COVID-19 FAQs

Diagnostic Laboratory Services

Question: How does Medicare pay for clinical diagnostic laboratory tests?

Answer: Medicare Part B, which includes a variety of outpatient services, covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. Medically necessary clinical diagnostic laboratory tests are generally not subject to coinsurance or deductible.

Question: Has CMS created any Healthcare Common Procedure Coding System (HCPCS) codes for COVID-19 laboratory testing?

Answer: Yes, CMS has created two codes in response to the urgent need to bill for these services. The codes are: U0001, CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel and U0002, 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC. Both codes are effective 2/4/2020 and will be available in the Medicare claims processing system on 4/1/2020. Please visit https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests

Laboratories can begin billing for the performance of these tests using these codes immediately via standard Fee-for-service billing practices. Medicare Administrative Contractors (MACs) are being instructed to hold claims submitted for these tests using these codes until the first week of April, at which time claims will be released so the adjudication process can continue.

Question: Are there other CPT codes available to bill for COVID-19 laboratory testing?

Answer: Yes. The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel has created CPT code 87635 (Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique) Please visit https://www.ama-assn.org/press-center/press-releases/new-cpt-code-announced-report-novel-coronavirus-test

Question: Are all of these codes available for laboratories to use to bill Medicare?

Answer: Yes. The CMS HCPCS codes will be available on the HCPCS and Clinical Laboratory Fee Schedule (CLFS) file beginning April 1, 2020 for dates of service on or after February 4, 2020. The AMA CPT code, 87635 will also be available on the HCPCS and CLFS file beginning April 1, 2020 for dates of service on or after March 13, 2020.

Question: My laboratory uses the CDC test kit; what code should we use to bill Medicare?

Answer: The appropriate code to use would be HCPCS Code U0001 (CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel).

Question: My laboratory does not use the CDC test kit; what code should we use to bill Medicare?

Answer: If your laboratory uses the method specified by CPT 87635, the appropriate code to use would be CPT 87635. If your laboratory has a test that uses a method not described by CPT 87635, the appropriate code to use would be HCPCS Code U0002.

Question: What code should we use to bill Medicare if new types of COVID-19 tests are created in the future?

Answer: The appropriate code to use would be HCPCS Code U0002 for COVID-19 test methods that are not specified by either U0001 or 87635. CMS will continue to monitor the types of COVID-19 testing methods and adjust coding as necessary depending on the methodology.

Question: How will Medicare pay for COVID-19 testing on the CLFS?

Answer: Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes and the CPT code in their respective jurisdictions until Medicare establishes national payment rates on the CLFS. Please see https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf for more information on current MAC payment rates. For more information on CMS's procedures for public consultation on payment for new clinical diagnostic laboratory tests on the CLFS, please see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory_Public_Meetings

Question: My laboratory does not use the CDC test kit and will have a delay in implementing the CPT code 87635 in our billing system. May we bill Medicare using U0002?

Answer: Yes. For the time being laboratories may continue to use U0002 to bill Medicare for tests described by the CPT code. We will provide advance notice if this changes.

<u>Physicians' Services</u>

Question: Does Medicare pay for a doctor or non-physician practitioner (NPP) to furnish care in a beneficiary's home?

Answer: Medicare pays for evaluation and management (E/M) and other services furnished in a beneficiary's home by a physician or NPP. Additionally, Medicare makes payment for a number of non-face-to-face services that can be used to assess and manage a beneficiary's conditions. These include: care management services, remote patient monitoring services, and communication technology based services.

Question: Does Medicare pay for a doctor, NPP, or nurse to call or use other technology to communicate with a patient?

Answer: Medicare pays for several services that are brief communications with practitioners for specific purposes. These services can be furnished via a number of communication technology modalities. For example, HCPCS code G2012 (virtual check-in) can be furnished using synchronous

technology such as a telephone call. HCPCS code G2010 (Remote evaluation of recorded video and/or images submitted by an established patient) can be furnished using asynchronous technology such as e-mail. And CPT codes 99421-99423 (patient-initiated digital communication) and HCPCS codes G2061-G2063 (online assessment) can be furnished using an online patient portal. We expect that these services will be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.

Question: Would Medicare pay for a doctor, NPP, or nurse to furnish visits to a patient at home via telehealth? What are the limitations?

