

Emergency-Related Policies and Procedures
That May Be Implemented Without § 1135 Waivers

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ALL EMERGENCIES

A - Flexibilities Available in the Event of an Emergency or Disaster

Question Number	Question and Answer
A-1	<p>Question: In the event of an emergency or disaster, what relief is available to providers, physicians and other suppliers, and/or beneficiaries under the Medicare fee-for service program?</p> <p>Answer: Currently, there is no authority for the Medicare fee-for service program to make payments for the purpose of emergency or disaster relief. Even in the circumstance of a disaster or emergency, Medicare fee-for-service is limited to making payments only for services covered under Medicare Parts A & B that are furnished to Medicare beneficiaries in accordance with program rules. That said, Medicare can make certain adjustments in response to a disaster or emergency to ease administrative burden on providers and on physicians and other suppliers and to enhance access to services by Medicare beneficiaries.</p>
A-2	<p>Question: What are the adjustments that Medicare fee-for-service can make in the event of an emergency or disaster?</p> <p>Answer: Broadly speaking, Medicare fee-for-service has three sets of potential temporary adjustments that can be made to address an emergency or disaster situation. These include:</p> <ol style="list-style-type: none"> 1. applying flexibilities that are already available under normal business rules; 2. waiver or modification of policy or procedural norms by the Administrator of the Center for Medicare and Medicaid Services (CMS) under his or her authority; and 3. waiver or modification of certain Medicare requirements pursuant to waiver authority under § 1135 of the Social Security Act. This waiver authority can be invoked by the Secretary of the Department of Health and Human Services (DHHS) in certain circumstances.
A-3	<p>Question: The previous answer referred to “potential temporary adjustments”. Aren’t these adjustments always implemented in the event of a disaster or emergency?</p> <p>Answer: No, not always. First, each emergency or disaster is unique and creates specific, and sometimes unique, challenges. Thus, the nature of the emergency or disaster will determine whether a particular adjustment is appropriate (or even authorized). Second, CMS will usually tailor its response to specific, identified needs that are communicated by or through State officials or health industry representatives in the affected area and, in some cases, only when supported by documentation of need. Third, a waiver or modification of requirements pursuant to § 1135 of the Social Security Act requires not only that the Secretary of DHHS specifically invoke that authority, but also that certain conditions are met first – namely, that there has been both a declaration by the Secretary of a public health emergency under Section 319 of the Public Health Service Act and a declaration by the President of a disaster or emergency under the Stafford Act or National Emergencies Act.</p>
A-4	<p>Question: Assuming that some level of response is forthcoming from Medicare fee-for-service in an emergency or disaster, what, specifically, do these emergency/disaster-related adjustments include?</p> <p>Answer: The questions and answers in this series, which are generally organized by benefit category or provider type, describe specific adjustments/responses and whether the emergency/disaster response is based on normal business rules, an adjustment within CMS’ discretion, or an adjustment that can be made only under a § 1135 waiver. Please refer to or policies regarding the specific benefit category or provider type related to the particular question.</p> <p>Updated: 5/1/2018</p>
A-5	<p>Question: How will the healthcare community know what adjustments are available from Medicare fee-for-service in a particular emergency or disaster?</p> <p>Answer: The contractors that process Medicare fee-for-service claims (Medicare Administrative Contractors (MAC), Durable Medical Equipment (DME) MACs, Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), and Carriers), will implement Medicare fee-for-service adjustments based on instructions from CMS. In the event of an emergency or disaster, providers and physicians and other suppliers should contact their servicing contractor. The DHHS Regional Office(s) for the affected area(s) will generally serve as the point of contact for State officials and industry associations. To raise an issue not addressed within these Q&As, send your query to emergency.ops@cms.hhs.gov.</p>

Question Number	Question and Answer
A-6	<p>Question: CMS had previously issued Transmittals that communicated Q&As about emergency-related policies in the event of an influenza pandemic. Are those policies still in effect?</p> <p>Answer: Not at this time. These updated Q&As are intended to apply more generally in any kind of an emergency or disaster, including but not limited to an influenza pandemic.</p>

B - Waiver of Certain Medicare Requirements

Question Number	Question and Answer
B-1	<p>Question: What are “waivers” under § 1135 of the Social Security Act; how are they established; and how do they apply to Medicare fee-for-service?</p> <p>Answer: Section 1135 of the Social Security Act authorizes the Secretary of the Department of Health and Human Services to waive or modify certain Medicare, Medicaid, CHIP, and HIPAA requirements. Two prerequisites must be met before the Secretary may invoke the § 1135 waiver authority. First, the President must have declared an emergency or disaster under either the Stafford Act or the National Emergencies Act. Second, the Secretary must have declared a Public Health Emergency (PHE) under Section 319 of the Public Health Service Act. Then, with respect to the geographic area(s) and time periods provided for in those declarations, the Secretary may elect to authorize waivers/modifications of one or more of the requirements described in Section 1135(b) and summarized below. The implementation of such waivers or modifications is typically delegated to the Administrator of CMS who, in turn, determines whether and the extent to which sufficient grounds exist for waiving such requirements with respect to a particular provider, or to a group or class of providers, or to a geographic area.</p> <p>Waivers authorized by the statute apply to Medicare in the context of the following requirements:</p> <ul style="list-style-type: none"> • conditions of participation or other certification requirements applicable to providers; • licensure requirements applicable to physicians and other health professionals; • sanctions for violations of certain emergency medical standards under the Emergency Medical Treatment and Labor Act (EMTALA) • sanctions relating to physician self-referral limitations (Stark) • performance deadlines and timetables (modifiable only; not waiveable); and • certain payment limitations under the Medicare Advantage program. <p>Medicare fee-for-service requirements, including most particularly (but not limited to) Medicare payment rules and amounts, are not, and cannot be, waived under § 1135. Nevertheless, some of the foregoing waivers, when invoked, may have the effect of making fee-for-service payments possible when, absent a waiver, such payments would not have been permissible.</p>
B-2	<p>Question: Does the § 1135 authority allow CMS to waive Medicare requirements that apply to individuals affected by the emergency/disaster? If so, would there be a set period of time for the emergency to exist, or would such waiver vary by affected individual?</p> <p>Answer: Section § 1135 waivers – when authorized – apply to requirements that apply to health care providers. Such waivers do not directly apply to individual beneficiaries. However, the waivers that are granted for health care providers are intended to reduce administrative burdens on those providers and to increase flexibilities in the delivery of health care with the intent of promoting greater access to care by individuals affected by the emergency or disaster.</p>
B-3	<p>Question: Will CMS provide disaster relief funding to hospitals following an emergency or disaster to make up for the lost reimbursement? If so what documentation will be required in patient clinical and financial records?</p> <p>Answer: There is currently no standing authority for CMS to provide special emergency/disaster relief funding following an emergency or disaster in order to compensate providers for lost reimbursement. Congress had appropriated disaster-specific special funding for the Hurricane Katrina disaster; but absent such special appropriation, Medicare does not provide funding for financial losses except as otherwise specified in existing regulations.</p>

Question Number	Question and Answer
B-4	<p>Question: At what point will individuals no longer be treated as “emergency victims?” Is there a set period of time or does it vary by individual?</p> <p>Answer: Emergency policies, including those policies made possible by the § 1135 waiver authority, generally do not apply to individual beneficiaries. These policies apply to the geographic area(s) in which the emergencies have been declared and may apply to individual health care providers or groups or types of providers. As described more fully in these emergency Q&As, the effect of waivers and of other flexibilities are intended to facilitate access to care by program beneficiaries. Generally speaking, Medicare fee-for-service emergency policies are in effect in the geographic areas, and for the length of time, specified by the President’s declaration of an emergency or disaster.</p>
B-5	<p>Question: How does a health care provider affected by an emergency request and receive approval for an 1135 waiver?</p> <p>Answer: Section 1135 waivers are generally not authorized in response to an individual provider’s request. Rather, such waivers are typically authorized for geographic areas for the duration of a declared emergency or disaster. To determine whether waiver authority has been invoked for a particular emergency or disaster and, if so, whether any such waiver would apply to your facility, contact your State Survey Agency (SA) or the Medicare contractor to which you submit claims. In some circumstances, providers may be required to submit documentation of need for a grant of waiver of certain requirements. In that event the SA or your servicing Medicare contractor will advise you of specific requirements.</p> <p>All providers impacted by an emergency or disaster should activate their disaster plans, especially those providers furnishing emergency treatment subject to the Emergency Medical Treatment and Labor Act (EMTALA).</p> <p>And all providers should assume that normal Medicare fee-for-service rules remain in effect unless official notice is made that waivers of such rules have been granted.</p>

C – General Payment Policies

Question Number	Question and Answer
C-1	<p>Question: Will Medicare fee-for-service pay when I try to get services in a State other than my home State?</p> <p>Answer: Yes. Fee-for-service (FFS) Medicare beneficiaries, that is beneficiaries who are enrolled in Original Medicare, may obtain health care services anywhere in the country. This is normal policy. The provider of services will bill the Medicare contractor with whom they are enrolled and with whom they normally conduct Medicare business.</p> <p>Non-FFS beneficiaries, that is beneficiaries enrolled in other types of Medicare plans (Medicare Advantage (MA), PACE, HCPPs enrollees, etc.), may be limited as to where they may obtain services but generally can obtain urgently needed or emergency health care services anywhere.</p>
C-2	<p>Question: Are contractors allowed to extend the due date for cost reports, to allow the providers additional time to submit them without having payments interrupted?</p> <p>Answer: Yes, 42 CFR § 413.24 (f) (2) (ii) allows this flexibility, “if a provider’s operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.”</p>

Question Number	Question and Answer
C-3	<p>Question: In declared disasters, can CMS make payment for services that are provided by healthcare professionals who, in normal circumstances, would not be permitted by Medicare to bill for their services to beneficiaries (e.g., RNs providing care typically provided by physicians or residents/medical students providing services without the required level of physician supervision)?</p> <p>Answer: There is no authority under Medicare Part B that permits a Medicare contractor to depart from the statutory provisions that specify to whom Medicare payment is made. Medicare payment cannot be made under the physician fee schedule (PFS) directly to an RN or any other individual without a separately enumerated benefit under Medicare law. The only way that these individuals can receive Medicare Part B payment for their services to Medicare patients is indirectly under the “incident to” provision. The “incident to” provision requires, among other things, that PFS payment is made to the employer of those who furnish services incident to a physician’s (or to certain types of non-physician practitioner’s) professional service and that the services be furnished under direct supervision by a physician (or certain types of non-physician practitioners). Hence, those who provide “incident to” services must be employed, leased, or contracted with the physician or non-physician practitioner, or the entity that bills for their services.</p>
C-4	<p>Question: What are the definitions of healthcare facility that must be met to qualify for reimbursement?</p> <p>Answer: Many different types of health care facilities qualify to participate in the Medicare program, and are considered to be either a “provider” or a “supplier.” Section 1861(u) of the Social Security Act defines a “provider of services” for Medicare as a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program. Section 1861(d) defines a “supplier” as a physician or other practitioner, a facility or other entity, with the exception of a provider of services, that furnishes Medicare items or services. The required characteristics of specific categories of providers and suppliers that are facilities (e.g., an ambulatory surgical center or a rural health clinic) are further defined by statute and regulation. Information on the Medicare certification requirements for various types of providers and institutional suppliers may be found on the Survey and Certification portion of CMS’ website: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Provider-Survey-and-Certification-Frequently-Asked-Questions.pdf</p>
C-5	<p>Question: If Telehealth is expanded to accommodate screening and home management of conditions that would usually be referred to the emergency department, can these requirements be relaxed and accommodated for reimbursement?</p> <p>Answer: No, under Medicare fee-for-service, there is no authority under current law to make such accommodations.</p>
C-6	<p>Question: LTC providers are trying to learn how to be reimbursed for their services furnished during an emergency/disaster. Evacuation-related billing is quite complex and both the evacuating and receiving facilities incur costs. It would be helpful if there was a simplified and consistent process for billing during emergency/disaster-related situations. A Medicare Part A default rate for residents taken in temporarily would be extremely helpful. The additional cost of admitting and discharging residents on a short term basis and the additional challenges to facilities who willingly assist in an emergency/disaster should not be overlooked, and reasonable reimbursement mechanisms should be made available to them.</p> <p>Answer: There is currently no statutory authority that would permit Medicare to pay for evacuation costs. Moreover, even in the circumstance where the HHS Secretary invokes the waivers authorized by § 1135 of the Social Security Act, evacuation costs would not be covered under Medicare by such waivers. However, depending on particular circumstances, an ambulance transport to the nearest appropriate facility equipped to treat the beneficiary may be covered by Medicare Part B if transport of the beneficiary by ambulance was medically necessary and all other Medicare coverage requirements were met (i.e., the vehicle must meet certain requirements, the crew must be certified as required, the transport must be from an eligible origin to an eligible destination, certain billing and reporting requirements must be met, and Medicare Part A payment is not made directly or indirectly for the services). The local claims processing contractor would evaluate such transports on a case-by-case basis.</p>

Question Number	Question and Answer
C-7	<p>Question: If a provider affected by a disaster has facility damage or destruction which results in the loss of documentation used to support payment, what flexibility is available?</p> <p>Answer: Instructions for how to handle situations where documentation to support payment has been lost or destroyed can be found in CMS' Program Integrity Internet Only Manual in Publication 100-08, Chapter 3, § 3.8 entitled "Administrative Relief from MR During a Disaster" at the following link: http://www.cms.gov/manuals/downloads/pim83c03.pdf.</p>

D - General Billing Procedures

Question Number	Question and Answer
D-1	<p>Question: Regarding the use of the disaster-related condition code "DR", should this code be used for all billing situations relating to a declared emergency/disaster (i.e., SNF, ESRD, or Hospitals)?</p> <p>Answer: Yes, 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. The "DR" condition code is intended for use by providers (but not by physicians and other suppliers) in billing situations related to a declared emergency/disaster. However, use of the DR condition code, which previously was left to the provider's or supplier's discretion, is now to be used only in certain circumstances. Effective August 31, 2009, use of the DR condition code is mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver" (as defined in the CMS Internet Only Manual, Publication 100-04, Chapter 38, § 10). Also, the DR condition code may be required in certain circumstances relating to a particular disaster or emergency to facilitate efficient processing of claims. Medicare claims processing contractors will advise providers when and under what circumstance such ad hoc use of the DR condition code will be required. (Note: 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". The CR modifier also may be required for any HCPCS code for which, at the Medicare claims processing contractor's discretion or as directed by CMS in a particular disaster or emergency, the use of the CR modifier is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.)</p>

Question Number	Question and Answer
D-2	<p>Question: Please provide direction regarding the use of the CR/DR modifier/condition code on claims for services furnished to patients that were moved to other areas, including other States outside the emergency area. Does a provider still use the CR/DR modifier/condition code when the provider is in a State other than the State where the emergency has been declared?</p> <p>Answer: Agency policy concerning the use of the DR condition code and the CR modifier is established by Change Request 6451 (Transmittal 1784, issued July 31, 2009). This Change Request provides that the DR condition code and the CR modifier are required in any one of three circumstances as follows: 1) a § 1135 waiver granted to a provider or supplier necessitates the use of the condition code or modifier, 2) CMS mandates their use, or 3) a claims administration contractor mandates their use. See Change Request 6451 for a more precise statement of the policy. When the President declares an emergency and the Secretary of the Department of Health and Human Services has also declared a public health emergency, CMS advises its contractors that use of the DR condition code or the CR modifier is required on a claim for an item or service furnished under a “formal waiver,” i.e., the first of the three possibilities discussed in Change Request 6451, and will also specify the emergency area and the beginning effective date. If CMS were to mandate the use of the condition code or modifier in other circumstances, i.e., the second of the three possibilities discussed in Change Request 6451, that decision would also be communicated to our contractors. Finally, under Change Request 6451, claims administration contractors are authorized – but not required – to mandate or authorize the use of the DR condition code or the CR modifier on claims related to a particular emergency, including claims from providers and suppliers furnishing items and services in States other than the State in which the emergency exists when the effects of the emergency affect the delivery of such items and services in other States. This is the third of the three possibilities discussed in Change Request 6451. Note, however, that the requirement or authorization to the use of the DR condition code or the CR modifier on a claim does not, itself, constitute a waiver of a Medicare requirement, but rather reflects that a waiver or other special condition may apply to the furnishing of an item or service in a Federally-declared emergency situation. In each case where the DR condition code or the CR modifier is required, our contractors will notify providers and suppliers of the particulars regarding such use.</p>
D-3	<p>Question: How does CMS want contractors to handle 5601 edits (overlaps) when one of the facilities is an emergency/disaster-impacted provider and the contractor is unable to contact it or obtain documentation? Contractors often request admit and discharge summaries from providers in order to resolve overlapping claims issues. What should contractors do when one of the providers is in the emergency/disaster-impacted area and the contractor is unable to contact it and obtain documentation?</p> <p>Answer: When two claims are overlapping and it is necessary to view the admission and discharge summaries to ascertain where the patient was on a given day, the contractor should pay the claim for the facility that is able to provide the documentation to support the days on their claim. Upon making contact with the affected provider, contractors may make any necessary adjustments to the claims.</p>
D-4	<p>Question: How should the CR modifier and the DR condition code be used for emergency related claims?</p> <p>Answer: The CR modifier and the DR condition code are still authorized for emergency-related claims. But see Change request 6451, issued on July 31, 2009 as Transmittal 1784, for updated procedures related to the use of the CR modifier and the DR condition code, and Section 38.10 of the Claims processing manual.</p> <p>Updated: 5/1/2018</p>
D-5	<p>Question: When and how can claims timely filing requirements for claims be waived?</p> <p>Answer: Section 6404(b)(1) of the Affordable Care Act (ACA) requires that all claims for services furnished on or after January 1, 2010, must be filed within 1 calendar year after the date of service. In addition, section 6404(b)(2) of the ACA requires that claims for services furnished before January 1, 2010, must be filed on or before December 31, 2010. Under the current regulations, the only exception to the time limits for filing claims is for error or misrepresentation of an employee, contractor, or agent of the Department (see 42 C.F.R. § 424.44(b) for details). Section 70.7.1 of Publication 100-04, Chapter 1 (General Billing Requirements) of the Internet Only Manual provides instructions on the process for submitting a request to the Medicare contractor for an exception to the timely filing requirements. We do not believe that providers affected by an emergency/disaster would be adversely affected by the timely filing requirement, given that the timely filing window is within 1 calendar year after the date of service.</p> <p>Updated: 5/1/2018</p>

