



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

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Note: We revised this article on March 20, 2020, 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.

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for 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:

- [Current Emergencies](#) 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.

- 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.

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

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

Blanket Waivers Issued by CMS

You do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities (SNFs)

- Section 1812(f): This waiver of 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. 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 (Blanket waiver for all impacted facilities).
- 42 CFR 483.20: This waiver provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities).

Home Health Agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission (Blanket waiver for all impacted agencies).
- To ensure the correct processing of home health emergency related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).

Critical Access Hospitals

This action 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. (Blanket waiver for all impacted hospitals)

Housing Acute Care Patients in Excluded Distinct Part Units

CMS has determined 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. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients.)

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of the emergency, need 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.

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of the emergency, need 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.

IRFs may exclude patients from the hospital's or unit's 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 and the patient's medical record properly identifies the patient as such. 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.

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) to exclude patient stays 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 which allows these facilities to be paid as LTCHs.

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by the Emergency

CMS has determined it is appropriate to issue a blanket waiver where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable, contractors 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.

For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf>.

Medicare Advantage Plan or other Medicare Health Plan Beneficiaries

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged, lost, or unavailable in an emergency. Beneficiaries who do not have their plan's contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

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 or unavailable due to the emergency.

Telehealth

Note: Unlike other claims for which Medicare payment is based on a "formal waiver," telehealth claims don't require the "DR" condition code or "CR" modifier. CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required.

Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Prior to this waiver Medicare could only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries:

- Medicare telehealth visits
- Virtual check-ins
- e-visits

For more information, review the Medicare Telemedicine Health Care Provider Fact Sheet at: <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet> and Medicare Telehealth Frequently Asked Questions at: <https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf>.

Summary of Medicare Telemedicine Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: <ul style="list-style-type: none"> • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs). For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/telehealth/telehealth-codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	HCPCS code G2012 HCPCS code G2010	For established patients
E-VISITS	A communication between a patient and their provider through an online patient portal	<ul style="list-style-type: none"> • 99421 • 99422 • 99423 • G2061 • G2062 • G2063 	For established patients

ADDITIONAL INFORMATION

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
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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