Answer: The Medicare statute currently limits payment for telehealth visits to services furnished to beneficiaries in certain types of healthcare facilities located in rural areas (originating sites). A beneficiary in a rural area cannot receive telehealth visits from their home except under certain exceptions. Those exceptions are for the treatment of a substance use disorder or co-occurring mental health disorder (as authorized by Section 2001 of the SUPPORT Act) and for the monthly ESRD-related clinical assessments (as authorized by section 50302(b)(1) of the Bipartisan Budget Act of 2018).

Question: Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

Answer: There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. Individual providers may use their MAC hotline number to verbally update their practice location over the phone and would be effective immediately so practitioners could continue providing care without a disruption.

Please see the FAQs regarding the 1135 telehealth waiver at:
https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Home Health

Question: For purposes of the statutory requirement that a patient have a face-to-face encounter with a physician or an allowed non-physician practitioner in order to qualify for Medicare home health care, can this encounter occur via telehealth during a pandemic outbreak of an infectious disease?

Answer: The face-to-face encounter, as described at 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, can be performed via telehealth in accordance with the requirements under 1834(m)(4)(C) of the Social Security Act. Under the expansion of telehealth under the 1135 waiver, beneficiaries are able to use telehealth technologies with their doctors and practitioners from home (or other originating site) for the face-to-face encounter to qualify for Medicare home health care.

Please see the FAQs regarding the 1135 telehealth waiver at:
https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Hospital Services

Question: During an emergency, will Medicare allow payment for care provided at a site not considered part of a healthcare facility (which are informally termed "alternative care sites" (ACSs)) for patients who are not critically ill? For example, if local hospitals are almost at capacity during an emergency and the few beds remaining must be reserved for patients needing ventilators and critical care, will Medicare pay for non-critical care provided at an ACS, such as a school gymnasium?

Answer: Even in the absence of an 1135 waiver, a hospital may add a remote location that provides inpatient services, provided that the remote location satisfies the requirements to be provider-based to the hospital's main campus. The remote location must satisfy all provider based requirements at 42 CFR 413.65, including the location requirements at 42 CFR 413.65(e)(3), in addition to the Hospital Conditions of Participation (CoPs). As soon as it adds an additional location, the hospital would be expected to file an amended Form CMS 855A with its Medicare Administrative Contractor. CMS generally requires a survey of compliance with all CoPs at all new inpatient locations, but also has discretion to waive the onsite survey in this area. An onsite survey is not required for the provider-based designation. Once approved, subsequent surveys of the hospital will include any provider based locations.

Question: Will a hospital be eligible for additional payment for rendering services to patients that remain in the hospital in the case where they continue to need medical care but at less than an acute level and those services are unavailable at any area SNFs because of an emergency, including the COVID-19 infection?

Answer: A physician may certify or recertify the need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF, but no bed is available in a participating SNF. Medicare will pay the DRG rate and any cost outliers for the entire stay until the Medicare patient can be moved to an appropriate facility.

Question: Are hospitals that are paid by Medicare through the Inpatient Prospective Payment System (IPPS) going to be paid using a special payment method? If not, is there a special Diagnostic Related Group (DRG) that IPPS hospitals will be reimbursed for this situation?

Answer: Normal prospective payment procedures apply to those hospitals reimbursed under the IPPS. There is no special DRG for COVID-19.

Question: We have a Medicare psychiatric patient that can't be placed in the distinct part inpatient psychiatric facility (IPF) unit because all patients are quarantined due to COVID-19. Can we still bill under the IPF unit provider number even though they are in a hospital acute care unit bed?

Answer: If the patient is not in the IPPS excluded IPF unit, even if the patient is a psychiatric patient, and as long as the placement of the patient in the hospital's acute care bed is not inappropriate to his/her condition, the hospital will receive IPPS payment for that patient's care. Billing under the IPF unit's provider number is not allowed.

Question: Will Medicare provide additional payment if a patient needs to be isolated or quarantined in a private room?

Answer: 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. Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room, if the private room is medically necessary. 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 the DRG rate and any cost outliers for the entire stay until the Medicare patient is discharged. The DRG rate (and cost outliers as applicable) includes payment for when a patient needs to be isolated or quarantined in a private room.

Question: Can a provider having both private and semiprivate accommodations charge the patient a differential for a private room where isolation of a beneficiary is required?

Answer: A provider having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary.

Drugs & Vaccines Under Part B

Question: Will Medicare Part B pay for vaccinations of Medicare beneficiaries?