Question Number	Question and Answer
D-6	<p>Question: Will the claim filing deadline be extended so that the clock starts ticking after the disaster or emergency is declared over?</p> <p>Answer: No. A waiver or modification of Medicare program requirements in accordance with § 1135 of the Social Security Act (such as a modification of the timely filing requirements) is generally only in effect for the duration of the declared emergency period, not after the period has ended. In addition, because the timely filing window is within 1 calendar year after the date of service, CMS does not expect that providers affected by an emergency would be adversely affected by the timely filing requirements.</p>
D-7	<p>Question: What does CMS recommend for filing claims during a declared emergency?</p> <p>Answer: If an emergency were to cause difficulties in filing claims electronically, the Secretary could determine that this unusual circumstance merited waiving mandatory electronic claims filing requirements under the Administrative Simplification Compliance Act (ASCA) and allow paper claims to be filed, if necessary.</p>
D-8	<p>Question: What should providers do when treating a Medicare beneficiary who cannot provide his or her Medicare health insurance claim number at the time services are rendered?</p> <p>Answer: Medicare beneficiaries should not be denied emergency healthcare services.</p> <p>During a situation where the health care needs are not an emergency, the provider should instruct the beneficiary to call the Social Security Administration at 1-800-772-1213 to obtain a new card or to order one on-line at: https://www.hhs.gov/answers/medicare-and-medicaid/how-do-i-replace-my-medicare-card/index.html</p> <p>Providers should hold their claims until the beneficiary receives the new card and provides them with their Medicare number. Claims cannot be processed without the Medicare Number (or health insurance claim number). The Medicare regulation at 42 CFR § 424.44 defines the timely filing period for Medicare fee-for-service claims. In this circumstance, claims must be filed within 1 calendar year after the date of service. The timely filing period should allow adequate time for the provider to receive the health insurance number and file the claim.</p> <p>In those situations where the beneficiary requires emergency healthcare services in a natural or manmade disaster, the provider should attempt to obtain the Medicare number from the beneficiary, beneficiary's family members, or other providers such as transferring facilities, if possible. Providers can also share patient information to the extent necessary to seek payment for these health care services. If the provider cannot obtain the Medicare number through these other individuals, providers should contact the local Medicare contractor to request the Medicare number. Individual practitioners, such as a sole proprietorship, should be prepared to furnish the following information regarding their enrollment in the Medicare program: the provider's Social Security Number, date of birth and PTAN. Organizational providers should be prepared to furnish the following information about their enrollment in the Medicare program: the name of the authorized or delegated official on file for the provider.</p>
D-9	<p>Question: In the event of a declared emergency or disaster that results the provider's loss of the means to submit claims electronically may the provider submit paper claims?</p> <p>Answer: If such a disruption is expected to last more than 2 business days, affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, a provider should simply hold claims for submission when power and/or communication are restored. A provider is to self-assess when this circumstance applies, rather than apply for contractor or CMS waiver approval. A provider may submit claims to Medicare on paper or via other non-electronic means when this circumstance applies. A provider is not expected to pre-notify its Medicare claims administration contractor that this circumstance applies as a condition of submission of non-electronic claims.</p>

E – Physician Services

Question Number	Question and Answer
E-1	<p>Question: If a physician leaves his/her location to provide services to beneficiaries in a jurisdiction/locality outside of his/her usual jurisdiction/locality, must the physician bill based upon the new location or may he/she bill based upon his/her usual jurisdiction/locality?</p> <p>Answer: Physicians must bill and be paid for the service based upon the actual location/locality in which the service is rendered.</p>
E-2	<p>Question: Will the 60-day locum tenens limit be extended for those affected by the disaster? Some physicians in nearby States are going to the affected disaster areas to help out. In their absence, locum tenens physicians (i.e., temporary or substitute physicians) are substituting for the physicians leaving their medical practices to work in the disaster areas.</p> <p>Answer: No, the 60-day limit for a locum tenens physician may not be extended. However, current Medicare policy allows physicians to cover absences of longer than 60 days by hiring multiple substitute physicians. For example, if a physician needs to be absent from his or her medical practice for 120 days, the absent physician may hire one locum tenens physician to work the first 60-day period and a different locum tenens physician to work the second 60-day period. As an alternative to hiring more than one locum tenens physician, a physician could return to work in his or her practice for a short period of time to reset the 60-day clock.</p> <p>In addition, Medicare policy (for locum tenens billing) does not allow absent physicians to bill for substitute physicians for an indefinite period of absence, nor does Medicare policy allow physicians and other entities to bill for locum tenens personnel to fill staffing voids. The services of temporary personnel to fill staffing needs may be billed using other methods.</p>
E-3	<p>Question: If a practitioner is temporarily working out of another doctor's office (within the same State) due to damage from the emergency, would they need to file a Change of Address for this temporary site?</p> <p>Answer: Yes. In most cases, the physician or non-physician can reassign his or her benefits to the other group by completing the CMS-855R. However, if the physician or non-physician practitioner has not updated their enrollment record in more than 5 years, then the individual practitioner would need to also submit the CMS-8551. Further questions should be referred to the provider's Medicare contractor. See § 424.521(2) - Request for payment by physicians, non-physician practitioners, physician and non-physician organizations, and ambulance suppliers. This precludes enrollment in advance of providing services to Medicare beneficiaries in the case of a disaster or emergency.</p> <p>Updated: 5/1/2018</p>
E-4	<p>Question: Will Health Professional Shortage Areas (HPSAs) be extended/expanded in an emergency or disaster?</p> <p>Answer: There are no plans at this time to implement an accelerated HPSA process for areas affected by an emergency or disaster.</p>
E-5	<p>Question: During an emergency/disaster, is it possible for civilian physicians to bill Medicare and Medicaid for care provided to patients in federal facilities?</p> <p>Answer: Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. However, current Medicare Part B physician payment policy does allow a physician who is individually enrolled in Medicare, and not an employee or contractor of the federal facility, to separately bill Medicare for services provided to a Medicare beneficiary, using the appropriate place of service code. Place of service (POS) code 26 is to be used for services provided in Military Treatment Facilities, which are medical facilities operated by one or more of the Uniformed Services. Military Treatment Facility also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF). Physician services provided in these locations are paid at the physician facility rate. A complete listing of available place of service codes can be found in Chapter 26 of the Medicare Claims Processing Manual.</p> <p>Updated: 9/27/17</p>

F – Ambulance Services

Question Number	Question and Answer
F-1	<p>Question: If the ambulance crew provides treatment but does not transport anyone, can the company bill Medicare for the services provided?</p> <p>Answer: No. Medicare law prohibits payment unless the transport of a Medicare beneficiary has taken place.</p>
F-2	<p>Question: Will Medicare pay for ambulance services for emergency evacuation situations?</p> <p>Answer: Medicare contractors may make payment for ambulance transports for evacuating patients from locations affected by an emergency/disaster. The regulatory requirements must be met in order for such ambulance transports to be covered (i.e., the vehicle must meet certain requirements, the crew must be certified, ambulance services must be medically necessary, the transport must be from an eligible origin and to an eligible destination, certain billing and reporting requirements must be met, and Medicare Part A payment is not made directly or indirectly for the services).</p>
F-3	<p>Question: How will ambulance services be paid when patients are moved from hospital to hospital or other approved locations?</p> <p>Answer: Charges for ambulance transportation will be paid 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. Outpatient claims may be submitted as separately billable claims for ambulance charges incurred by those patients who were transported from the originating hospitals and subsequently discharged by receiving hospitals.</p>
F-4	<p>Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to an emergency/disaster, and who wishes to return to a nursing facility closer to family members or home after the emergency/disaster is over?</p> <p>Answer: Part B of the Medicare program covers only local ambulance transportation to and from the nearest appropriate SNF equipped to treat the beneficiary, as long as the beneficiary is not a SNF resident in a covered Part A stay whose transport would be subject to consolidated billing rules. If there are exceptional circumstances that require transport outside the locality, Medicare can pay for this transport, but only if the destination is still the nearest SNF with appropriate facilities. In any case, the ambulance transport must be medically necessary.</p>
F-5	<p>Question: Do the condition code "DR" (disaster related) and modifier "CR" (catastrophic/disaster related) apply to hospital-based ambulance providers?</p> <p>Answer: The "DR" condition code and the "CR" modifier both apply to ambulance claims submitted by institutional providers to Medicare FIs or MACs. However, only the "CR" modifier, but not the "DR" condition code, applies to suppliers submitting claims to Medicare Carriers or MACs. Neither carriers nor the Part B side of MACs use the "DR" condition code.</p>
F-6	<p>Question: For ambulance claims submitted by institutional providers, does it matter which modifier (the "CR" modifier or the "DR" condition code) is used for an institutional claim?</p> <p>Answer: An institutional provider would use the "CR" modifier to designate any service line item on the claim that is disaster related. If all of the services on the claim are disaster related, the institutional provider should use the "DR" condition code to indicate that the entire claim is disaster related.</p>
F-7	<p>Question: For ambulance claims submitted by institutional providers, where would we use the "CR" modifier on institutional claim submittals?</p> <p>Answer: On the ANSI X12 837 Institutional claim format, this information would go in loop 2400 SV202-3 or SV202-4. On a paper claim, it would be entered in block 44 on the CMS UB-04 form.</p>
F-8	<p>Question: For ambulance claims submitted by institutional providers, where would we use the "DR" (disaster related) condition code on institutional claim submittals?</p> <p>Answer: On the ANSI X12 837 Institutional claim format, this information would go in loop 2300 HI01-2. On a paper claim, it would be entered in blocks 24 -30 on the CMS UB-04 form.</p>

Question Number	Question and Answer
F-9	<p>Question: On claims for ambulance services, would I include the origin/destination modifiers?</p> <p>Answer: You should include an origin/destination modifier for all ambulance claims submitted for separate payment and that are not, under Medicare rules, included in the Medicare payment for an inpatient institutional service.</p>
F-10	<p>Question: If a beneficiary, 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?</p> <p>Answer: Medicare's payment to ambulance providers includes payment for all necessary supplies, including oxygen. Thus, if the transport is a Medicare-covered service (e.g., the beneficiary must be transported by ambulance 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 DME supplier for furnishing portable oxygen when supplemental oxygen is needed for the beneficiary during the transport.</p>

Question Number	Question and Answer
F-11	<p>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?</p> <p>Answer: CMS defines “approved destination” in the Code of Federal Regulations (CFR), 42 CFR § 410.40(e), Origin and Destination requirements. Medicare can only pay for ambulance transportation when it meets the Origin and Destination Requirements and all other coverage requirements in Medicare regulations and manuals. These requirements specify that an appropriate destination is one of the following:</p> <ul style="list-style-type: none"> · Hospital; · Critical Access Hospital (CAH); · Skilled Nursing Facility (SNF); · Beneficiary’s home; · Dialysis facility for ESRD patient who requires dialysis. <p>Beneficiaries residing in a SNF who are receiving Part B benefits only are eligible for ambulance transport to one additional “approved destination”: 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.</p> <p>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.</p> <p>We do not expect an emergency/disaster to affect the availability of hospital or other facility services; however, should a facility which 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.</p> <p>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.</p> <p>The waiver authority under § 1135 does not authorize a waiver of the ambulance payment and coverage requirements, such as the approved destination requirements described above. 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 (whether under a § 1135 waiver or existing rules). If the alternative care site is granted approval by the State Agency to be 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 in the absence an 1135 waiver.</p> <p>Updated: 1/9/19</p>
F-12	<p>Question: If EMS providers render care and advice at the site, and release or redirect patients to primary care and not the Emergency Department, will this care be reimbursed as an Emergency Visit?</p> <p>Answer: With respect to Medicare FFS, there is no statutory benefit category that allows Medicare to pay for the services of an EMT or paramedic in the absence of a medically necessary ambulance transport. The Medicare statute does allow payment to ambulance suppliers and providers. However, the Medicare ambulance benefit covers only a medically necessary ambulance transport of a Medicare beneficiary to the nearest appropriate facility (e.g., a hospital or critical access hospital) equipped to treat the beneficiary, and payment to the ambulance supplier or provider under the ambulance fee schedule covers both the ambulance transport and all covered supplies and services associated with such transport as may be medically necessary for the beneficiary. The statute does not permit payment to an ambulance supplier or provider (e.g., hospital-owned) without transport even if a waiver is in effect under section 1135 of the Social Security Act. Therefore, no separate Medicare FFS payment is available for services provided by an EMT or paramedic.</p>

Question Number	Question and Answer
F-13	<p>Question: If a Medicare beneficiary is transported by ambulance to a local skilled nursing facility (SNF) because the ambulance was unable to transport the beneficiary to the hospital located in another community for factors such as weather, would Medicare payment be available under either of the following two scenarios?</p> <ol style="list-style-type: none"> 1. The ambulance service would use space in the SNF that was not used by patients and would provide the care for the patient under the direction of the ambulance medical director. 2. The staff from the SNF would help provide care for the patients, freeing the ambulance service staff to take other calls. <p>Answer: These scenarios implicate both payment policy and conditions of participation and the permissibility of either scenario may depend on whether a waiver under § 1135 of the Social Security Act has been granted to the SNF in question. First, in the absence of an 1135 waiver, if the patient needs a hospital level of care and not a SNF level of care, the SNF cannot be considered a hospital alternative care site. Therefore, the ambulance transport of the patient to the SNF would not be payable under Medicare because the SNF would not be the nearest appropriate facility that is capable of furnishing the required level and type of care for the beneficiary's illness or injury (see 42 CFR § 410.40(e) for destination requirements under Medicare fee-for-service). In addition, because the SNF cannot be considered a hospital alternative care site for furnishing a hospital level of care, no Medicare payment would be available for any services furnished to the patient while a resident of the SNF.</p> <p>Even if 1135 waivers were generally available for a particular emergency, because SNFs are not equipped to provide a hospital level of care, and because neither of the described scenarios entail a hospital working with a SNF to create an alternate hospital care site at the SNF, with the hospital providing additional staffing, CMS would likely have strong reservations about approving such a waiver request, regardless of whether or not the ambulance service would be providing personnel to monitor the patient(s) at the SNF. However, CMS would review the particular circumstances of the actual situation to make a determination under an 1135 waiver as to what practices would be permitted, along with whether Medicare could pay for any covered services and under which benefit the services would be paid.</p>

G – Laboratory & Other Diagnostic Services

Question Number	Question and Answer
G-1	<p>Question: In situations where laboratory specimens are destroyed or compromised by a disruptive event, how will laboratories be paid?</p> <p>Answer: Contractors may consider payment for another drawing fee, specimen transport, or test if the results have not been communicated to the patient's physician.</p>
G-2	<p>Question: Will Medicare pay for diagnostic tests for infectious diseases (e.g., nasal swabs) for beneficiaries?</p> <p>Answer: Under Part B, Medicare will cover diagnostic tests as set forth in 42 CFR § 410.32 and other existing policies. Note, however, that the Social Security Act contains exclusions that bar payment if an item or service was provided free of charge and in other circumstances as specified in 42 CFR Part 411.</p>
G-3	<p>Question: Will Medicare reimburse for rapid flu tests?</p> <p>Answer: Rapid Flu tests may be considered a Medicare benefit under § 1861(s)(3) of the Social Security Act as a diagnostic laboratory test. All services, including rapid flu tests, furnished under the Medicare program must be medically reasonable and necessary and appropriate for diagnosis and/or treatment of an illness or injury.</p>

