admits and discharges related to the emergency so that it can meet the 25-day average length of stay payment requirement for LTCHs.

#### **Home health agencies**

- Timeframe requirements related to OASIS transmission have been waived.
- Medicare administrative contractors can extend the auto-cancellation date of requests for anticipated payment (RAP).

#### **Provider enrollment**

- A toll-free hotline (yet to be established) will enable noncertified Part B suppliers, physicians, and nonphysician practitioners to receive temporary Medicare billing privileges.
  - The application fees, fingerprint-based criminal background checks, and site visit requirements will be waived during the emergency.
  - All revalidation actions will be postponed.
  - Licensed providers will be able to provide services outside of the state they are enrolled in.
  - Pending or new provider applications will be expedited.

#### **Care outside of state of licensure**

- Both Medicare and Medicaid providers will be able to care for patients in states where they are not licensed as long as they are licensed in another state.

#### **General Billing**

Medicare claims for services provided under the Social Security Act section 1135 or 1812(f), which applies specifically to SNF services provided without meeting the 3-day qualifying stay, and fall under waivers because of this PHE should include the following:

- A condition code of DR (disaster related) on institutional provider claims using ambulatory surgery center (ASC) X12 837 institutional claims format or paper form CMS-1450
- Modifier CR (Catastrophe/disaster related) for institutional and noninstitutional Part B claims submitted using the ASC X12 837 professional claim format or paper form CMS-1500 or, for pharmacies, in the NCPDP format

#### **Appeals**

- The deadline for providers to file appeals under Medicare, Medicare Advantage, or Part D will be extended.
- The timeliness requirement for responding to requests for additional information to adjudicate an appeal will be waived.
- Appeals with incomplete appointment of representation forms and communication only with the beneficiary will be processed.
- Appeals without required elements will be processed using available information.
- Appeals will be processed as if good cause requirements have been met.

#### **Medicaid and CHIP**

States can apply for waivers of federal requirements under section 1135 of the Social Security Act by merely describing the extent of the emergency and its impact on Medicaid and the Children's Health Insurance Program. Requests should be emailed directly to CMS at Jackie.Glaze@cms.hhs.gov.