Answer: Medicare Part B pays for preventive Hepatitis B vaccinations for high-and intermediate-risk beneficiaries and also for influenza and pneumococcal vaccinations for all Medicare beneficiaries. Medicare Part B will also pay for medically reasonable and necessary vaccinations of beneficiaries against a microbial agent or its derivatives (e.g., tetanus toxin, Hepatitis A) following likely exposure in accordance with normal Medicare coverage rules.

Under current law, once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine.

Question: If new drugs are created to treat COVID-19, can they be billed?

Answer: New drugs that are covered under Medicare Part B, including new antiviral drugs, can be paid by the Medicare Administrative Contractors until they receive a code and are on the pricing files. New drugs that are covered under Medicare Part D can be billed to the beneficiary's Part D plan.

Question: If a State distributes CDC's Strategic National Stockpile (SNS) drugs to hospitals (https://www.phe.gov/about/sns/Pages/default.aspx), what are the Medicare billing rules? How should hospitals handle billing for services that involve the use of SNS provided drugs?

Answer: For services rendered to Medicare beneficiaries, standard Medicare billing rules apply. Based on existing policy, providers may not seek reimbursement for no cost items such as SNS drugs. Specifically, the policy is described in the CMS Internet Only Manual Pub. 100-04, Chapter 32, Section 67 which states that provider may not seek reimbursement for no cost items as noted in Section 1862(a)(2) of the Social Security Act.

Question: Will Medicare Part B cover a 90-day supply of drugs in the event that a pandemic occurs, when such drugs are needed for a patient's chronic condition?

Answer: With respect to drugs covered under Part B, with the exception of immunosuppressive drugs -- which are generally limited to a 30-day supply – but including drugs that need to be administered through Durable Medical Equipment, local MACs have discretion to pay for a greater-than-30-day supply of drugs. When considering whether to pay for a greater-than-30- day supply of drugs, MACs will take into account the nature of the particular drug, the patient's diagnosis, the extent and likely duration of disruptions to the drug supply chain during an emergency, and other relevant factors that would be applicable when making a local determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.

With respect to immunosuppressive drugs, although Medicare would customarily not pay for more than a 30-day supply because dosage frequently diminishes over a period of time and it is not uncommon for the physician to change the prescription from one drug to another. In the event of an emergency, local MACs may consider allowing payment for a medically necessary, greater-than-30-day supply of Medicare-covered, immunosuppressive drugs on a case-by-case basis taking local considerations into account.

Question: Can a Medicare beneficiary receive more than a 30-day supply of Medicare Part B covered drugs during an emergency?

Answer: In most situations where there are specific limits on coverage of additional quantities or time limited coverage periods that are 30 days or less, Medicare Part B does not pay for additional quantities. For example, oral anti-emetic drugs are covered only when they are used immediately before, at, or within 48 hours after administration of an anticancer chemotherapeutic agent. For immunosuppressive drugs, claims processing contractors will generally not consider a supply of immunosuppressive drugs in excess of 30 days to be reasonable and necessary and will deny payment, unless there are special circumstances. Information on exceptions for special circumstances would be made available by the local MAC that processes a provider or supplier's immunosuppressive drug claims.

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. See section 80.3.3, Special Requirements for Immunosuppressive Drugs)

Ambulance Services

Question: If the ambulance crew provides treatment but does not transport anyone, can the company bill Medicare for the services provided?

Answer: No. Medicare law prohibits payment for an ambulance service unless the transport of a Medicare beneficiary has taken place. However, when a physician or NPP furnishes services from an ambulance, he or she may bill for those services under the Medicare Physician Fee Schedule, assuming that the services furnished were in accordance with applicable state law and services are within his or her scope of practice requirements.

Question: How will ambulance services be paid when patients are moved from hospital to hospital or other approved locations?

Answer: Medicare will pay for ambulance transportation according to the usual payment guidelines. Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals should be included on the inpatient claims submitted by the originating hospitals. Payment will be included in the diagnostic related group (DRG) payment amounts made to hospitals paid under the prospective payment system.

Question: If a beneficiary who is living at home and using a stationary oxygen unit, has to be transported to another location by ambulance (because other means of transportation are contraindicated), can Medicare pay for any portable oxygen necessary to transport the beneficiary?

Answer: Medicare's payment to ambulance suppliers and providers for ambulance transports includes payment for all necessary supplies, including oxygen, provided during the transport. Thus, if the transport is a Medicare-covered service (e.g., the beneficiary must be transported by ambulance to a covered destination because other means of transportation are contraindicated), then no separate payment for furnishing oxygen would be available.