H – Drugs & Vaccines Under Part B

Question Number	Question and Answer
H-1	<p>Question: Will Medicare help pay for an influenza vaccine only if it has been approved by the FDA?</p> <p>Answer: Yes, Medicare will cover a vaccine only if the FDA has approved it or authorized its distribution, including approvals/authorizations under the FDA's emergency use authority under § 564 of the Federal Food, Drug, and Cosmetic Act.</p>
H-2	<p>Question: Will Medicare pay for a physician's administration of an influenza vaccine to a beneficiary?</p> <p>Answer: Yes, Medicare pays for the administration of the vaccine when it is administered by a qualified Medicare provider or supplier who meets the applicable requirements for billing for the standard influenza virus vaccine and its administration.</p>
H-3	<p>Question: Will Medicare Part B pay for vaccinations of Medicare beneficiaries?</p> <p>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.</p>
H-4	<p>Question: What can Medicare beneficiaries, who generally receive their Part B drugs at the doctor's office, do when that office is inaccessible?</p> <p>Answer: If possible, patients should contact their original physician's office to determine if there is an alternate location where they can receive services. If this is not possible, then patients may find another physician. That new physician can provide the necessary Part B drugs and Medicare will pay for them since beneficiaries in original, i.e., fee-for service, Medicare can receive health care services anywhere in the country. (Note: Medicare Advantage (MA) enrollees also can get urgently needed or emergency health care services anywhere.)</p>
H-5	<p>Question: If a State distributes CDC's Strategic National Stockpile (SNS) drugs to hospitals, what are the Medicare billing rules? How should hospitals handle billing for services that involve the use of SNS provided drugs?</p> <p>Answer: For services rendered to Medicare fee-for-service (FFS) beneficiaries, standard Medicare FFS billing rules apply. This would include following existing policy on no cost items, such as SNS drugs located 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.</p> <p>Updated: 5/1/2018</p>
H-6	<p>Question: Will Medicare Part B cover a 90-day supply of drugs in the event that a pandemic occurs, when such drugs are needed to address a chronic condition.</p> <p>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 DME, contractors 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, contractors 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 determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.</p> <p>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 because it is not uncommon for the physician to change the prescription from one drug to another), in the event of an emergency, contractors may consider allowing payment for a medically necessary, greater-than-30-day supply of Medicare-covered, immunosuppressive drugs on a case-by-case basis.</p>

Question Number	Question and Answer
H-7	<p>Question: A Medicare beneficiary's supply of a Part B covered drug was affected by the emergency such that the remainder of the prescribed amount of the drug became unusable or lost and must be replaced. Will Medicare pay for a replacement prescription within the timeframe covered by the original prescription?</p> <p>Answer: Contractors may allow payment for replacement prescription fills (for a quantity up to the amount originally dispensed) when reasonable and necessary in circumstances where the dispensed medication is lost or otherwise rendered unusable by damage due to the emergency. Non-institutional providers must use the CR modifier in billing situations related to a declared emergency/disaster. In addition, non-institutional providers should keep documentation that indicates whether the drug was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the disaster.</p> <p>Updated: 9/11/17</p>
H-8	<p>Question: Can a Medicare beneficiary receive more than a 30-day supply of Medicare Part B covered drugs during an emergency?</p> <p>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. However, contractors have the authority to make exceptions for the 30 day limit on immunosuppressive drug under special circumstances; information on such exceptions would be made available by the Medicare Administrative Contractor that processes a provider or supplier's immunosuppressive drug claims.</p> <p>Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf (Exception for "special circumstances" is in section 80.3)</p> <p>Updated: 5/1/18</p>

I – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Question Number	Question and Answer
I-1	<p>Question: If a beneficiary’s durable medical equipment, prosthetic, orthotic, or supply (DMEPOS) is lost, damaged, destroyed, or otherwise rendered unusable due to a circumstance related to an emergency, can the beneficiary obtain a replacement item and if so how would the supplier bill for such item?</p> <p>Answer: Yes, a beneficiary is generally able to receive replacement of a DMEPOS equipment/item.</p> <p><i>Policy</i> See the Medicare Claims Processing Manual Chapter 20, Section 50, regarding Medicare’s customary payment policy for replacement of DMEPOS. This policy remains in effect even when an emergency or a major disaster is declared by the President of the United States. The following explains the existing policy:</p> <p>Except as noted below, Medicare pays for the replacement of equipment/item(s) which (a) the beneficiary owns, (b) is oxygen equipment, or (c) is a capped rental item(s) when the equipment/item(s) is lost, destroyed, irreparably damaged, or otherwise rendered unusable.</p> <p>Medicare does not pay for the replacement of items that require frequent and substantial servicing as defined in 42 CFR 414.222. For oxygen equipment and capped rental equipment other than complex rehabilitative power wheelchairs, payment for the replacement of the equipment is made by starting a new 36-month rental period for oxygen equipment or a new 13-month rental period for capped rental equipment. Payment for replacement of complex rehabilitative power wheelchairs (Healthcare Common Procedure Coding System codes K0835 thru K0864) can be made on a lump sum purchase or rental basis.</p> <p>In all cases for which Medicare payment of a replaced equipment/item is available, the replacement must be furnished by a Medicare-enrolled supplier. New face-to-face, physician’s order, and certificate of medical necessity requirements are still in effect, unless specified otherwise by CMS – that is:</p> <ul style="list-style-type: none"> • The President of the United States declares a state of emergency for the particular area, • The Health and Human Services Secretary declares a Public Health Emergency for the particular area, <u>and</u> • CMS issues a specific waiver allowing for such a waiver based on Section 1135 of the Social Security Act. <p><i>Billing</i> The “CR” modifier (catastrophe/disaster related) should be included on claims when a formal waiver has been issued as described above.</p> <p>The “RA” modifier (replacement of a DME item) is always required on a claim line for a replacement item. If the beneficiary is displaced from a federally-declared emergency or major disaster area, the beneficiary may obtain the replacement item from a Medicare-enrolled supplier located outside such area. If the supplier is aware that the item is a replacement, the supplier should annotate the claim line with the “RA” modifier.</p> <p>The “KT” modifier (beneficiary resides in a competitive bidding area (CBA) and travels outside that CBA and receives a competitive bid item) is always required on a claim line for a replacement competitive bid item if a beneficiary permanently residing in a CBA is displaced from a federally-declared emergency or major disaster area, and the replacement item is a competitively bid item. In this circumstance, payment for the CB item will be made at the single payment amount for the beneficiary’s permanent residence in a CBA.</p> <p>The “99” modifier (modifier overflow) should be used if the claim line requires more than four modifiers to indicate to the Medicare Administrative Contractor (MAC) that one or more additional modifiers are applicable.</p> <p>Updated: 12/5/17</p>

Question Number	Question and Answer
I-2	<p>Question: If a beneficiary, living at home and using a stationary oxygen unit, has to be transported to another location, can Medicare pay for any portable oxygen necessary to transport the beneficiary?</p> <p>Answer: Yes. Medically necessary oxygen in connection with and as part of the ambulance service would be included in Medicare's payment to an ambulance supplier when a beneficiary is transported by ambulance and such transport is a Medicare-covered service. In addition, separate payment under Part B can be made to a DME supplier for portable oxygen when medically necessary to transport the beneficiary if the transport itself is not covered by Medicare.</p> <p>Updated: 10/26/17</p>
I-3	<p>Question: Will Medicare cover and pay for a surgical mask to prevent the spread of infectious diseases, if prescribed by a physician?</p> <p>Answer: No. There is no Medicare benefit category that would allow for separate coverage of a surgical mask.</p> <p>Updated: 10/26/17</p>
I-4	<p>Question: Will CMS cover the cost of a generator for medical needs for an individual beneficiary for home or portable use?</p> <p>Answer: Although a generator may be used to power durable medical equipment, it is not, nor can it be considered to be, medical equipment. By law, Medicare does not have the authority to pay for generators.</p> <p>Updated: 10/26/17</p>
I-5	<p>Question: A supplier has been dispensing portable oxygen tanks to beneficiaries every day because power is out in their area and their oxygen concentrators do not function without power. Can CMS provide reimbursement in addition to the fee schedule amount that the supplier is already receiving for that patient? That is, due to the above-normal amount being dispensed can payment be higher than the usual monthly oxygen payments? If so, would there be any particular billing requirements other than the "CR" modifier?</p> <p>Answer: No. If a supplier chooses to provide portable oxygen equipment in lieu of stationary equipment during this time, the supplier will not receive an additional Medicare payment. If a beneficiary's concentrator does not work due to a power outage, the supplier may meet the beneficiary's stationary oxygen needs by furnishing gaseous or liquid stationary equipment until the power is back on in the beneficiary's home. The supplier may also choose to pick up the concentrator while the beneficiary is using other stationary oxygen modalities.</p> <p>Medicare payment for stationary oxygen equipment, stationary oxygen contents, and portable oxygen contents is included in the supplier's monthly fee schedule payment amount. A supplier may receive an "add on" amount as payment for portable oxygen equipment in certain situations if a beneficiary receives portable oxygen after a finding of medical need. Other than this "add on" amount for patients found to have a medical need for portable oxygen, the monthly payment amount for oxygen and oxygen equipment does not vary depending on the modality of oxygen that is furnished.</p> <p>Updated: 12/5/17</p>
I-6	<p>Question: Can the face-to-face requirement for certain DMEPOS be waived in an emergency?</p> <p>Answer: The face-to-face requirement may only be waived if the following occurs:</p> <ul style="list-style-type: none"> • The President of the United States declares a state of emergency for the particular area, • The Health and Human Services Secretary declares a Public Health Emergency for the particular area, <u>and</u> • CMS issues a specific waiver allowing for such a waiver based on Section 1135 of the Social Security Act. <p>If such conditions apply, CMS will notify the public on its Emergency Response and Recovery website. Absent a formal waiver indicated above, the face-to-face requirement remains in effect.</p> <p>Updated: 10/26/17</p>

Question Number	Question and Answer
I-7	<p>Question: Can medical necessity documentation requirements for DMEPOS be waived in an emergency?</p> <p>Answer: Medical necessity documentation requirements may only be waived if the following occurs:</p> <ul style="list-style-type: none"> • The President of the United States declares a state of emergency for the particular area, • The Health and Human Services Secretary declares a Public Health Emergency for the particular area, <u>and</u> • CMS issues a specific waiver allowing for such a waiver based on Section 1135 of the Social Security Act. <p>If such conditions apply, CMS will notify the public on its Emergency Response and Recovery website. Absent a formal waiver indicated above, medical necessity documentation requirement remains in effect.</p> <p>Updated: 10/26/17</p>
I-8	<p>Question: How can people with Medicare who have been displaced, without access to their usual suppliers, get access to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) such as wheelchairs and therapeutic shoes?</p> <p>Answer: Beneficiaries who have access to a telephone may contact 1-800-MEDICARE for information regarding suppliers servicing their current location. Alternatively, if beneficiaries have access to the Internet, they go to the following medicare.gov website to obtain a directory listing suppliers by geography, proximity and name: http://www.medicare.gov/supplier.</p> <p>Updated: 10/26/17</p>
I-9	<p>Question: Could CMS summarize Medicare's payment rules regarding payment for oxygen services in an emergency, especially with regard to changes in delivery modalities (portable versus stationary) made necessary by the emergency?</p> <p>Answer: The Medicare monthly payment amount for oxygen and oxygen equipment includes payment for all of the different oxygen modalities (concentrator, liquid, gaseous) and also includes payment for portable oxygen contents. If suppliers have to switch patients to a different modality (i.e., from concentrator to gaseous or liquid stationary or portable equipment), for example, because of a power outage, the Medicare payment already factors those costs into the monthly payments. Therefore, no additional payment for switching to a different modality can be made in these situations as the Medicare payment includes payment for all modalities.</p> <p>The monthly portable equipment add-on payment includes an additional payment (added on to the monthly payment for oxygen and oxygen equipment) when portable equipment is used and medically necessary. This is only an add-on payment to the monthly payment amount for oxygen and oxygen equipment and should not be confused with a monthly payment for furnishing portable oxygen equipment and oxygen contents. Again, the Medicare monthly payment for oxygen and oxygen equipment includes payment for all modalities of stationary oxygen and payment for any necessary oxygen contents, both stationary and portable oxygen contents.</p> <p>The portable equipment add-on payment can be made in cases where the patient was not already using portable oxygen equipment and needs to be furnished with portable oxygen equipment, for example, during a federally-declared emergency or major disaster. However, if the patient was already receiving portable oxygen equipment, additional payments beyond what the supplier is already receiving for furnishing portable oxygen equipment on a monthly basis cannot be made because this amount includes the monthly payment amount and the add-on payment .</p> <p>Finally, if oxygen equipment is lost, for example, as a result of a federally-declared emergency or major disaster, the supplier can follow the normal process for submitting a claim for replacement of the lost equipment in disaster situations. Medicare begins the 36-month payment period over in situations where lost oxygen equipment must be replaced and proper documentation describing the need for replacement and the required medical necessity documentation is furnished. The DME MACs will process the claims for replacement of lost oxygen equipment using the process established for processing disaster claims.</p> <p>Updated: 12/5/17</p>

Question Number	Question and Answer
I-10	<p>Question: Due to the limited utilities (phone, power and internet) a beneficiary seeks an alternative oxygen supplier to support his/her respiratory needs during the state of emergency. Can the secondary provider bill for respiratory services rendered to a patient residing in the federally-declared emergency or major disaster area?</p> <p>Answer: The alternate supplier of oxygen and oxygen equipment needs to seek payment from the supplier that received the Medicare monthly payment amount for the remainder of the paid month during which the beneficiary relocated or needed to obtain services from an alternate supplier. The Medicare fee-for-service program does not authorize a duplicate payment for the same month. Once the month for which the initial supplier received payment is over, the alternate supplier can bill for the next continuous month, but the supplier of the equipment left behind in the patient's home cannot be paid.</p> <p>Updated: 12/5/17</p>
I-11	<p>Question: A number of patients have chosen to remain at home without power even though they are using mechanical ventilators (Healthcare Common Procedure Coding System (HCPCS) codes E0465 & E0466) and Respiratory Assist Devices (RADs). To support these life-sustaining devices requires supplemental external batteries to maintain the respiratory devices to continue to function and support the respiratory needs of the patients. Can suppliers bill for supplemental batteries to support these devices for patients residing in the federally-declared emergency or major disaster area?</p> <p>Answer: No. The statute does not allow payment for power generators or alternative power sources needed in the event of power outages.</p> <p>Updated: 10/26/17</p>
I-12	<p>Question: Due to a federally-declared emergency or major disaster, beneficiaries have reported that their existing medical supplies were destroyed (Positive Airway Pressure (PAP) masks, tubing and head gear, oxygen tubing, ventilator/trachea cuffs, etc.). While a beneficiary is displaced from his/her home, a supplier is requesting for emergency replacement of certain supplies (e.g., PAP masks/supplies) that may be otherwise not allowed by Medicare due to frequency limitations (e.g., if an item is only allowed to be provided quarterly, but a quarter has not yet elapsed since the last replenishment). Would CMS allow for a supplier to bill for these needed medical supplies?</p> <p>Answer: Medicare will pay for the replacement of medically necessary supplies and accessories for beneficiary owned DME or capped rental DME in the event that these items are lost, destroyed, irreparably damaged, or otherwise rendered unusable, for example, due to circumstances related to an emergency in a federally declared emergency or major disaster. The replacement accessories may be furnished by a new supplier if the supplier on record is unable to provide the replacement accessories to the beneficiary.</p> <p>Updated: 10/26/17</p>
I-13	<p>Question: Due to flash flooding, beneficiaries needed to leave their homes quickly and were unable to transport their hospital bed to the new location. These beneficiaries' medical needs require the support and position from a hospital bed. Can the supplier bill for both the primary hospital bed and the secondary temporary replacement hospital bed until the beneficiary is able to return to their home?</p> <p>Answer: The alternate supplier of the hospital bed needs to seek payment from the supplier that received the Medicare monthly rental payment amount for the remainder of the paid month during which the beneficiary relocated or needed to obtain services from an alternate supplier. The Medicare fee-for-service program does not authorize a duplicate payment for the same month. Once the rental month for which the initial supplier received payment is over, the alternate supplier can bill for the next continuous month, but the supplier of the equipment left behind in the patient's home cannot be paid.</p> <p>Updated: 10/26/17</p>

Question Number	Question and Answer
I-14	<p>Question: Where can beneficiaries learn more about disaster resources in areas impacted by a federally declared emergency or natural disaster?</p> <p>Answer: Beneficiaries can review a broad range of information at the FEMA website https://www.fema.gov/disasters. Additionally, beneficiaries should review information and follow instructions provided by their State or territory for a particular emergency or disaster.</p> <p>Updated: 10/26/17</p>

