



Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

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Note: We revised the article to add a row at the end of the Waiver/Flexibility table (page 7) to address services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient. Also, we added the section on Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for **physicians**, providers and suppliers who bill Medicare Fee-For-Service (FFS).

PROVIDER INFORMATION AVAILABLE

The Secretary of the Department of Health & Human Services declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020 Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to March 1, 2020.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past 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.

More Information:

- [Coronavirus Waivers and Flexibilities](#) webpage
- [Instructions](#) to request an individual waiver if there is no blanket waiver

BACKGROUND

Section 1135 and Section 1812(f) Waivers

As a result of this PHE, 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.

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.

Clarification for Using the “CR” Modifier and “DR” Condition Code

When a PHE is declared and section 1135 authority is invoked, CMS has the authority to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Act, to approve blanket waivers of certain Social Security Act requirements. These waivers help prevent gaps in access to care for beneficiaries impacted by the emergency. In previous emergencies, CMS issued a limited number of waivers for the Medicare Fee-for-Service program. In order to allow CMS to assess the impact of prior emergencies, CMS has required the use of modifier “CR” and condition code “DR” for all services provided in a facility operating pursuant to CMS waivers that typically were in place, for limited geographical locations and durations of time.

For the COVID-19 PHE, CMS has issued many additional blanket waivers, flexibilities and modifications to existing deadlines and timetables that apply to the whole country. The full list of waivers and flexibilities can be found [here](#). Due to the large volume and scope of these new blanket waivers and flexibilities, CMS is clarifying which require the usage of modifier “CR” or condition code “DR” when submitting claims to Medicare. The chart below identifies those blanket waivers and flexibilities for which CMS requires the use of the modifier or condition code. Submission of the modifier or condition code is not required for any waivers or flexibilities not included in this chart.

Please note that CMS will not deny claims due to the presence of the “CR” modifier or “DR” condition code for services/items related to a COVID-19 waiver that are not on this list, or for services/items that are not related to a COVID-19 waiver. There may be potential claims implications, such as claims denials, for claims that do not contain the modifier or condition code as required in the below chart. However, providers do not need to resubmit or adjust previously processed claims to conform to the requirements below, unless claims payment was affected.

Waiver/Flexibility	Summary	CR	DR
Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient psychiatric units to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit as a result of a disaster or emergency.		X
Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units	Allows acute care hospitals to house acute care inpatients in excluded distinct part units, such as excluded distinct part unit IRFs or IPFs, where the distinct part unit's beds are appropriate for acute care inpatients.		X

Waiver/Flexibility	Summary	CR	DR
Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient rehabilitation units to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit as a result of this PHE.		X
Supporting Care for Patients in Long Term Care Acute Hospitals (LTCHs)	CMS has determined it is appropriate to issue a blanket waiver to long-term care hospitals (LTCHs) where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement at § 412.23(e)(2), which allows these hospitals to participate in the LTCH PPS. In addition, during the applicable waiver time period, CMS has determined it is appropriate to issue a blanket waiver to hospitals not yet classified as LTCHs, but seeking classification as an LTCH, to exclude patient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which must be met in order for these hospitals to be eligible to participate in the LTCH PPS.		X
Care for Patients in Extended Neoplastic Disease Care Hospital	Allows extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which allows these facilities to be excluded from the hospital inpatient prospective payment system and paid an adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based reimbursement rules.		X
Skilled Nursing Facilities (SNFs)	Using the authority under Section 1812(f) of the Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).		X

Waiver/Flexibility	Summary	CR	DR
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, allow the DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.	X	
Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)	Modifies the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency, plus an additional period of no more than 60 continuous days after the public health emergency expires. On the 61st day after the public health emergency ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock. Physicians and eligible physical therapists must continue to use the Q5 or Q6 modifier (as applicable) and do not need to begin including the CR modifier until the 61st continuous day.	X	
Critical Access Hospitals	Waives the requirements that Critical Access Hospitals limit the number of inpatient beds to 25, and that the length of stay, on an average annual basis, be limited to 96 hours.		X
Replacement Prescription Fills	Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the disaster or emergency.	X	
Hospitals Classified as Sole Community Hospitals (SCHs)	Waives certain eligibility requirements for hospitals classified as SCHs prior to the PHE, specifically the distance requirements and the "market share" and bed requirements (as applicable).		X

