

Inpatient Hospital Care Update

UPDATED INFO

See yellow highlights for updated content from previous published version.

Background

During the COVID-19 Coronavirus Public Health Emergency (PHE) regarding inpatient hospital care CMS 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, was implemented, effective April 1, 2020.

As a result, CMS 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 was made available on the CMS [MS-DRG Classifications and Software](#) webpage.²

CMS further indicated 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 was also 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, in their summary of the CARES Act, noted the provision by the legislation to allow a 20% add-on to the DRG rate for patients with COVID-19. This add-on applies 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

To address potential Medicare program integrity risks, “effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the MS-DRG weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient’s medical record.

Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission. For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient’s medical record to satisfy this documentation requirement.⁵

For example, a copy of a positive COVID-19 test result that was obtained a week before the admission from a local government run testing center can be added to the patient’s medical record. In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement.”

CMS has indicated that they may conduct post-payment reviews. If the positive test result is not present in the medical record the additional 20% payment will be recouped. The MLN article referenced indicates “a hospital that diagnoses a patient with COVID-19 consistent with the ICD-10-CM Official Coding and Reporting Guidelines but does not have evidence of a positive test result can decline,

at the time of claim submission, the additional payment resulting from the application at the time of claim payment of the 20 percent increase in the MS-DRG relative weight to avoid the repayment. To do so, the hospital will inform its MAC (no instruction for how to make this notification was provided in the article) and the MAC will notate the claim with MAC internal claim processing coding for processing. The Pricer software will not apply the 20 percent increase to the claim when that MAC internal claim processing coding is present on a claim with the ICD-10-CM diagnosis code U07.1 (COVID-19)."

On July 30, 2020 CMS announced due to new treatments developed for treatment of the COVID-19 Coronavirus, it is critical to be able to track the use of these treatments and their effectiveness in real-time. CMS responded to this need, implementing new procedure codes to allow Medicare and other insurers to identify the use of the therapeutics Remdesivir and convalescent plasma for treating hospital in-patients with COVID-19.⁶

The new codes effective August 1, 2020 enable CMS to conduct real-time surveillance and obtain real-world evidence in how these drugs are working and provide critical information on their effectiveness and how they can protect patients. These codes can be reported to Medicare and other insurers. They may also allow hospitals to use the codes to identify the use of COVID-19 therapies and help facilitate monitoring and data collection.

These new codes are being implemented into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS).

More information may be found at:

[ICD-10 MS-DRGs Version 37.2 Effective August 1](#)

The ICD-10 MS-DRG V37.2 Grouper Software, Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V37.2 manual will be available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html>

The Code Tables, Index and related Addenda files for the 12 new procedure codes are available at: <https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS>

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 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.
5. CMS MLN Matters, SE2015, August 17, 2020.
6. CMS MLN Matters, Special Edition, July 30, 2020. ■