J – End Stage Renal Disease (ESRD) Facility Services

Question Number	Question and Answer
J-1	<p>Question: Will a hospital be reimbursed for dialysis services performed on an emergency basis if the hospital does not have a hospital-based renal dialysis center?</p> <p>Answer: Yes. When an ESRD patient cannot obtain his or her regularly scheduled dialysis treatment at a certified ESRD facility and has a medical need to receive an unscheduled or emergency dialysis session in an outpatient hospital setting, the service is payable under the outpatient prospective payment system. The hospital bills under the appropriate revenue code center for HCPCS G0257: UNSCHEDULED OR EMERGENCY DIALYSIS TREATMENT FOR AN ESRD PATIENT IN A HOSPITAL OUTPATIENT DEPARTMENT THAT IS NOT CERTIFIED AS AN ESRD FACILITY.</p> <p>The provisions of payment for this service are applicable to dialysis performed following or in connection with a vascular access procedure, dialysis performed following treatment for an unrelated medical emergency, and emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment. Generally, CMS will monitor the use of HCPCS code “G0257” to ensure that certified dialysis facilities are not incorrectly using this code and that the same dialysis patient is not repeatedly using this code, which would indicate routine dialysis treatment. As a result of an emergency/disaster, however, CMS understands that the unscheduled or emergency dialysis treatment may be necessary for a longer period of time than under otherwise normal circumstances. Hospital outpatient departments may continue to provide this service on an emergent or unscheduled basis, absent any functional, nearby, certified dialysis facility to perform the service. For validation purposes, hospitals should include the condition code “DR” (disaster related) on the claim. In addition, the ESRD patient’s home facility would be responsible for obtaining and reviewing the patient’s medical records to ensure that appropriate care was provided in the hospital and that, to ensure continuity of care, any necessary modifications are made to the patient’s plan of care upon the patient’s return to the facility.</p>
J-2	<p>Question: Dialysis providers are required to maintain a Blood Urea Nitrogen (BUN) test weekly on hemodialysis, CCPD patients, and monthly for CAPD home patients. The dialysis provider receiving patients from emergency/disaster-impacted areas may not have this information on hand to bill. What guidance can be given to providers for this situation?</p> <p>Answer: The provider should bill using the latest BUN results available which may be the one taken at the time of treatment. Additional instructions may be found in the IOM 100-4, Chapter 8, Section 50.9, which provides instructions about coding for the adequacy of hemodialysis, as measured by the Urea Reduction Ratio (this section also includes information about the use of modifier “G6” for ESRD patients for whom less than seven dialysis sessions have been provided in the month).</p>
J-3	<p>Question: If a hospital has more inpatient dialysis patients than it is equipped to dialyze but there is a functional outpatient dialysis center nearby to which the hospital sends patients, can both providers bill Medicare?</p> <p>Answer: No. If a hospital inpatient is sent to a functional outpatient dialysis unit nearby, that service should be performed “under arrangements” with the hospital. When services are provided under an arrangement, the first facility retains the professional responsibility for those services and also for obtaining reimbursement for them. The second facility is permitted to seek payment only from the first facility and may not bill the patient or the Medicare program. Hence, under the scenario posed above, the hospital inpatient bundling rule would apply and the hospital should bill for the inpatient stay and dialysis service.</p>

Question Number	Question and Answer
J-4	<p>Question: Value codes “A8” and “A9” are required to be reported on each dialysis claim to report the patient height and weight. The payment for the claim is determined by this information. Given emergency/disaster situations, this information may not be gathered and on hand for billing. Can billing guidance be provided?</p> <p>Answer: This information is necessary for the Medicare system to pay the claim. The height and weight must be reported. Absent the tools to precisely determine the height and weight the provider may use the height and weight as reported by the patient from their last session. For patients impacted by the emergency/disaster, clinically appropriate estimates of weight and height would be acceptable when usual methods are not available. Documentation of the height and weight should be included in the patient’s medical records including a description of any alternative methods used as a result of the circumstances. If the height and/or weight were not obtained because of emergency/disaster-related conditions, the provider may submit a claim for the first treatment that does not include the height and/or weight. Include on the claim the condition code DR (disaster related). The FI or MAC will populate the height and/or weight values using the latest information available in the claims history.</p>

K – Home Health Services

Question Number	Question and Answer
K-1	<p>Question: How will payments be processed for home health agencies (HHAs) in an emergency or disaster?</p> <p>Answer: In the event of an emergency or disaster, CMS will advise the RHHIs or MACs to facilitate payment for home health services for beneficiaries who have been displaced due to the emergency/disaster. The RHHI or MAC will work with the HHAs that have transferred or received patients to ensure that claims are processed timely and issues are addressed quickly.</p>
K-2	<p>Question: Can the “residence” component of the homebound requirements be suspended by allowing the delivery of home health services at any site of temporary residence during an emergency or disaster? Can this include a residence that is a nursing facility or hospital provided the patient is otherwise not at such level of care when the patient is using the facility as a medical shelter?</p> <p>Answer: The Social Security Act stipulates that beneficiaries must be confined to the home in order to be eligible to receive home health services. A beneficiary’s home is any place in which a beneficiary resides that is not a hospital, skilled nursing facility (SNF), or nursing facility as defined in § 1861(e)(1), § 1819(a)(1), or § 1919(a)(1) of the Social Security Act, respectively. Under the temporary, extraordinary circumstance of a declared emergency or disaster, place of residence can include services provided at temporary locations like a family member’s home, a shelter, a community facility, a church, or a hotel. A hospital, SNF, or nursing facility as defined above would not be considered a temporary residence.</p>
K-3	<p>Question: Can the application of Partial Episode Payment (PEP) be suspended for patients displaced to other home health agencies (HHAs) due to an emergency?</p> <p>Answer: Normal prospective payment procedures will apply. We believe it crucial that home health agencies remain responsible for home health beneficiaries, up until a PEP situation is determined. The PEP appropriately truncates the previous episode, and allows for a subsequent episode to be established with each home health agency being reimbursed for the services provided.</p>
K-4	<p>Question: If a home health agency (HHA) affected by an emergency is unable to submit within 60 days the final claims for home health episodes that are already begun, Medicare will automatically cancel the request for anticipated payment (RAP) for those episodes. The recovery of the RAP payments will decrease already strained cash flow for this agency. Will CMS waive the requirement to submit final home health claims within 60 days of the end of the emergency episode?</p> <p>Answer: CMS is instructing the Regional Home Health Intermediaries (RHHIs) and MACs to temporarily cease to automatically cancel the RAPs of HHAs in the emergency-affected region. The RHHIs/MACs will identify all HHAs located within the areas affected by the emergency. RAPs for these agencies will be assigned a new cancellation date to be specified. This will allow an additional 60-90 days for the HHAs to resume submission of final claims.</p>

Question Number	Question and Answer
K-5	<p>Question: How should home health agencies (HHAs) that have received patients that were displaced by a declared emergency code their claims for these new admissions?</p> <p>Answer: HHAs should report condition code 47 (indicating transfer from another HHA) on their requests for anticipated payment (RAPs) for these patients. The use of this code will ensure that Medicare systems do not reject the RAP due to the overlapping home health episode at the prior HHA. This is standard coding procedure for all transfers under the home health prospective payment system, so no other special indicators are needed on these RAPs.</p>
K-6	<p>Question: If beneficiaries who have been receiving home health services cannot obtain emergency-related treatment during the emergency (e.g., medication, vaccination, etc.) from home health agencies (HHAs) within their service area, will CMS suspend any geographic service limitations (consistent with any applicable State requirements) to permit out-of-area HHAs to fill unmet needs?</p> <p>Answer: A Medicare-approved HHA that is able to provide home health services beyond its current geographic service area may do so on a temporary basis during the emergency period, provided that the HHA is in full compliance with State and local law, that the HHA is able to ensure that staff is competent and able to provide appropriate patient care, and that the purpose of the expansion is to provide care to the patients affected by the emergency.</p>
K-7	<p>Question: Can consolidated billing requirements for home health agencies be suspended during an emergency for which an 1135 waiver has been issued?</p> <p>Answer: No. Normal prospective payment procedures will apply. This is true whether or not an 1135 waiver has been issued.</p>
K-8	<p>Question: Our office has been destroyed by flood waters. Although we have electronic medical records, some paper documents including signed Face-to-Face Encounter Forms and Physician Plans of Care have been destroyed. What recourse do we have related to billing for the services that have been provided to these clients?</p> <p>Answer: Instructions for how to handle situations where documentation to support payment has been lost or destroyed can be found in CMS' Program Integrity Internet Only Manual in Publication 100-08, Chapter 3, § 3.8 entitled "Administrative Relief from MR During a Disaster" at the following link: http://www.cms.gov/manuals/downloads/pim83c03.pdf. A note should be entered (and dated) in the medical record that the documentation of "XYZ" was destroyed in the hurricane.</p>
K-9	<p>Question: What documentation does a provider need to have on file to submit as proof of the destruction of medical records for future ADRs, CERTs, RACs, etc.?</p> <p>Answer: Instructions for how to handle situations where documentation to support payment has been lost or destroyed can be found in CMS' Program Integrity Internet Only Manual in Publication 100-08, Chapter 3, § 3.8 entitled "Administrative Relief from MR During a Disaster" at the following link: http://www.cms.gov/manuals/downloads/pim83c03.pdf. A note should be entered (and dated) in the medical record that the documentation of XYZ was destroyed in the hurricane.</p>
K-10	<p>Question: For Home Health Services, how will the requirement for securing physician signatures within 30 days on orders be addressed?</p> <p>Answer: This is not a Federal requirement but may be State specific. CMS requires a signature prior to billing the final claim.</p>
K-11	<p>Question: Are the home health requirements for a face-to-face encounter waived under Section 1135 of the Act?</p> <p>Answer: No. The required timeframe for the occurrence of a home health face-to-face encounter is typically flexible enough to allow HHAs to meet this requirement, even in emergency situations. A face-to-face encounter can occur up to 90 days prior to the start of care or within 30 days after the start of care. (see section 30.5.1.1 in Chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-02)). However, if conditions related to the emergency cause a provider to expect to be unable to meet these timeframes, that provider should contact the CMS RO to allow for tracking and completion of this encounter as soon as conditions allow.</p> <p>Updated: 9/11/17</p>

Question Number	Question and Answer
K-12	<p>Question: For Home Health Services, how will CMS address timely initiation of care when results are collected for Home Health Compare?</p> <p>Answer: The information below was posted on the Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS) website on Monday, 10/29/12:</p> <p>The Centers for Medicare & Medicaid Services (CMS) has advised us to alert Home Health Care CAHPS (HHCAHPS) Survey vendors who are conducting the HHCAHPS Survey by telephone data collection mode to stop telephone data collection in all states in which there has been a state of emergency declared due to Hurricane Sandy. All such vendors should identify the states in which a state of emergency has been declared and stop data collection in those states until the state of emergency has been lifted. HHCAHPS Survey data collection activities should resume immediately after the state of emergency has been lifted.</p> <p>All HHCAHPS Survey vendors located in states impacted by Hurricane Sandy should notify the HHCAHPS Coordination Team if your organization stops normal business operations due to the hurricane. All such agencies should submit a Discrepancy Notification Report describing the number of days your organization could not conduct HHCAHPS Survey activities due to Hurricane Sandy, and the date by which you expect to resume HHCAHPS Survey activities.</p> <p>Please contact the HHCAHPS Coordination Team by email (HHCAHPS@RTI.org) or by calling (866) 354-0985 if you have any questions about this issue.</p>
K-13	<p>Question: For a Home Health Agency that is adversely affected by a disaster or emergency, can an extension be granted for Additional Documentation Requests (ADRs) and/or audit responses?</p> <p>Answer: CMS issued instructions to all Medicare claims administration contractors on November 7, 2012, providing documentation and audit relief instructions specific to Hurricane Sandy disaster areas. This direction provides general administrative relief for individual physicians, providers and suppliers across the States of New York (NY), New Jersey (NJ), and Connecticut (CT) in addition to the case by case exceptions that exist in Chapter 3 § 3.8 of the CMS Program Integrity Internet Only Manual Publication 100-08 entitled "Administrative Relief from Medical Review During a Disaster". Generally, CMS has designated a 30 day relief in circumstances where additional documentation requests and audit responses were initiated across the three States of NY, NJ, and CT and an additional 30 days (a total of 60 days) have been granted for Federal Emergency Management Agency disaster declarations eligible for direct federal assistance. A fact sheet outlining this information, as well as other circumstances, can be found at the following link (http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/HurricaneSandy.html).</p>

L – Hospice Services

Question Number	Question and Answer
L-1	<p>Question: What is a hospice agency's responsibility in the event of a disaster?</p> <p>Answer: A hospice agency, as indicated in 42 CFR § 418.100(b), "Disaster preparedness," must have an acceptable written plan to be followed in the event of an internal or external disaster, including care of casualties arising from such a disaster.</p>
L-2	<p>Question: If a hospice provider cannot provide care for its patients, can these patients transfer to another hospice provider?</p> <p>Answer: Under the Social Security Act at § 1812(d)(2)(C) and CMS regulations at 42 C.F.R. § 418.30(a), a Medicare beneficiary may transfer from one hospice agency to another hospice for any reason once per election period. If a Medicare beneficiary has already utilized this one-time right to transfer but needs to move again because of a public health emergency, § 1861(dd)(5)(D) of the Act provides for a hospice agency to arrange with another hospice for the delivery of services in extraordinary circumstances. We would not deem a change in hospice under these circumstances to be a voluntary transfer under 42 C.F.R. § 418.30 (i.e., the beneficiary would still be entitled to a voluntary transfer after a transfer for "extraordinary circumstances").</p>

Question Number	Question and Answer
L-3	<p>Question: In the event that the originating hospice is able to resume provision of services to their patients, should patients be transferred back to the originating hospice?</p> <p>Answer: CMS believes that patients should be provided with the choice of resuming care from the originating hospice or continuing with the existing hospice provider. If the beneficiary remains with the “host”/replacement hospice at the end of the emergency period, we would consider this a transfer under our regulations at 42 CFR § 418.30. If a beneficiary uses the services of an alternate hospice agency for a short period of time under arrangement with the patient’s “home” hospice due to extraordinary circumstances, neither the departure from nor return to the original hospice agency would be considered a “transfer” within the meaning of 42 CFR § 418.30.</p>
L-4	<p>Question: How should a hospice that temporarily receives a patient from another hospice handle administration of that patient’s care plan if the patient arrives with no alternate caregiver information, and/or the admissions officer believes that the patient may be legally incompetent to make health care decisions for him/herself?</p> <p>Answer: Under CMS rules, the health and safety of the patient always comes first. The receiving hospice should complete an assessment of the patient to identify immediate needs and establish a plan of care with the interdisciplinary group (IDG). The receiving hospice should make every effort to contact the original hospice and/or attending physician to discuss the previously implemented plan of care and, if necessary, to determine if the patient is legally competent. If the receiving hospice has access to the plan of care established by the original hospice every attempt should be made to follow the plan if the needs of the patient are such that the original plan will provide the appropriate interventions.</p>
L-5	<p>Question: Who can speak/sign paperwork on behalf of the patient (including discharge and transfer decisions)?</p> <p>Answer: A person’s legal authority to make healthcare decisions on behalf of another is a matter of State law; hospices should confer with their counsel to determine whether their State law has provisions which address health care decision-making in emergency/extraordinary circumstances. If the hospice patient cannot speak or sign paperwork, the receiving hospice should make arrangements to get permission for treatment and care pursuant to state requirements.</p>
L-6	<p>Question: Will the hospice inpatient and aggregate payment caps be waived?</p> <p>Answer: Because these caps are not conditions of participation or program participation provisions within the meaning of § 1135 of the Act, it does not appear that statutory authority exists to allow CMS to waive these payment caps.</p>
L-7	<p>Question: If a hospice patient is transferred out of the impacted area due to emergency evacuation by ambulance and admitted to Hospice Inpatient Respite Care several hours away for safety, who is responsible for the ambulance bill to the destination and the return trip?</p> <p>Answer: The emergency waiver authority under § 1135 of the Social Security Act (Act) does not affect how Medicare hospice services are covered. Specifically, as in non-emergency situations, those services and items covered pursuant to §1861(dd)(1)(l) of the Act (which authorizes coverage of “any other item or service which is specified in the plan of care and for which payment may otherwise be made...”) would continue to be covered pursuant to existing standards of coverage and payment. Generally speaking, if the ambulance transfer was medically necessary, and if the patient’s plan of care described that the patient’s terminal illness required ambulance transfer, the hospice would be responsible for the ambulance bill. In a scenario where ambulance transport arrangements are made by a patient’s family, and the ambulance transport needs are not documented in the hospice plan of care, the patient would be responsible for the ambulance bill.</p>
L-8	<p>Question: A hospice has been putting some of its patients in a facility for respite care (due to no heat, electricity, etc.) and is worried about going beyond the five-day limit. Can the 5-day limit be waived?</p> <p>Answer: CMS has no authority to extend the hospice respite limit beyond 5 days. For the 6th and subsequent days, the hospice should bill for routine home care (RHC) and the beneficiary would be liable for room and board. The Federal Emergency Management Agency (FEMA) and/or the State may be able to assist with room and board costs but room and board cannot be paid out of the Medicare Trust Fund when a home level of care is provided.</p>

