COVID-19 CORONAVIRUS

Coding Updates

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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 ■