Waiver/Flexibility	Summary	CR	DR
Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)	For hospitals classified as MDHs prior to the PHE, waives the eligibility requirements that the hospital has 100 or fewer beds during the cost reporting period and that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods.		X
IRF 60 Percent Rule	Allows an IRF to exclude patients from its inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.		X
Waivers of certain hospital and Community Mental Health Center (CMHC) Conditions of Participation and provider-based rules	Allows a hospital or Community Mental Health Center (CMHC) to consider temporary expansion locations, including the patient's home, to be a provider-based department of the hospital or extension of the CMHC, which allows institutional billing for certain outpatient services furnished in such temporary expansion locations. If the entire claim falls under the waiver, the provider would only use the DR condition code. If some claim lines fall under this waiver and others do not, then the provider would only append the CR modifier to the particular line(s) that falls under the waiver.	X	X
Billing Procedures for ESRD services when the patient is in a SNF/NF	In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition.	X	X

Waiver/Flexibility	Summary	CR	DR
Clinical Indications for Certain Respiratory, Home Anticoagulation Management, Infusion Pump and Therapeutic Continuous Glucose Monitor national and local coverage determinations	In the interim final rule with comment period (CMS-1744-IFC and CMS-5531-IFC) CMS states that clinical indications of certain national and local coverage determinations will not be enforced during the COVID-19 public health emergency. CMS will not enforce clinical indications for respiratory, oxygen, infusion pump and continuous glucose monitor national coverage determinations and local coverage determinations.	X	
Face-to-face and In-person Requirements for national and local coverage determinations	In the interim final rule with comment period (CMS-1744-IFC) CMS states that to the extent a national or local coverage determination would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements would not apply during the COVID-19 public health emergency.	X	
Requirement for DMEPOS Prior Authorization	The requirement to submit a prior authorization request for certain DMEPOS items and services was paused. Suppliers were given the option to voluntarily continue submitting prior authorization requests or to skip prior authorization and have the claim reviewed through post payment review at a later date. Claims that would normally require prior authorization, but were submitted without going through the process should be submitted with a CR modifier.	X	
Signature requirements for proof of delivery	The signature requirement for Part B drugs and certain Durable Medical Equipment (DME) that require a proof of delivery and/or a beneficiary signature was waived. Providers should use a CR modifier on the claim and document in the medical record the appropriate delivery date and that a signature could not be obtained because of COVID-19.	X	
Part B Prescription Drug Refills	MACs may exercise flexibilities regarding the payment of Medicare Part B claims for drug quantities that exceed usual supply limits, and to permit payment for larger quantities of drugs, if necessary. MACs may require the use of the CR modifier in these cases.	X	

Waiver/Flexibility	Summary	CR	DR
Services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient.	During the COVID-19 PHE, hospitals may furnish clinical staff services in the patient's home as a provider-based outpatient department and bill and be paid for these services as Hospital Outpatient Department (HOPD) services when the patient is registered as a hospital outpatient. Hospitals should bill as if the services were furnished in the hospital, including appending the PO modifier for excepted items and services and the PN modifier for non-excepted services. The DR condition code should also be appended to these claims.		X

Medicare FFS Questions & Answers (FAQs) available on the [Waivers and Flexibilities webpage](#) apply to items and services for Medicare beneficiaries in the current emergency. These FAQs are displayed in these files:

- [COVID-19 FAQs](#)
- FAQs that apply [without any Section 1135](#) or other formal waiver.
- FAQs apply only [with a Section 1135](#) waiver or, when applicable, a Section 1812(f) waiver.

Blanket Waivers Issued by CMS

View the [complete list](#) of COVID-19 blanket waivers.

Billing for Professional Telehealth Distant Site Services During the Public Health Emergency

CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

View a [complete list](#) of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the PHE, bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Modifier 95, indicating that the service rendered was actually performed via telehealth

As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on

Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

CMS released a video providing answers to common questions about the Medicare telehealth services benefit.

[Video](#)

Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier

Teaching physicians and residents: Expansion of CPT codes that may be billed with the GE modifier under 42 CFR 415.174 on and after March 1, 2020, for the duration of the public health emergency:

- Residents furnishing services at primary care centers may provide an expanded set of services to beneficiaries, including levels 4-5 of an office/outpatient Evaluation and Management (E/M) visit, telephone E/M, care management, and some communication technology-based services
- This expanded set of services are CPT codes 99204-99205, 99214-99215, 99495-99496, 99421-99423, 99452, and 99441-99443 and HCPCS codes G2010 and G2012
- Teaching physicians may submit claims for these services furnished by residents in the absence of a teaching physician using the GE modifier

Medicare Administrative Contractors will automatically reprocess claims billed with the GE modifier on or after March 1, 2020, that were denied. You do not need to do anything.

Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the PHE; 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; and are in any of the following categories of HCPCS evaluation and management codes:

- 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

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- 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)

Previously, CMS made available the CS modifier for the gulf oil spill in 2010; however, CMS recently repurposed the CS modifier for COVID-19 purposes. Now, for services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers

During the COVID-19 PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. On an interim basis, we are expanding the list of destinations that may include but are not limited to:

- Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)
- Community mental health centers
- Federally Qualified Health Centers (FQHCs)
- Rural health clinics (RHCs)
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility is not available
- Beneficiary's home

CMS expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
- Modifier E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
- Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N - Alternative care site for SNF
- Modifier P - Physician's office
- Modifier R - Beneficiary's home

For the complete list of ambulance origin and destination claim modifiers see [Medicare Claims Processing Manual Chapter 15](#), Section 30 A.

New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- 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

Note that G2024 is applicable to patients in a non-covered stay in a SNF and not to those residents in Medicare-covered stays (whose bundled lab tests would be covered instead under Part A's SNF benefit at Section 1861(h) of the Act).

These codes are billable by clinical diagnostic laboratories.

Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients

CMS instructed Medicare Administrative Contactors and notified Medicare Advantage plans to cover coronavirus disease 2019 (COVID-19) laboratory tests in nursing home residents and patients. This instruction follows the Centers for Disease Control and Prevention's (CDC) recent update of COVID-19 [testing guidelines for nursing homes](#) that provides recommendations for testing of nursing home residents and patients with symptoms consistent with COVID-19 as well as for asymptomatic residents and patients who have been exposed to COVID like in an outbreak. Starting on July 6, 2020, and for the duration of the public health emergency, consistent with sections listed below of CDC guidelines titled, "Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel," Original Medicare and Medicare Advantage plans will cover diagnostic COVID-19 lab tests and non-cover tests not considered diagnostic.

- Viral Testing of Residents for SARS-CoV-2

- Initial Viral Testing in Response to an Outbreak
- Recommended testing to determine resolution of infection with SARS-CoV-2
- Public health surveillance for SARS-CoV-2

Tests that are considered non-diagnostic are not covered.

Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information

CMS recognizes that disruptions arising from a PHE can affect coverage under the SNF benefit:

- Prevent a beneficiary from having the 3-day inpatient qualifying hospital stay (QHS)
- Disrupt the process of ending the beneficiary's current benefit period and renewing their benefits.

Emergency waivers of QHS and benefit period requirements under §1812(f) of the Social Security Act help restore SNF coverage that beneficiaries affected by the emergency would be entitled to under normal circumstances.

Using the authority under section 1812(f) of the Social Security Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

For the QHS waiver:

- All beneficiaries qualify, regardless of whether they have SNF benefit days remaining
- The beneficiary's status of being "affected by the emergency" exists nationwide under the current PHE. (You do **not** need to verify individual cases.)

In contrast, for the Benefit Period Waiver:

- To qualify for the benefit period waiver, it must be demonstrated that a beneficiary's continued receipt of skilled care in the SNF is in some way related to the PHE. One example would be when a beneficiary who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube. We would also note that beneficiaries who do not themselves have a COVID-19 diagnosis may nevertheless be affected by the PHE. For example, when disruptions from the PHE cause delays in obtaining treatment for another condition.
- Would not apply to those beneficiaries who are receiving ongoing skilled care in the SNF that is unrelated to the emergency - a scenario that would have the effect of prolonging the current benefit period and precluding a benefit period renewal even

under normal circumstances. For example, if the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60 day “wellness period.”

- In making such determinations, a SNF resident’s ongoing skilled care is considered to be emergency-related *unless* it is altogether unaffected by the COVID-19 emergency itself (that is, the beneficiary is receiving the very same course of treatment as if the emergency had never occurred). This determination basically involves comparing the course of treatment that the beneficiary has actually received to what would have been furnished *absent* the emergency. Unless the two are exactly the same, the provider would determine that the treatment has been affected by – and, therefore, is related to – the emergency.
- **Providers should use the above criteria in determining when to document on the claim that the patient meets the requirement for the waiver.**

In this situation, we would also ask those providers to work with their respective MACs to provide any documentation needed to establish that the COVID-19 emergency applies for the benefit period waiver under §1812(f) for each benefit period waiver claim. Additionally, we also recognize that during the COVID-19 PHE, some SNF providers may have not yet submitted the PPS assessments for the benefit period waiver. In these limited circumstances, providers may utilize the Health Insurance Prospective Payment System (HIPPS) code that was being billed when the beneficiary reached the end of their SNF benefit period.

Billing Instructions

The following guidance provides specific instructions for using the QHS and benefit period waivers, as well as how this affects claims processing and SNF patient assessments.

To bill for the QHS waiver, include the DR condition code.

To bill for the benefit period waiver:

- Submit a final discharge claim with patient status 01.
- Readmit the beneficiary (Day 101) to start the benefit period waiver.