Question Number	Question and Answer
L-9	<p>Question: Are the hospice requirements for a face-to-face encounter waived under Section 1135 of the Act?</p> <p>Answer: No. The required timeframe for the occurrence of a hospice face-to-face encounter is typically flexible enough to allow hospices to meet this requirement, even in emergency situations. A face-to-face encounter can occur up to 30 days prior to the start of the third benefit period and 30 days prior to any subsequent benefit periods thereafter (see section 20.1 in chapter 9 of the Medicare Benefit Policy Manual (Pub. 100-02)). However, if conditions related to the emergency cause a provider to expect to be unable to meet these timeframes, that provider should contact the CMS RO to allow for tracking and completion of this encounter as soon as conditions allow.</p> <p>Updated: 9/11/17</p>
L-10	<p>Question: For Hospice, how will timing of the certification of terminal illness (CTI) be addressed?</p> <p>Answer: We have no authority to change or waive any CTI requirements. A hospice can continue to get a verbal certification of terminal illness for new admissions, and must complete the written certification before filing the claim.</p>
L-11	<p>Question: For Hospice, how will the general inpatient care (GIP) daily visit requirement be addressed?</p> <p>Answer: Medicare does not have a daily GIP visit requirement.</p>
L-12	<p>Question: If a hospice patient has been moved from his private home to a facility due to a disaster/emergency, who is responsible for room and board costs? Should the hospice bill the GIP rate or the respite rate? What happens when the patient's 5-day respite limit has been exceeded? If the patient's home is still without power, or is damaged, or otherwise not usable after the 5 days of respite, should the hospice revoke the patient?</p> <p>Answer: We have no authority to extend the respite limit beyond 5 days. A hospice patient receiving routine home care (RHC) at home who moves to a facility can receive respite care for up to 5 days. The hospice is responsible for paying the facility for the room and board during the 5 days of respite, based on its agreement with that facility. For the 6th and subsequent days, the hospice should bill routine home care, and the beneficiary would be liable for room and board. The Federal Emergency Management Agency (FEMA) and/or the State may assist with room and board; room and board cannot be paid out of the Medicare Trust Fund when a home level of care is provided.</p> <p>GIP is not justified simply because the home lacks power or is damaged; in the fiscal year (FY) 2008 hospice wage index final rule, we wrote, "To receive payment for general inpatient care under the Medicare hospice benefit, beneficiaries <u>must</u> require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting. It is the level of care provided to meet the individual's needs and not the location of where the individual resides, or caregiver breakdown, that determine payment rates for Medicare services." (72 FR 50220).</p> <p>A hospice cannot revoke the hospice benefit for a beneficiary; only a beneficiary can revoke the hospice benefit.</p>
L-12	<p>Question: Will Hospice providers be extended a waiver for late filing of a Notice of Election (NOE)? Example of issue: Due to the flood and mandatory evacuations, we were unable to file the NOE within the required five days?</p> <p>Answer: Our regulations at 42 CFR 418.24(a)(4)(i), and Chapter 9, section 20.2.1.1 of the Medicare Benefit Policy Manual provides the exceptions to the timely filing requirement for the hospice Notice of Election (NOE). There are four circumstances that may qualify the hospice for an exception to the consequences of filing the NOE more than 5 calendar days after the effective date of election and one of those exceptions includes fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate. The hospice must document the circumstance to support a request for an exception, which would waive the consequences of filing the NOE late. Using that documentation, the hospice's Medicare contractor will determine if a circumstance encountered by a hospice qualifies for an exception to the consequences for filing an NOE more than 5 calendar days after the effective date of election. Please refer to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11, "Processing Hospice Claims" for requirements for NOE submission, reporting provider-liable days, and qualifying circumstances for a request for exception.</p>

M - Hospital Services - General

Question Number	Question and Answer
M-1	<p>Question: I was scheduled for surgery at my hospital next week, but my hospital is unable to get to me. I already had all my tests done. Can I have the surgery at another hospital? Will I need to have the tests done again?</p> <p>Answer: If your physician has re-established his practice near you, you can contact him/her at the new location. However, if you cannot locate your physician, you will need to see another physician who will want to perform his/her own evaluation. If the test results are available, repeat tests may not be necessary. If the test results are not available, they will need to be repeated. A new physician may also have differing criteria as to who is eligible for surgery. Those criteria do vary among health care providers.</p>
M-2	<p>Question: How do Inpatient Prospective Payment System (PPS) hospitals apply for the Capital PPS Extraordinary Circumstances Exception payments?</p> <p>Answer: To receive payments under the Capital PPS Extraordinary Circumstances Exception provision, a hospital that may be eligible for such payments must make a written request to its CMS Regional Office (RO) within 180 days after the occurrence of the extraordinary circumstance causing the unanticipated expenditures for a determination by CMS. If necessary, additional supporting information and documentation may be sent after the 180 day period provided that an initial written request was made to the appropriate RO in a timely manner. A complete written request should include an explanation with supporting documentation of the circumstances that led to the unanticipated capital expenditure, the estimated amount of the expenditure and the sources and amounts of any anticipated reimbursement from other sources (including insurance, litigation and government funding (e.g., FEMA)) directly related to the capital expenditure. The RO will evaluate the completed request and forwards its recommendation to the Administrator for a decision based on the nature of the circumstances, any recovered proceeds from other parties and the amount of financial loss documented by the hospital.</p>
M-3	<p>Question: Patients are taken to a second facility for chemotherapy services because of inadequate staff at the original facility due to the emergency. How should this be billed?</p> <p>Answer: For inpatients, the originating medical facility must bill for these services as part of the original inpatient stay and reimburse the second facility for the use of their chemotherapy services. It is important that this occur so that claims are not submitted with overlapping dates of service. If the originating facility is not able to operate, the receiving facility may bill Medicare, beginning with the date they assumed responsibility for the inpatient. If the services were rendered in an outpatient setting at both facilities, both facilities may bill for their own services as long as the dates of services do not overlap. Specifically, each facility may bill for the particular dates on which they serviced the beneficiary by providing chemotherapy. All facilities need to use the specific line item dates of service for each beneficiary encounter.</p>
M-4	<p>Question: If a hospital inpatient is evacuated to an undisclosed location due to an emergency, what Patient Status (PS) Code should I use on the bill?</p> <p>Answer: Given the unknown location of the patient, it would be acceptable for any type of discharging hospital (inpatient acute, inpatient psychiatric, inpatient rehabilitation, long term care, children's, cancer, critical access, etc.) to code PS Code "01", Discharged to home/self-care, in this situation. The following system edits and automatic adjustment processes are in place to help ensure that final payment amounts to providers are correct.</p> <ul style="list-style-type: none"> · If the patient was in an acute care hospital, was evacuated (discharged) to an undisclosed location and was subsequently admitted to another inpatient acute care hospital, then the first bill will be automatically adjusted with the PS "02" to pay as if the patient was transferred to another acute care hospital. · Similarly, if the patient was in an acute care hospital and was subsequently admitted to a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or other facility that causes the first hospital to be subject to the post-acute care transfer payment methodology, when the subsequent provider submits its bill, the bill from the first provider will be automatically adjusted to pay as if the patient was transferred to the subsequent facility. · If a patient was in a long-term care hospital, and was evacuated (discharged) to an undisclosed location, the payment to the long-term care hospital would be subject to the short stay outlier payment methodology if the length of stay prior to the evacuation warranted that payment adjustment.

Question Number	Question and Answer
M-5	<p>Question: What special considerations will CMS provide on calculating the wage index subsequent to an emergency or disaster? There would be aberrant wage data for the period after the emergency/disaster hit.</p> <p>Answer: If an emergency or disaster were to occur, any additional labor costs that a hospital might incur to address the situation would not be recognized in the wage index until 4 years later. This is the amount of time that is required for the universe of hospitals' cost reports from any wage index base year to be collected and reviewed by CMS. This time frame also provides for a process for hospitals to review and correct their data before it is used in computing the final wage index. Therefore, until the entire wage index development process is completed, neither CMS nor any affected hospitals would have an accurate and objective way of estimating how much the affected hospitals will be paying for labor costs related to the emergency/disaster or of predicting what effect any changes in their labor costs will have on the wage index.</p>
M-6	<p>Question: When a teaching hospital, located in a declared emergency/disaster area, receives residents from teaching hospitals located outside the declared emergency/disaster area to provide care, can the receiving hospital count the additional residents for purposes of indirect medical education (IME) and direct graduate medical education (GME) payment?</p> <p>Answer: CMS issued an interim final rule with comment period (CMS-1531-IFC, which appeared at 71 FR 18654, April 12, 2006) in order to provide teaching hospitals in certain emergency situations the ability to temporarily transfer their IME and direct GME FTE resident cap positions to any hospital in the country through Emergency Medicare GME Affiliation Agreements. Currently, the provisions in CMS-1531-IFC address emergency situations in which a hospital in an emergency area must find alternate training sites for its displaced residents -- generally to hospitals located outside of the emergency area. However, in a declared public health emergency, where a hospital in an emergency area needs to train <u>additional</u> residents in order to provide adequate care for the patients affected by the disaster, unless a regular Medicare affiliation could be used to add cap to the affected hospital from another hospital, given the existing statutory caps on hospitals, the regulations do not provide for a temporary adjustment to the affected hospital's FTE caps to the extent needed to allow the hospital to count the <u>additional residents for IME and direct GME payment purposes</u>.</p>
M-7	<p>Question: If a teaching hospital affected by the emergency temporarily loses some or all of its residents for a period of time due to the emergency, what will be the effect on calculating direct and indirect graduate medical education (GME) payments?</p> <p>Answer: As for the hospital affected by the emergency:</p> <p>The Medicare statute requires that a hospital is paid in the current year based on a three-year "rolling average" count of residents; that is, the average of the number of residents in the current year and two prior years. This is a statutory requirement intended to distribute the impact of increasing or decreasing the number of residents at a hospital over a three-year period. Thus, if a hospital temporarily loses some or all of its residents for a period of time due to an emergency, the hospital would still be able to receive IME and direct GME payments because the effect of decreasing the number of residents at the hospital will be spread over a three-year period.</p> <p>As for the host hospital:</p> <p>Emergency Medicare GME affiliations allow for long distance affiliations so that hospitals can send displaced residents to train at host hospitals anywhere in the country and transfer cap slots to cover the displaced residents, thus allowing the host hospital to count these FTE residents for GME payment purposes.</p>

Question Number	Question and Answer
M-8	<p>Question: How should the following situation be handled relative to Medicare billing? Hospital "A" is evacuated due to a declared emergency and patients are sent to hospital "B". These same patients are later moved to a shelter because hospital "B" is now forced to evacuate because of the emergency.</p> <p>Answer: In this scenario, Hospital "A" has sent the patient to Hospital "B." Although not stated in the question, the implication is that the patient has been formally released by Hospital "A" to Hospital "B" and therefore is treated as having been discharged from Hospital "A" and transferred to Hospital "B". In this scenario, Hospital "A" would discharge the patient and reflect a transfer to Hospital "B" indicating the appropriate patient status (from locator 17 of the UB-04): 02 – if transferred to another acute care facility (PPS); 03 – if transferred to a SNF; 04 – if transferred to a nursing home not considered a skilled facility; 05 – if transferred to a Cancer or Children's Hospital; 62 – if transferred to an Inpatient Rehab Facility (IRF); 63 – if transferred to a Long Term Care Hospital (LTCH); 65 – if transferred to a Psychiatric Facility; 66 – if transferred to a Critical Access Hospital; or 70 – if transferred to another type of facility not defined on the list.</p> <p>Assuming that Hospital "B" will be receiving the patient back due to their medical condition still warranting acute medical care, Hospital "B" would reflect the admission date from Hospital "A" as the actual date of patient receipt and would reflect the days absent in a non-medical facility as furlough/leave of absence days and continue their care upon return of the patient.</p>
M-9	<p>Question: Can CMS clarify its waiver authority, especially about having federal nurses come to the hospital and help with staffing issues. Hospitals can't bill Medicare because it is a bundled service program? There has to be a way to unbundle those services. For-profit hospitals can't get reimbursement through NDMS. Will this change?</p> <p>Answer: Hospitals should bill Medicare as they normally would for inpatient or outpatient services even when such services included the volunteered professional services of a registered nurse. Current Medicare policy does not allow for these services to be unbundled and billed.</p> <p>The Medicare hospital Conditions of Participation (CoPs) require that non-employed registered nurses working in the hospital must adhere to the hospital's policies and procedures and must be adequately supervised and evaluated. The hospital must also verify that the nurse holds a current license.</p> <p>HHS is exploring how NDMS may work during an H1N1 emergency.</p>
M-10	<p>Question: We have a Medicare psychiatric patient that can't be placed in the psych unit because all patients are quarantined due to the flu. Can we still bill under the psych provider number even though they are in an acute bed?</p> <p>Answer: If the patient is not in the PPS excluded Psych unit, even if the patient is a psych 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 inpatient PPS payment for that patient's care. Billing under the psych unit's provider number is not allowed.</p>
M-11	<p>Question: Due to the evacuation of a PPS hospital, the Medicare patients were transferred to a non-Medicare medical facility. How is the claim to be billed?</p> <p>Answer: The PPS hospital should bill Medicare for all days and charges associated with the patient's care as if the patient was never transferred from the PPS facility. The PPS facility should make arrangements to reimburse the non-Medicare facility for services/charges associated with the period of time the Medicare patient was in their facility.</p>

Question Number	Question and Answer
M-12	<p>Question: A Hospital has a Part A claim in the T status for reason code 37045, as an outlier date is needed. They have lost all records and do not know how to obtain the cost outlier date. They only have the lump sum of the charges that were sent to Medicare. They do know the threshold amount was met in April. The claim charges are \$304,982.95 and the PPS Dollar Threshold amount is \$130,054.29. At this time, the provider needs to know what date they can use to show the threshold amount of \$130,054.29 was reached. The date of the threshold can impact the claim reimbursement.</p> <p>Answer: Without the records the only feasible workaround would be to take the total charges and divide by the number of days to come out with a daily average charge. Then, using the threshold amount, determine which date the threshold would have hit based on the daily average charge. Use that date as the threshold date and document the process in notes, in case the records are found later and the exact date could be determined.</p>
M-13	<p>Question: During an emergency, will Medicare fee-for-service allow payment for care provided at a site not considered part of the 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 fee-for-service pay for non-critical care provided at an ACS, such as a school gymnasium?</p> <p>Answer: In the absence of an 1135 waiver, a hospital may add a remote location that provides inpatient services to the hospital's Medicare certified beds under its existing provider agreement, provided that the remote location satisfies the requirements to be provider-based to the hospital's main campus (including being located within 35 miles pursuant to 42 CFR 413.65(e)(3)). The remote location must satisfy all provider-based requirements including being compliant with the hospital Conditions of Participation (CoPs). The hospital would be expected to file an amended Form CMS 855A with its Medicare Administrative Contractor or legacy Fiscal Intermediary as soon as possible adding an additional location. 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.</p>
M-14	<p>Question: If a patient is taken to a second facility for chemotherapy services because the equipment at the original facility is not operating, how should these services be billed?</p> <p>Answer: If the patient was an outpatient at both hospitals, the first hospital would bill for the covered outpatient department (OPD) services it provided while the beneficiary was its outpatient. Once the beneficiary ceased to be the first hospital's outpatient and he/she became the second hospital's outpatient, the second hospital would bill for any covered OPD services it provided.</p> <p>If the patient at the first facility was an inpatient and was not discharged prior to receiving chemotherapy services, the originating medical facility may provide the chemotherapy services under arrangement with the second facility and must bill for these services as part of the original inpatient stay and reimburse the second facility for the use of their chemotherapy services. The second hospital may not bill Medicare directly for any services in this situation.</p> <p>Alternatively, if the originating facility discharged or transferred the patient, it would bill for the inpatient services it provided and the case would be paid at either the full hospital inpatient prospective payment system (IPPS) amount (if the patient was discharged) or at the transfer IPPS payment (if the patient was transferred and treated as inpatient at the second hospital). If the patient is treated as an inpatient by the second hospital, it would bill and be paid for a full IPPS payment. If the patient is discharged from the first hospital and treated as an outpatient at the second hospital, the second hospital would bill for the outpatient services it provided.</p>