However, if the transport does not qualify as a Medicare-covered service, then payment under Part B may be made to a Durable Medical Equipment supplier for furnishing portable oxygen when supplemental oxygen is needed for the beneficiary during the transport.

Question: In emergency/disaster situations, how does CMS define an "approved destination" for ambulance transports and would it include alternate care centers, field hospitals and other facilities set up to provide patient care in response to the emergency/disaster?

Answer: CMS defines "approved destination" at 42 CFR § 410.40(f), Origin and Destination requirements. Medicare can only pay for ambulance transportation when it meets the Origin and Destination Requirements and all other coverage requirements. These requirements specify that an appropriate destination is one of the following:

- Hospital;
- Critical Access Hospital (CAH);
- Skilled Nursing Facility (SNF);
- Beneficiary's home;
- Dialysis facility for ESRD patient who requires dialysis.

Beneficiaries residing in a SNF, who are receiving Part B benefits only, are eligible for ambulance transport to one additional "approved destination," that is, from a SNF to the nearest supplier of medically necessary services not available at the SNF where the

beneficiary is a resident. For SNF residents receiving Medicare Part A benefits, this type of ambulance service is subject to SNF consolidated billing.[1]

A physician's office is not a covered destination. However, under certain circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

Should a facility that would normally be the nearest appropriate facility be unavailable during an emergency/disaster, Medicare may pay for transportation to another facility so long as that facility meets all Medicare requirements and is still the nearest facility that is available and equipped to provide the needed care for the illness or injury involved.

42 CFR 410.40 allows Medicare to pay for an ambulance transport (provided that transportation by any other means is contraindicated by the patient's condition and all other Medicare requirements are met) from any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.

However, Medicare payment for an ambulance transport to an alternative care site may be available if the alternative care site is determined to be part of an institutional provider (hospital, CAH or SNF) that is an approved destination for an ambulance transport under 42 CFR § 410.40. If the alternative care site is part of an institutional provider (hospital, CAH or SNF) that is an approved destination under 42 CFR § 410.40 for an ambulance transport, Medicare will pay for the transport on the same basis as it would to any other approved destination.

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[1] In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF 1 In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF stay which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not.

The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception: There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.

For Medicare beneficiaries in a covered Part A stay, these separately payable services include:
•physician's professional services;
•certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
•certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
•erythropoietin for certain dialysis patients;
•certain chemotherapy drugs;
•certain chemotherapy administration services;
•radioisotope services; and
•customized prosthetic devices.

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services for these beneficiaries can be separately billed to and paid by the Medicare contractor.

Physicians, non-physician practitioners, and suppliers should contact their Part B MAC or Durable Medical Equipment (DME) MAC with questions about SNF consolidated billing. There is also additional information about SNF consolidated billing on the CMS Medicare Learning Network (MLN) Publications webpage.

Institutional providers should contact their Part A MAC with questions about SNF consolidated billing. There is also additional information about SNF consolidated billing on the CMS Medicare Learning Network (MLN) Publications webpage.

Medicare Payment to Facilities Accepting Government Resources

Question: Can a skilled nursing facility accept Federal, State, or local government resources (e.g., supplies and staffing assistance) to help with the COVID-19 emergency and still bill Medicare?

Answer: Although Medicare usually doesn't allow payment for services that are paid for by a governmental entity, there is an exception for services furnished as a means of controlling infectious diseases (see 42 CFR 411.8(b)(4)).

Question: Does Medicare pay health care providers such as hospices, hospitals and skilled nursing facilities separately for personal protective equipment and supplies necessary to prevent the spread of infectious disease?

Answer: Medicare payments for health care services include the supplies necessary to appropriately provide the service, including any personal protective equipment and supplies appropriate for the patient's condition and treatment. There are not separate payments for those supplies. However, additional resources for infection control, such as supplies or staffing assistance, may be made available from other local, state, or federal government agencies. Although Medicare usually doesn't allow payment for services that are paid for by a governmental entity, there is an exception for services furnished as a means of controlling infectious diseases (see 42 CFR 411.8(b)(4)).

Oxygen

Question: Does Medicare cover home use of oxygen for patients diagnosed with COVID-19?

Answer: Yes, we are exercising enforcement discretion to cover medically necessary home use of oxygen for patients diagnosed with COVID-19 during the emergency.

CMS is currently reviewing NCDs and LCDs to identify and remove barriers to beneficiaries with COVID-19 receiving home oxygen and we hope to have more information on this process soon.