For admission under the benefit period waiver:

- Complete a 5-day PPS Assessment. (The interrupted stay policy does not apply.)
- Follow all SNF Patient Driven Payment Model (PDPM) assessment rules.
- Include the HIPPS code derived from the new 5-day assessment on the claim.
- The variable per diem schedule begins from Day 1.

For SNF benefit period waiver claims, include the following:

- Condition code DR - identifies the claims as related to the PHE

- Condition code 57 (readmission) - this will bypass edits related to the 3-day stay being within 30 days
- COVID100 in the remarks - this identifies the claim as a benefit period waiver request.

If you previously submitted a claim for a benefit period waiver that rejected for exhausted benefits, take either of the following actions:

1. If you billed the discharge and readmission correctly:
 - Cancel the rejected claim to remove it from claims history. DO NOT submit an adjustment to the rejected claim.
 - Once the cancel has finalized, resubmit the initial claim.
 - If you submit a claim without COVID100 in the remarks, we cannot process it for an additional 100 benefit days.
2. If you did not previously bill for a discharge on the last covered day to start a new admission with the benefit period waiver days:
 - Cancel the paid claim that includes the last covered coinsurance benefit day.
 - Once the cancel is processed, resubmit as a final bill with patient status equal to 01.
 - Cancel the initial benefit period waiver claim that rejected for exhausted benefits. You can submit this concurrently with the cancel of the paid claim.
 - Once the rejected claim is cancelled, submit an initial bill for the benefit period waiver following the same instructions as #1 above.

Please note, as previously stated, ongoing skilled care in the SNF that is **unrelated** to the PHE does not qualify for the benefit period waiver. You must determine if the waiver applies in accordance with the criteria set forth above. If so:

- Fully document in medical records that care meets the waiver requirements; this may be subject to post payment review.
- Track benefit days used in the benefit period waiver spell and only submit claims with covered days 101 - 200.
- Once the additional 100 days have been exhausted, follow existing processes to continue to bill Medicare no-pay claims until you discharge the beneficiary.
- Identify no-pay claims as relating to the benefit period waiver by using condition code DR and including "BENEFITS EXHAUST" in the remarks field.

MACs must manually process claims to pay the benefit period waiver but will make every effort to ensure timely payment. Please allow sufficient time before inquiring about claims in process.

Note: You must abide by all other SNF billing guidelines.

Beneficiary Notice Delivery Guidance in Light of COVID-19

If you are treating a patient with suspected or confirmed COVID-19, CMS encourages the

provider community 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)

In light of concerns related to COVID-19, current notice delivery instructions provide flexibilities for delivering notices to beneficiaries in isolation. These procedures include:

- 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.

We encourage the provider community to review all of the specifics of notice delivery, as set forth in Chapter 30 of the Medicare Claims Processing Manual at <https://www.cms.gov/media/137111>.

ADDITIONAL INFORMATION

The complete list of COVID-19 blanket waivers is available at <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

Review information on the current emergencies webpage at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

Providers may also want to view the Survey and Certification Frequently Asked Questions at

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>.

DOCUMENT HISTORY

Date of Change	Description
July 8, 2020	We revised the article to add a row at the end of the Waiver/Flexibility table (page 7) to address services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient. Also, we added the section on Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier. All other information remains the same.
July 1, 2020	We revised the billing instructions on page 12 of this article. Changes include instructions to readmit the beneficiary on day 101 to start the Skilled Nursing Facility (SNF) benefit period waiver. All other information remains the same.
June 26, 2020	We revised the article to add the section, "Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information" and related billing instructions. All other information remains the same.
June 19, 2020	We revised the article to add the section, "Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients." All other information remains the same.
June 1, 2020	We revised the article to add a section on Clarification for Using the "CR" Modifier and "DR" Condition Code. All other information remains the same.
April 10, 2020	<p>Note: We revised this article to:</p> <ul style="list-style-type: none"> • Link to all the blanket waivers related to COVID-19 • Provide place of service coding guidance for telehealth claims • Link to the Telehealth Video for COVID-19 • Add information on the waiver of coinsurance and deductibles for certain testing and related services • Add information on the expanded use of ambulance origin/destination modifiers • Provide new specimen collection codes for clinical diagnostic laboratories billing • Add guidance regarding delivering notices to beneficiaries. <p>All other information is the same.</p>

Date of Change	Description
March 20, 2020	We revised the article to add a note in the Telehealth section to cover the use of modifiers on telehealth claims and to explain the DR condition code is not needed on telehealth claims under the waiver. All other information is the same.
March 19, 2020	We corrected a typo in the article. One of the e-visit codes was incorrectly stated as 99431 and we corrected it to show 99421.
March 18, 2020	We revised this article to include information about the Telehealth waiver. All other information remains the same.
March 16, 2020	Initial article released.

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