Question Number	Question and Answer
M-15	<p>Question: Will CMS provide for "cost based" reimbursement for loss on disposal of depreciable assets for directly affected providers?</p> <p>Answer: Losses resulting from the involuntary conversion of depreciable assets that occurred due to a declared emergency or disaster are includable in the allowable costs of providers paid under a reasonable cost methodology (e.g., Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs)) or the reasonable cost portion of a blended prospective payment under 42 CFR § 413.134(f)(6). For the portion of payment attributable to TEFRA based payment, we recognize these costs. For providers paid under 100% of their respective Federal PPS rate (e.g., SNFs, IRFs, IPFs, LTCHs, HHAs, ESRD facilities, short-term acute care Inpatient PPS hospitals), where payments are bundled, there would be no mechanism to independently pay for disposable depreciable assets under reasonable cost. In the case where there is a capital extraordinary circumstance exception (per 42 CFR § 412.348(f)) for short-term acute care Inpatient PPS hospitals, those costs may be includable in the allowable costs upon which the exception payment will be based.</p>
M-16	<p>Question: Are there any additional payments for hospitals' capital costs as a result of the unanticipated capital expenditures they face due to a declared emergency or disaster?</p> <p>Answer: Under the existing regulations for short-term acute care hospitals under the Inpatient Prospective Payment System (PPS) (see 42 CFR § 412.348(f)), there is an Extraordinary Circumstances Exception provision under the capital PPS that provides an additional payment if a hospital incurs unanticipated capital expenditures in excess of \$5 million (net of proceeds from other funding sources, including insurance, litigation, and government funding (e.g., FEMA aid)) due to extraordinary circumstances beyond the hospital's control (such as a hurricane, flood, or other declared emergency or disaster). For most hospitals, the additional payments are based on 85 percent of Medicare's share of allowable inpatient capital costs attributed to the extraordinary circumstance (100 percent for sole community hospitals). There may be an offset to this amount based on a comparison of the hospital's cumulative capital PPS Medicare payments to a specified percent of its Medicare allowable costs over the past 10 years.</p>

Question Number	Question and Answer
M-17	<p>Question: December 10, 2012, is the deadline for hospitals to request revisions to their data for the fiscal year (FY) 2014 wage index. Some hospitals are currently closed or operating at significantly reduced levels due to damage from Hurricane Sandy and may be unable to meet this deadline. Has CMS considered extending the deadline past December 10, or establishing other procedures for correcting the FY 2014 wage index data for affected hospitals?</p> <p>Answer: CMS has adopted the following process and schedule for correcting the FY 2014 wage index data for hospitals experiencing disruptions to their operations due to the effects of Hurricane Sandy:</p> <p>The servicing Medicare claims administration contractors will -</p> <ul style="list-style-type: none"> • Identify hospitals that are closed or are operating at significantly reduced levels due to damage from Hurricane Sandy. • Begin the wage index desk review for these hospitals' data immediately after the December 10, 2012, deadline for the receipt of hospitals' revision requests. • If a hospital's wage data fails any of the desk review edits, the Medicare contractors will contact the hospital, or the hospital's home office, in an effort to obtain corrected data, or a reasonable explanation for the aberrant data. • If after contacting the hospital or home office and the hospital or home office is unable to address wage index data issues due to Hurricane Sandy's impact on its operations, the Medicare contractor will instruct the hospital to choose between the following 3 options for making revisions to its data for the FY 2014 wage index: <ol style="list-style-type: none"> 1. Extend the deadline, until January 10, 2013, for submitting wage index data revisions; 2. For only the data elements that have failed desk review edits, the contractors will adjust such data to the hospital's prior year (FY 2013 wage index) levels; 3. Use the hospital's FY 2013 wage index data entirely in lieu of the hospital's original data submitted for the FY 2014 wage index. CMS will inflate such data to FY 2014 wage index levels via inflation adjustment factors. (Contractors will advise CMS if this option is chosen.) <p>If a hospital's data fails any of the desk review edits and the hospital cannot be reached for an option, CMS will apply Option 3 in an effort to mitigate disruption to the area's wage index. The servicing contractor will inform the hospital's State Hospital Association that CMS will use the hospital's FY 2013 wage index data to calculate the FY 2014 wage index.</p>
M-18	<p>Question: Our facility in the emergency area is experiencing a new problem with discharging Medicare patients. Apparently, if a patient is unhappy with his or her discharge plan, he or she has 48 hours to appeal it. Hospitals are experiencing patients using the appeal process because they don't want to be discharged to a shelter. Is this appeal right something that can be waived or otherwise addressed so that hospitals can move patients out and create capacity for patients who really need acute care?</p> <p>Answer: CMS cannot waive this beneficiary protection. However, in declared emergencies we asked the Quality Improvement Organization (QIO) to expedite these appeals to ensure that hospitals may timely discharge these patients while still affording them protection from inappropriate discharge.</p>
M-19	<p>Question: A facility has taken in patients, has them under observation, and is providing them with oxygen. The facility is stating that it is a safety hazard to discharge patients because they have no electricity and are unable to access their oxygen which is noted on their charts. The provider wants to know how to bill their claims.</p> <p>Answer: If the facility is providing observation services consistent with the CMS definition of observation in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6, then the facility can bill Medicare for observation services, whether or not the facility provides oxygen as a part of the services provided to the patient.</p>

N – Hospital Services – Emergency Medical Treatment and Labor Act (EMTALA)

Question Number	Question and Answer
N-1	<p>Question: Evacuees from States affected by the public health emergency may arrive at hospital emergency departments merely to obtain refills of prescriptions that they lost when they evacuated during a disaster or public health emergency. Must these individuals be given an EMTALA medical screening examination when they come to the emergency department?</p> <p>Answer: Even under non-emergency circumstances, the Emergency Medical Treatment and Labor Act (EMTALA) regulations make it clear that individuals seeking examination or treatment for a medical condition (e.g. prescription refills) need not be given a complete medical screening examination, but rather, one that is appropriate for the request that they make in order to determine that an EMD does not exist. Hospitals may wish to develop specific protocols that include a streamlined screening examination for individuals seeking prescription refills, consistent with the EMTALA regulations at 42 CFR § 489.24.</p>
N-2	<p>Question: Is it permissible for a hospital to triage individuals with suspected cases of an infectious disease (including particularly an H1N1 flu virus infection) to an alternative site for evaluation under EMTALA? If so, how do we bill for these services?</p> <p>Answer: Under current Emergency Medical Treatment and Labor Act (EMTALA) law and regulations, hospitals are permitted to move individuals out of their dedicated emergency departments to another part of the hospital (on the hospital's same campus) in order to provide the required medical screening examination (MSE) and then, if an emergency medical condition is found to exist, to provide stabilizing treatment or arrange for an appropriate transfer. Sometimes hospitals refer to these as "fast-track clinics" and use them either all year round or during surge in demand for emergency department services during the seasonal cold and flu season. The medical screening examination provided in the "clinic" must be performed consistent with the requirements of the EMTALA provision, by qualified medical personnel who can perform an MSE that is appropriate to the individual's presenting signs and symptoms.</p> <p>If, prior to directing the individual elsewhere in the hospital, qualified medical personnel in the emergency department completed an appropriate MSE and determined that the individual does not have an emergency medical condition, then the hospital has no further EMTALA obligation to that individual and the issue of moving the individual to an alternate site, either on or off the hospital's campus, would be moot from an EMTALA perspective.</p> <p>For services rendered to Medicare fee-for-service (FFS) beneficiaries, standard Medicare FFS billing rules apply. Hospitals should work with their other payers to determine if special billing rules may apply.</p>
N-3	<p>Question: What is CMS's procedure for addressing requests to waive EMTALA?</p> <p>Answer: Because each emergency or disaster presents a unique set of circumstances, especially as they relate to the demand for emergency treatment, CMS calibrates its response to EMTALA-related issues to coincide with the nature of each emergency. CMS handles these matters on a case-by-case basis. In an emergency or disaster, CMS, both centrally and through its Regional Offices, will open communications with affected State governments (especially the State Survey Agencies) and with providers, trade groups, and other stakeholders to learn about local conditions. In addition, the State survey agencies are responsible for reporting the status of health care providers affected by the emergency to their CMS Regional Office and CMS relies upon that information to make recommendations to the Secretary regarding the need for EMTALA waivers.</p>
N-4	<p>Question: Has HHS issued any § 1135 waivers in the past that specifically address EMTALA?</p> <p>Answer: Since § 143 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 amended § 1135 of the Social Security Act to add the waiver authority, § 1135 waivers have been issued for Hurricanes Katrina, Rita, Gustav and Ike, for the flooding in Iowa and Indiana during CY 2008, and for the flooding in North Dakota and Minnesota in CY 2009. In each emergency event, sanctions for certain types of EMTALA violations were waived for 72 hours after implementation of an affected hospital's disaster protocol. However, if a public health emergency were to involve a pandemic infectious disease, the Secretary could invoke his or her waiver authority under § 1135 to waive certain EMTALA sanctions and such an EMTALA waiver would continue in effect until the termination of the applicable public health emergency declaration (in accordance with § 1135(e)(1)(B) of the Act).</p>

Question Number	Question and Answer
N-5	<p>Question: If a hospital remains open during a disaster, and is operating at or in excess of its normal operating capacity and cannot get sufficient staff, may the hospital shut down its emergency department (ED) without violating EMTALA?</p> <p>Answer: Hospitals are not required under the Medicare Conditions of Participation to operate emergency departments, and thus always have the option of closing this service, so long as there is no State law requirement for the hospital to maintain an ED, and so long as the hospital employs an orderly closure process. Once the hospital no longer has a dedicated emergency department, it no longer has an EMTALA obligation to provide screening and stabilization to individuals who come to the hospital.</p> <p>However, if the question is about whether an ED may temporarily refuse to see all new patients, due to capacity problems, such refusal may not be permitted under EMTALA in certain circumstances. The EMTALA regulations do permit hospitals to place themselves on "diversionary" status when they lack the staff or facilities to accept additional emergency patients, i.e., they may, by phone or other electronic communications system, advise non-hospital-owned ambulances to go to another hospital. Again, while they are permitted to do this under EMTALA, their actions must also be consistent with State or local requirements governing ambulances and hospital diversionary status. However, even in this circumstance, if the ambulance nevertheless brings an individual onto the property of the hospital on diversion, then the hospital has an EMTALA obligation to provide an appropriate medical screening examination and, if the individual has an emergency medical condition, to provide stabilizing treatment.</p> <p>Furthermore, if a hospital with a dedicated emergency department is operating under a section 1135 waiver, which includes a waiver under section 1135(b)(3) of the Act, sanctions for the direction or relocation of an individual to receive medical screening at an alternate location do not apply so long as the direction or relocation is pursuant to an appropriate State emergency preparedness plan or State pandemic preparedness plan and the hospital does not discriminate on the individual's source of payment or ability to pay.</p>
N-6	<p>Question: Emergency Flu Response--We are planning to use an outpatient area of the hospital as an Emergency Department (ED) extension to see overflow patients from the ED. Can we still bill the ED Levels for the facility charges (99281 - 99285)? If the physician seeing these patients is not board certified in Emergency Medicine but is board certified in Family Practice, can the facility bill the ED levels? This question is only in regard to the OPSS facility-side, not professional billing.</p> <p>Answer: The hospital may bill CPT codes 99281 through 99285 for emergency visit services furnished in the outpatient area where this separately identifiable area meets the definition of a Type A emergency department (ED) (and complies with all other applicable requirements). If the separately identifiable area operates less than 24 hours per day, 7 days per week for emergency services, and it meets the definition of a Type B ED (dedicated emergency department that incurred EMTALA obligations, but did not meet the CPT definition of an ED) (and meets all other applicable requirements), then it may bill emergency visit services using HCPCS codes G0380 through G0384 as appropriate. The specialty of the physician ordering the emergency services for hospital outpatients (emergency physician, family medicine, or other) in the area of the hospital where emergency services are furnished does not affect whether the facility is considered a Type A or B ED for purposes of billing under the OPSS.</p>

Question Number	Question and Answer
N-7	<p>Question: Given that EMTALA requires Medicare participating hospitals with emergency departments to provide certain health care services regardless of individuals' legal status when they present with emergency medical conditions, and given that the MMA provided monies under section 1011 of the Act to reimburse hospitals for services related to EMTALA, would these provisions (EMTALA and section 1011) cover prophylaxis of contacts (treatment for an individual who has been exposed to a contagious disease) or vaccination?</p> <p>Answer: The answer depends on the specific medical circumstances involved. EMTALA requires that if an individual presents to a hospital with a dedicated emergency department, and requests treatment for a medical condition, the hospital is required to provide an appropriate medical screening to determine if an emergency medical condition exists. If an emergency medical condition does exist, the hospital is required to provide necessary stabilizing treatment or provide for an appropriate transfer to another facility. Section 1011 provides reimbursement to eligible providers for services required by or related to EMTALA when furnished to certain undocumented aliens. Therefore, if an individual who is an undocumented alien (or otherwise eligible under section 1011) presents to a hospital with a medical condition and requires treatment to stabilize an emergency medical condition, that treatment would be considered to be an EMTALA-related service and may be eligible for reimbursement under section 1011. Not all individuals who have been exposed to a contagious disease or are seeking a vaccination may have an emergency medical condition as that term is defined under EMTALA. For instance, if treatment is provided that is solely for preventative purposes, that treatment could not be considered an EMTALA-related service.</p>

O – Hospital Services – Acute Care

Question Number	Question and Answer
O-1	<p>Question: Will a hospital be eligible for additional payment for rendering services to patients that remain in the hospital due to the fact that they continue to need medical care but at less than an acute level and those services are unavailable at any SNFs in the area because of the emergency?</p> <p>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.</p>
O-2	<p>Question: Are prospective payment providers going to be paid using a special payment method? If not, is there a special DRG that IPPS providers will be reimbursed for this situation?</p> <p>Answer: Normal prospective payment procedures apply to those hospitals reimbursed under the inpatient prospective payment system.</p>
O-3	<p>Question: Due to the unexpected emergent nature of the PPS hospital evacuation, there was not time to work out a financial arrangement with the receiving health care institution. Are PPS hospitals responsible to reimburse the receiving hospital for full charges or how can assistance be provided if problems arise with post evacuation payment negotiations?</p> <p>Answer: Financial agreements between providers are a private matter between those two parties. CMS cannot dictate the terms of these agreements or interfere in providers' negotiations. If the facilities are unable to work out a financial arrangement, CMS may consider allowing each facility to bill for the services it provided. CMS will make these considerations on a case-by-case basis.</p>

Question Number	Question and Answer
O-4	<p>Question: How do Inpatient Prospective Payment System (PPS) hospitals apply for the Capital PPS Extraordinary Circumstances Exception payments?</p> <p>Answer: To receive payments under the Capital PPS Extraordinary Circumstances Exception provision, a hospital that may be eligible for such payments must make a written request to its CMS Regional Office (RO) within 180 days after the occurrence of the extraordinary circumstance causing the unanticipated expenditures for a determination by CMS. If necessary, additional supporting information and documentation may be sent after the 180 day period provided that an initial written request was made to the appropriate RO in a timely manner. A complete written request should include an explanation with supporting documentation of the circumstances that led to the unanticipated capital expenditure, the estimated amount of the expenditure and the sources and amounts of any anticipated reimbursement from other sources (including insurance, litigation and government funding (e.g., FEMA)) directly related to the capital expenditure. The RO will evaluate the completed request and forwards its recommendation to the Administrator for a decision based on the nature of the circumstances, any recovered proceeds from other parties and the amount of financial loss documented by the hospital.</p>
O-5	<p>Question: Our hospital received a Medicare inpatient that was evacuated from another hospital that is located in an area that experienced an emergency. The patient was transferred from and to a general acute care hospital that is subject to the inpatient prospective payment system (IPPS). How will Medicare pay for this patient? Will it make a difference if there is a § 1135 waiver for a public health emergency? Will it make a difference if the patient was transferred through the National Disaster Medical System (NDMS)?</p> <p>Answer: Medicare’s payment policy for Medicare inpatients will be the same irrespective of whether there is a § 1135 waiver or the patient was transferred through the NDMS. We will address how Medicare’s payment policy applies to this scenario in several different situations.</p> <p><u>Patient is Discharged from the Receiving Hospital.</u> If the receiving hospital discharges the Medicare patient, Medicare’s normal IPPS payment rules will apply. It will receive Medicare’s normal DRG payment (including outliers if applicable) and the evacuating hospital in the emergency area will receive an acute-to-acute transfer payment up to the full DRG amount.</p> <p><u>Patient is Returned from the Receiving Hospital back to the Original Evacuating Hospital.</u> Payment is “under arrangement” for brief evacuations where the patient returns to the originating hospital (see question and answer about temporary transfers of patients and for more information about financial arrangements between hospitals). There is a single DRG payment to the original evacuating hospital in the emergency area. Otherwise, the acute-to-acute transfer rules apply. For example, if the evacuating hospital has transferred care to the receiving hospital for an extended stay, Medicare’s transfer rules would apply. The evacuating hospital would receive an acute-to-acute transfer payment up to the full DRG amount. If the receiving hospital then transfers the patient back to the originating hospital, it would also receive an acute-to-acute transfer payment up to the full DRG amount. If the original evacuating hospital then discharges the patient, it would receive Medicare’s normal IPPS payment for the second stay. In this scenario, Medicare would make two transfer payments (for the original stay in the evacuating hospital and to the hospital receiving the patient who is not expected to stay briefly and whose care has been transferred) and a third DRG payment back to the original evacuating hospital for the second stay when the patient is discharged. Once again, the three DRG payments in this latter scenario would only occur if the evacuation is expected to be more than brief and there has been a complete transfer of care from the evacuating hospital to the receiving hospital.</p> <p><u>Patient is Still in the Receiving Hospital.</u> If the patient still needs an acute level of inpatient care, see above answers depending on whether patient is discharged or transferred back to original evacuating hospital. If the patient is in need of a sub-acute level of care such as in a skilled nursing facility but a sub-acute bed is unavailable, any inpatient days can be counted as “administratively necessary days.” Medicare would count any charges on those days as being part of the acute IPPS stay towards meeting the cost outlier threshold. If the patient is not in need of either an acute level of inpatient care or a sub-acute level of care, any days that the patient remains in the hospital are not paid for under the IPPS. Charges for any services provided on those days do not count towards determining whether Medicare will make a cost outlier payment.</p>

Question Number	Question and Answer
O-6	<p>Question: In some cases, a hospital is not only transferring the patient, but is also transferring personnel and equipment. How are the costs handled in this situation?</p> <p>Answer: These hospital costs would be reimbursed as an element of the DRG which is paid under the MS-DRGs. The hospital transferring the patient (and personnel and equipment) should bill Medicare indicating a discharge/transfer (using the appropriate patient status code). The acute to acute transfer rules apply. The evacuating hospital would receive an acute to acute transfer payment up to the full DRG amount. If the receiving hospital discharges the patient, they would receive the full DRG amount. Any arrangement for use of the transferring hospital's equipment and personnel would be a private matter between the two hospitals.</p>
O-7	<p>Question: In some instances, hospital "A" transferred a patient to hospital "B" because of an emergency but, because of the emergency, hospital "B" then had to transfer the patient again to hospital "C" (or another health care facility) and hospital "A" is no longer aware of the location of its patient. What does hospital "A" do when it cannot locate a previously transferred patient?</p> <p>Answer: If hospital "B" subsequently transferred the patient to hospital "C" (or another health care facility) or discharged the patient, hospital "A" should bill Medicare indicating the transfer to hospital "B" (using the appropriate patient status code as indicated below). The patient is admitted to hospital "B" on the day of the transfer from hospital "A" and discharged upon transfer to hospital "C" (or another health care facility) or the patient's discharge.</p> <p>Below are the patient status codes to be used by transferring hospitals (from locator 17 of the UB-04):</p> <ul style="list-style-type: none"> 02 – if transferred to another acute care facility (PPS); 03 – if transferred to a SNF; 04 – if transferred to a nursing home not considered a skilled facility; 05 – if transferred to a Cancer or Children's Hospital; 62 – if transferred to an Inpatient Rehab Facility (IRF); 63 – if transferred to a Long Term Care Hospital (LTCH); 65 – if transferred to a Psychiatric Facility; 66 – if transferred to a Critical Access Hospital; or 70 – if transferred to another type of facility not defined on the list.

P – Hospital Services – Critical Access Hospitals (CAHS)

Question Number	Question and Answer
P-1	<p>Question: Will CMS allow CAHs to stock more than 25 beds, to be ready for surge capacity needs, on campus, without being out of compliance as a CAH, since the beds would not be used except in an emergency?</p> <p>Answer: CAHs already have the capability of having extra furniture as long as it is clearly in storage and is not staffed and ready for use. The CAH bed limit is statutory and would require either a statutory change or a section 1135(b) waiver to authorize any exceptions. However, under normal circumstances, CMS counts as part of the 25-bed limit any rooms/spaces that are equipped and clearly ready to be used by simply rolling a "stored" bed into that space. There is a difference between having warehoused beds that provide the ability to add surge capacity during a declared emergency and having beds that can be readily used whenever the CAH wishes to exceed the 25 bed limit. In a clear emergency situation, CMS would notify providers of the extent to which beds could be moved from storage and readied for use (and not counted).</p>
P-2	<p>Question: Does a Critical Access Hospital (CAH) get paid differently depending on whether it is a new admission or a transfer of a patient that is evacuated from an area undergoing an emergency?</p> <p>Answer: No. A CAH will receive 101 percent of reasonable costs for all inpatient services furnished by the CAH (other than services of distinct part units) irrespective of whether the patient was discharged from a hospital in an emergency area and then admitted to the CAH or transferred from that hospital.</p>

Q – Hospital Services – Inpatient Rehabilitation Facilities (IRFs)

Question Number	Question and Answer
Q-1	<p>Question: What billing and Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument (PAI) procedures should be used when an IRF evacuates a Medicare beneficiary to another IRF?</p> <p>Answer: An evacuating IRF may “transfer”, as defined in 42 CFR 412.602, beneficiaries for short periods of time to another IRF without formally releasing (i.e., “discharging”) the patient. The transferring IRF should make arrangements to reimburse the receiving IRF. In this case, the transferring IRF retains overall responsibility for the patient’s care, and should make sure that the necessary medical documentation is transferred with the patient. Then, the receiving IRF can continue to treat the patient in accordance with the established plan of care. The transferring IRF also retains responsibility for completing the IRF-PAI, and for billing the entire stay to CMS. This procedure is most appropriate when the evacuating IRF expects to bring the patient back within a reasonable period of time.</p> <p>When an evacuating facility formally discharges patients, the evacuating facility should consider the expected duration of the evacuation, and the amount of time the patient has already been in the evacuating facility. First, if the beneficiary is transferred for 3 consecutive calendar days or fewer, the evacuating facility should be aware that the IRF interrupted stay policy specified in 42 CFR § 412.624(g) may apply. If the patient is evacuated and returns on the same day, payment for the patient’s entire IRF length of stay (both in the evacuating facility and in the receiving facility) is made to the evacuating facility based on the patient’s initial case mix group (CMG) assignment. When the patient has completed his or her entire rehabilitation episode stay and is discharged, the evacuating IRF is responsible for billing the claim and completing and transmitting the IRF-PAI information according to the special payment provisions for interrupted stays that are outlined in 42 CFR § 412.624(g) and § 412.618(a)(1).</p> <p>Second, if the beneficiary is transferred for more than 3 consecutive calendar days, the evacuating facility should be aware that the IRF short-stay transfer policy may apply. Under the IRF short-stay transfer policy specified in 42 CFR § 412.624(f), the transferring IRF receives a reduced per diem payment for patients who are transferred to another institutional site of care (for example, another IRF, a SNF, or an acute care hospital) after having stayed in the IRF for less than the average length of stay for the patient’s assigned CMG. This situation does not affect the receiving facility’s payment, which would be subject to all of the normal Medicare payment provisions as applicable. The patient must be formally discharged from the evacuating facility and then admitted to the receiving facility.</p> <p>Finally, if the discharged beneficiary had been a patient in the evacuating IRF for a number of days at least equal to the average length of stay for the patient’s assigned CMG and was transferred for more than 3 consecutive calendar days, the patient must still be formally discharged from the evacuating facility and then admitted to the receiving facility. Both facilities will need to meet all applicable Medicare payment requirements.</p>

R – Hospital Services – Long Term Care Hospitals (LTCHs)

Question Number	Question and Answer
R-1	<p>Question: For LTCH patients (and other hospitals and post-acute patients) admitted due to a declared emergency, who exhaust their Medicare Part A benefit, will CMS extend Part A coverage and payment for the duration of a declared emergency related admission?</p> <p>Answer: Medicare does not have the authority to extend Part A coverage for those that have exhausted their benefit, but we would note that the Social Security Act (Section 1812) provides beneficiaries with 60 nonrenewable lifetime reserve days from which a beneficiary can draw upon if hospitalized for more than 90 days in a benefit period.</p>

S – Hospital Services – Mobile Emergency Hospitals

Question Number	Question and Answer
S-1	<p>Question: Some States are considering utilizing mobile hospitals, based on military field hospital model as a means of meeting their emergency preparedness needs. Under what scenario could these mobile units be eligible for Medicare funding?</p> <p>Answer: It may be possible for a Medicare participating hospital to operate a mobile facility as a part of the hospital, as long as the mobile unit complies with all the hospital conditions of participation (including the Life Safety Code) and the provider-based rules (including remaining within 35 miles of the main provider). If the mobile unit meets the provider-based regulations at 42 C.F.R. § 413.65, then they use the main hospital's provider number. If not, then the mobile unit will be treated as a freestanding clinic. CMS will gladly work with any State wishing to develop mobile capacity. Situations involving use of mobile units will be evaluated on a case-by case basis.</p>

T – Skilled Nursing Facilities

Question Number	Question and Answer
T-1	<p>Question: Our SNF was affected by an emergency and, as a consequence, some of our patients were transferred to other providers. We have not submitted claims for the month of the transfer. What is the correct patient status code that should be used?</p> <p>Answer: Those affected providers that are aware of the location of their former resident's transfer should include the correct patient status code for the transfer (i.e., patient status code "03" = transfer to SNF). If not aware of the exact transfer, providers should use patient status code "01" (discharged to home or self-care) in order to bypass any potential overlapping claim situations. Providers should include "declared emergency" on their remarks page prior to submitting the claim to Medicare.</p>
T-2	<p>Question: Our SNF has received beneficiaries transferred from another SNF provider affected by an emergency. I have submitted my claims to Medicare for the month after the transfer but I am receiving an overlap with the prior month's claim previously sent by the affected SNF. How can I get my claim paid?</p> <p>Answer: Receiving providers should make sure they include remarks indicating "declared emergency" on any claims affected by the emergency. The receiving provider should contact their FI or MAC for assistance with these overlap situations. FIs and MACs shall identify the overlap and develop the claim accordingly, including working with other FIs that might service the affected SNF.</p> <p>If the transferring provider submitted its "transfer-month" claim with a patient status of "30" (still patient) but the patient was actually transferred in that month, the FI/MAC shall adjust the claim or work with the transferring provider's servicing FI/MAC to have the claim adjusted and use an appropriate patient status code to indicate a transfer.</p>
T-3	<p>Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to a declared emergency and who wishes to return to a nursing facility closer to family members or home after the emergency/disaster is over?</p> <p>Answer: Part B of the Medicare program covers only local ambulance transportation to and from the nearest appropriate SNF facility, as long as the beneficiary is not a SNF resident in a covered Part A stay whose transport would be subject to consolidated billing rules. If there are exceptional circumstances that require transport outside the locality, Medicare can pay for this transport, but only if the destination is still the nearest SNF with appropriate facilities. In any case, the ambulance transport must be medically necessary.</p>
T-4	<p>Question: How should a facility bill for a beneficiary who was classified into rehabilitation Resource Utilization Group, Version IV (RUG-IV) group prior to an emergency when the facility is no longer able to provide therapy services as a result of the dislocations associated with the emergency?</p> <p>Answer: Refer to the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, section 2.3 for guidance. Additionally, your servicing Regional Offices, State agency, or MAC can be contacted for further guidance.</p>

Question Number	Question and Answer
T-5	<p>Question: Do SNFs have access to Capital PPS Extraordinary Circumstances Exception payments in the same way that inpatient prospective payment system (IPPS) hospitals do? A SNF, just like an IPPS hospital, could have capital-related outlier costs associated with treating an expanded population during an emergency.</p> <p>Answer: No. Section 1886(g)(1)(A) of the Social Security Act which establishes a prospective payment system for inpatient hospital capital-related costs does not apply to skilled nursing facilities. The SNF PPS does not currently have a similar mechanism for addressing unusually high capital costs.</p>
T-6	<p>Question: Will physician extenders be allowed to initially certify the need for skilled care in the absence or unavailability of physicians?</p> <p>Answer: Section 1814(a)(2) of the Social Security Act in fact already allows a nurse practitioner (NP), a clinical nurse specialist (CNS), or a physician assistant (PA) to perform not only the subsequent SNF re-certifications but the initial certification as well, so long as the NP, CNS, or PA is working in collaboration with a physician and does not have a direct or indirect employment relationship with the SNF. Beyond that, the already-existing policy that allows for delayed certifications/re-certifications (as set forth in the Internet-Only Manual at Pub. 100-1, Chapter 4, § 40.5) should be sufficient to address any contingencies related to a declared emergency.</p>
T-7	<p>Question: A provider has residents who are returning to an evacuated facility. If a resident previously exhausted the 100-day benefit period, remained at a skilled level of care, (status code 30, no code 22), was not discharged but was evacuated for a few days and now is back in the facility still requiring skilled care, does that Medicare beneficiary receive any additional days?</p> <p>Answer: No. Our intent in issuing a § 1812(f) waiver is to provide additional benefits for a beneficiary who had exhausted the 100 days of SNF benefits available in the current benefit period and was in the process of establishing a new benefit period. A new benefit period is established after a period of 60 consecutive days' elapses during which the beneficiary is not receiving skilled care in a SNF or inpatient hospital care. In the situation described above, because the beneficiary at the time of a disaster or emergency situation is still receiving skilled care in the SNF after exhausting the 100 days of SNF benefits, he or she would not be in the process of establishing a new benefit period at that point and, consequently, would not qualify for additional coverage under the § 1812(f) waiver.</p>
T-8	<p>Question: Can MDS or RUG IV classification system requirements used for determining SNF PPS reimbursement amounts be waived or modified during an emergency situation to allow for increased payment?</p> <p>Answer: There is no provision for such modifications in the absence of a waiver under §1135 of the Social Security Act. (However, for situations in which a §1135 waiver has, in fact, been issued, please refer to the discussion of this topic appearing in Section K of the "All Hazards" FAQs at: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Provider-Survey-and-Certification-Frequently-Asked-Questions.pdf)</p>
T-9	<p>Question: If, in an emergency, a patient cannot be handled in the nursing home and must be admitted to the hospital for medically necessary treatment, must this care be provided in the emergency department to qualify for reimbursement?</p> <p>Answer: There are no requirements that residents of nursing homes must be admitted to the hospital. Rather, nursing homes "must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." As the requirement is already flexible, there may be no need to "relax" or institute an alternative rule.</p>

Question Number	Question and Answer
T-10	<p>Question: If a Medicare beneficiary is transported by ambulance to a local skilled nursing facility (SNF) because the ambulance was unable to transport the beneficiary to a hospital located in another community because of factors such as weather, would Medicare payment be available under either of the following two scenarios?</p> <ol style="list-style-type: none"> 1. The ambulance service would use space in the SNF that was not used by patients and would provide the care for the patient under the direction of the ambulance medical director. 2. The staff from the SNF would help provide care for the patients, freeing the ambulance service staff to take other calls. <p>Answer: These scenarios implicate both payment policy and conditions of participation and the permissibility of either scenario may depend on whether a waiver under § 1135 of the Social Security Act has been granted to the SNF in question. First, in the absence of an 1135 waiver, if the patient needs a hospital level of care and not a SNF level of care, the SNF cannot be considered a hospital alternative care site. Therefore, the ambulance transport of the patient to the SNF would not be payable under Medicare because the SNF would not be the nearest appropriate facility that is capable of furnishing the required level and type of care for the beneficiary's illness or injury (see 42 CFR § 410.40(e) for destination requirements under Medicare fee-for-service). In addition, because the SNF cannot be considered a hospital alternative care site for furnishing a hospital level of care, no Medicare payment would be available for any services furnished to the patient while a resident of the SNF.</p> <p>Even if 1135 waivers were generally available for a particular emergency, because SNFs are not equipped to provide a hospital level of care, and because neither of the described scenarios entail a hospital working with a SNF to create an alternate hospital care site at the SNF, with the hospital providing additional staffing, CMS would likely have strong reservations about approving such a waiver request, regardless of whether or not the ambulance service would be providing personnel to monitor the patient(s) at the SNF. However, CMS would review the particular circumstances of the actual situation to make a determination under an 1135 waiver as to what practices would be permitted along with whether Medicare could pay for any covered services and under which benefit the services would be paid.</p>
T-11	<p>Question: If an individual is unable to go home from a skilled nursing facility (SNF) after the 100 days is over due to an emergency, will Medicare pay after the 100 days that ended during the emergency period? If so, what type of minimum data set (MDS) needs to be done and how would the SNF bill Medicare?</p> <p>Answer: It should be noted that the <i>only</i> payment provisions that can be waived under §1812(f) relate to the SNF benefit's qualifying hospital stay requirement, and to the renewal of exhausted SNF benefits for a beneficiary who was in the process of ending a benefit period at the time of the disaster. All other SNF coverage and payment requirements, including those relating to the required SNF level of care, remain in effect in situations where a SNF resident is unable to be discharged to his or her own home due to the disaster. Accordingly, the difficulty in securing a safe post-discharge environment in this situation cannot, in itself, serve as a basis for continued Part A coverage of the SNF stay. While Medicare coverage would remain available for certain individual medical and other health services under Part B, Medicare cannot pay under Part A <i>for the continued SNF stay itself</i> if the resident no longer requires an SNF level of care at that point or if the resident's available benefit days are exhausted during the emergency period. Nevertheless, as noted in Medicare Learning Network (MLN) Matters article #SE1247 (available online at www.cms.gov/Outreach-andEducation/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1247.pdf), the Federal Emergency Management Agency (FEMA) website at www.fema.gov/ contains information on special disaster assistance, including the availability of emergency shelters for those who are unable to remain in or return to their homes due to a disaster.</p>

Question Number	Question and Answer
T-12	<p>Question: Is there any guidance concerning skilled nursing facility (SNF) consolidated billing during an emergency? For instance, if a patient was scheduled to receive a computed tomography (CT) scan in a hospital, but due to emergency circumstances, the patient was re-routed to a free-standing imaging provider, would the SNF be responsible for payment?</p> <p>Answer: As explained more fully in other Qs&As in this section, the <i>only</i> payment provisions that can be waived under §1812(f) relate to the SNF benefit's qualifying hospital stay requirement, and to the renewal of exhausted SNF benefits for a beneficiary who was in the process of ending a benefit period at the time of the disaster. All other SNF coverage and payment requirements remain in effect, including the consolidated billing rules under which certain designated high-intensity outpatient services (such as CT scans) are separately payable under Part B <i>only</i> when furnished in the <i>hospital</i> setting. Thus, the SNF itself would remain responsible for a CT scan performed in a <i>nonhospital</i> setting, even if the use of the nonhospital setting is caused by a disaster-related dislocation.</p>
T-13	<p>Question: If a skilled nursing facility (SNF) is able to keep patients that don't have a place where they may be safely discharged, but are not in need of skilled services and therefore billed at the non-skilled rate, would those days count against their 100 days? Or once they are no longer receiving skilled services, would they start a 60 day break, even though they stay in the facility and are covered by Medicare?</p> <p>Answer: As explained more fully in other Qs&As in this section, when a SNF resident is unable to be discharged to his or her own home due to the disaster, the difficulty in securing a safe post-discharge environment in this situation cannot, in itself, serve as a basis for continued Part A coverage of the SNF stay. While Medicare coverage would remain available for certain individual medically necessary medical and other health services under Part B, Medicare cannot pay under Part A <i>for the continued SNF stay itself</i> if the resident no longer requires an SNF level of care at that point (whether skilled services are provided or not). Nevertheless, it is worth noting that special disaster assistance from the Federal Emergency Management Agency (FEMA) can include the availability of emergency shelters for those who are unable to remain in or return to their homes due to the disaster. Moreover, a 60-day break in skilled care in the SNF does, in fact, serve to end the beneficiary's current benefit period, and this would be the case regardless of whether a disaster-related waiver is in effect.</p>
T-14	<p>Question: A skilled nursing facility (SNF) had a Medicare resident who was at the facility all day, received rehabilitation services and nursing care, and the family took the patient home to sleep because they had power and it was warmer there – the SNF was on generator power. The patient slept at the family's home and was returned to the SNF the next morning, where he received rehabilitation services, nursing care, etc. Does the SNF need to code the day as a skipped day, or will CMS take into consideration the extenuating circumstances and allow it to bill for the services that were provided to him that day?</p> <p>Answer: If a SNF resident departs (but is not formally discharged) from a facility and does not return by midnight of the day of departure, the day preceding the midnight on which the resident was absent from the SNF constitutes a leave of absence (LOA) and that day is not a covered Part A day under the SNF prospective payment system policy. This is known as the "midnight rule." We note that while the LOA day is not a covered Part A day, the therapy given on that day may still be counted in a look-back period that includes that day pursuant to the policies outlined in Chapter 2 of the MDS 3.0 RAI Manual (available online in the "Downloads" section at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).</p>

U – Mental Health Counseling

Question Number	Question and Answer
U-1	<p>Question: Will Medicare help pay for counseling to help the beneficiary deal with the mental health issues associated with the emergency?</p> <p>Answer: Certain mental health service benefits (including counseling) may be available to Medicare beneficiaries with Part B coverage. In certain situations, partial hospitalization may also be covered.</p>

V – Rural Health Clinics / Federally Qualified Health Clinics

Question Number	Question and Answer
V-1	<p>Question: Medicare covered services are provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). May RHCs and FQHCs provide these services to those affected by an emergency? How does Medicare pay for these services?</p> <p>Answer: All Medicare Part B beneficiaries, including those affected by an emergency, are eligible to receive covered services from any Medicare-participating RHC or FQHC, subject to applicable co-pays. The Medicare portion of the payment to the RHC or FQHC is based on the clinic's costs, subject to a limit.</p> <p>Under law, Medicare-covered RHC and FQHC services include:</p> <ul style="list-style-type: none"> • services by physicians, nurse practitioners, physician assistants, clinical psychologists, and clinical social workers; • services and supplies incident to the services of these professionals; • certain visiting nurse (VN) services to the homebound; • pneumococcal and influenza vaccines and their administration; and • for FQHCs only, certain other preventive primary services.

W – Fee-for-Service Administration

Question Number	Question and Answer
W-1	<p>Question: There does not appear to be any contingency to deal with a situation in which a Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) is severely impacted by an emergency/disaster and unable to be responsive. Would the work load of an impacted FI/MAC be transferred to other FIs/MACs?</p> <p>Answer: CMS requires that every Medicare contractor have a continuity of operations plan (COOP) to ensure that operations are not materially disrupted so that providers and beneficiaries continue to be served. CMS reviews and approves such plans to ensure that our customers will be adequately served in the event of an emergency/disaster. CMS also has an Agency-wide COOP which, among other things, would address the situation where a particular contractor was wholly or partially unable to maintain operations. For security reasons, the specifics of such COOPs are not made public.</p>

X – Financial Management Policies

Question Number	Question and Answer
X-1	<p>Question: Can the 14-day payment floor be temporarily suspended to improve the cash flow of Part A providers and Part B providers?</p> <p>Answer: No. Cash flow problems can better be resolved through accelerated payments (Part A providers) or advance payments (Part B providers) rather than through suspension of the mandatory payment floor.</p>
X-2	<p>Question: Are accelerated or advance payments available for providers whose practices and/or businesses were severely affected by an emergency/disaster?</p> <p>Answer: For providers who are still rendering some services or who are taking steps to be able to render services again, accelerated or advance payments may be available. Providers in this position should contact their fiscal intermediary, carrier, or MAC for details.</p>
X-3	<p>Question: What is CMS' guideline regarding initiating electronic funds transfer (EFT) for providers affected by an emergency/disaster who had previously received paper payment (check)?</p> <p>Answer: Providers affected by an emergency/disaster may request in writing to their Medicare contractor that they receive payment via electronic funds transfer. The provider must supply all appropriate EFT information, i.e., physician/provider/supplier information and depository information by completing an EFT Authorization Agreement. Also, the provider must have a fully completed CMS enrollment application on file with the contractor. The Medicare contractor must verify the information received from the provider (confirm provider ID number, bank routing number, and account number). Additionally, the contractor may accept fax signatures and waive the 15-day pre-certification period. All Medicare FIs, Carriers, and MACs may continue to initiate EFT via fax and waive the 15-day pre-certification period, as described above, until further notice from CMS.</p>

Question Number	Question and Answer
X-4	<p>Question: If a provider has Medicare debt that it is repaying through the offset of current Medicare payments or an extended repayment plan (ERP) and the provider's or supplier's business was severely affected by the emergency/disaster, can the repayment time be deferred and/or extended?</p> <p>Answer: A provider/supplier may be able to defer two consecutive monthly payments under the ERP, or offset of current Medicare payments may be stopped for a period of up to 60 days, if justified. A provider in this position should contact its fiscal intermediary, carrier, or MAC to make this request. The contractor will determine the appropriate action based on criteria issued by CMS.</p>
X-5	<p>Question: If providers choose to waive Medicare deductible or coinsurance amounts for victims of the emergency/disaster, may the providers claim these waived amounts on the cost report as bad debt? If so, what documentation will be required in order to satisfy auditors?</p> <p>Answer: Providers can waive the coinsurance and deductible amounts and claim bad debt for Medicare patients that they determine to be indigent as provided in 42 CFR § 413.89 and the Provider Reimbursement Manual Part 1, Chapter 3, § 312. The Provider Reimbursement Manual Part 1, Chapter 3, § 312(B) indicates that the "provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence".</p>
X-6	<p>Question: In situations in the past in which accelerated or advance payment have been requested, the request has gone through a very convoluted and stringent process moving from the FI and/or RO and often to CMS central. We would hope that in a catastrophic disaster that involves severe disruption in the health care and financial system infrastructure, that CMS central would communicate clearly to its regions and contractors the nature of the requirements for accelerated/advance payment are and encourage flexibility in reviewing requests, especially related to solvency reviews.</p> <p>Answer: It is CMS' intent to provide expeditious customer service on accelerated or advance payments. However, as with most situations requiring payment, there is a concern that a provider will remain viable, or quickly regain viability, in order to repay the accelerated/advanced payment. Such payments are dependent on future billings; viability is an important factor and FIs/MACs and Regional Offices must ensure that the payments can be repaid through future billings.</p>
X-7	<p>Question: Will CMS charge interest in a catastrophic disaster in which the financial difficulties are out of the provider's control?</p> <p>Answer: Both CMS and the Secretary of the Department of Health and Human Services can waive interest on debts arising from a Medicare overpayment or debt under separate authorities. The nature of a particular emergency would be a key factor in the Secretary's decision to waiver interest on such debts.</p>
X-8	<p>Question: Will CMS consider periodic interim payments to providers as a means of ensuring continued cash flow?</p> <p>Answer: No. Accelerated payments (Part A) or advance payments (Part B) would be a better means of ensuring continued cash flow</p>
X-9	<p>Question: CMS policy for expedited/advance payments is very restrictive. Does CMS have the authority to loosen these rules? If not, would CMS support legislation that would provide additional flexibility to provide for expedited/advance payment in specific disaster circumstances (e.g., to provide advances on payments to facilities experiencing a temporary decline in patient population due to disaster so as to allow the facility to get back up and running)?</p> <p>Answer: Policy and procedures on advance and accelerated payments are tied to the expectation that claims or bills are forthcoming; the delay is temporary and accelerated and advance payments are simply that-- "advanced" funds with the expectation that bills will be used to offset the advance. Medicare's mission is to reimburse for covered Medicare services; therefore, Medicare billings are critical to its mission. There are other agencies responsible for relief and rebuilding programs in the wake of disasters or emergencies.</p>
X-10	<p>Question: Do Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs) have the authority to approve an extension of the deadline to submit a credit balance report for providers in an area affected by an emergency?</p> <p>Answer: Contractors have the authority to approve an extension of the deadline to submit a credit balance report for providers in an area affected by an emergency or disaster. Extensions should be approved for no longer than 90 days or 1 quarter.</p>

Question Number	Question and Answer
X-11	<p>Question: When should contractors send CMS reports on approvals and denials of provider requests for cost report credit balance report extensions in areas affected by an emergency or disaster?</p> <p>Answer: Contractors should submit Emergency reports monthly by the 5th of the following month until notice to cease doing so is issued.</p>
X-12	<p>Question: Should contractors suspend cost report audits of providers in an area affected by the emergency?</p> <p>Answer: Contractors shall evaluate on a case-by-case basis if they should continue cost report desk review and audit activities for providers in areas affected by the emergency.</p>
X-13	<p>Question: When should contractors resume audit activities in areas affected by an emergency?</p> <p>Answer: Contractors should evaluate on a case-by-case basis when they should resume audit activities in the affected areas.</p>
X-14	<p>Question: In the event of an emergency, which providers and suppliers in need of debt repayment relief will be considered to be in an affected area?</p> <p>Answer: A provider or supplier is considered to be located in an affected area if: (a) the provider's facility was physically located within the affected area; and/or (b) the area within which the provider was certified to render services was substantially encompassed within the affected area. Excluded from eligibility for this form of relief are providers and suppliers who have filed for bankruptcy, who are the subject of an active fraud investigation, or who are known to have ceased or suspected of having ceased to do business with, or having discontinued participation in, the Medicare program.</p>
X-15	<p>Question: Are there any changes to accelerated/advance reporting in the event of an emergency?</p> <p>Answer: Yes. Contractors shall add two new fields to their reporting data to reflect the beginning date of withholding and the outstanding balance.</p>
X-16	<p>Question: Do FIs or A/B MACs have the authority to approve accelerated payments in the event of an emergency?</p> <p>Answer: FIs or A/B MACs are given the authority to approve two (2) accelerated payments per provider. Once a provider makes a request for a third accelerated payment, the FIs or A/B MACs shall make a recommendation to the CMS RO or the PO and the CMS RO will determine if the accelerated payment is to be approved.</p>
X-17	<p>Question: Are there any providers who may not receive accelerated payments in the event of an emergency?</p> <p>Answer: Providers who are in a bankruptcy situation, who have an active fraud investigation, or who have not submitted claims within the last three (3) months should not have an accelerated payment approved. If the FI or A/B MAC believes an accelerated payment should be approved in these situations, the FI or A/B MAC shall forward the case to the CMS' RO and copy the A/B MAC PO.</p> <p>Providers who have existing Medicare debts may receive an accelerated payment. Funds from an accelerated payment should not be used to offset any existing debt the provider currently owes Medicare.</p>
X-18	<p>Question: Are there any physicians or suppliers who may not receive advance payments in the event of an emergency?</p> <p>Answer: Physicians/suppliers who are in a bankruptcy situation, who have an active fraud investigation or who have not submitted claims within the last three (3) months should not have an advance payment approved. If the Carrier, A/B MAC or DME MAC believes an advance payment should be approved in these situations, the Carrier, A/B MAC or DME MAC shall forward the case to the CMS RO or PO.</p> <p>Physicians/suppliers who have existing delinquent Medicare debts should not receive an advance payment. Again, if the Carrier, A/B MAC or DME MAC believes an advance payment should be approved in these situations, the Carrier, A/B MAC or DME MAC shall forward the case to the CMS RO and copy the PO.</p>

Question Number	Question and Answer
X-19	<p>Question: In the event of an emergency, would CMS consider making advance payments to hospitals that cancel elective cases, and other paying procedures that generate money for hospitals, in order to respond to the influx of medical cases during an emergency, that may not be paying Medicare patients, nor allow for sustainable margins.</p> <p>Answer: No, it is not a Medicare option to grant this request. Payment in such cases, if any, would be made by, and at the discretion of, the Federal Emergency Management Agency (FEMA) and providers seeking such payments should be referred to FEMA.</p>
X-20	<p>Question: What guidelines will contractors follow related to PIP and pass-through payments in the event of an emergency?</p> <p>Answer: Contractors shall work with affected providers (in specified geographic areas) to ensure appropriate cash flow. The following guidelines should be used in making determinations of appropriate PIP or interim pass-through payments:</p> <p>Follow normal operating procedures (i.e., 42 CFR § 413.64(h)(7) and 42 CFR § 413.64(c)(4)), in the recalculation of PIP and interim pass-through payments. When necessary, suspend or adjust PIP and interim pass-through payments to any facility that is not operational or has significantly changed its operations. Also, if any facility changes operations in the future, re-compute PIP and/or interim pass-through payments timely.</p>
X-21	<p>Question: What guidelines shall contractors follow relating to tentative and final settlements in the event of an emergency?</p> <p>Answer: Contractors shall follow the following guidelines on tentative and final settlements for affected providers (in specified geographic areas):</p> <p>Issue tentative and final settlements based on normal procedures for providers whose operations were not impacted by the emergency.</p> <p>Determine on a case-by-case basis, if tentative and final settlements should be issued for providers in the affected areas that were impacted by the emergency. Contractors shall issue tentative and final settlements to providers impacted by the emergency if the settlement results in a payment to the provider. Contractors may delay issuing tentative and final settlements if circumstances merit a delay.</p> <p>Where a contractor determines it should delay making a tentative or final settlement to a provider in the affected area, please notify CMS Central Office of this determination (the POC and timeframes to be specified at the time of the emergency/disaster). The contractor shall re-assess the provider's status every 30 days to determine when it should proceed with the outstanding tentative or final settlement. Contractors shall update such notice by the 15th of each month with any additions or deletions in delayed settlements.</p>
X-22	<p>Question: Are requests for accelerated and advance payments or requests to defer 1 or 2 monthly payments of an ERS retroactive to the effective date of the Secretary's issuance of the 1135 waiver?</p> <p>Answer: Yes</p>
X-23	<p>Question: May a provider delay its monthly payment of their Extended Repayment Schedule (ERS)?</p> <p>Answer: Yes, payments may be deferred; however, the provider should contact their Medicare contractor for more information.</p>
X-24	<p>Question: Are requests for accelerated and advance payments or requests to defer 1 or 2 monthly payments of an ERS retroactive to the effective date of the Secretary's issuance of the waiver?</p> <p>Answer: Yes.</p>
X-25	<p>Question: Will the recovery process for providers receiving an accelerated or advance payment be different due to a Public Health Emergency?</p> <p>Answer: If the provider is operating at normal capacity within the first 60 days of receiving an accelerated or advance payment, normal recovery mechanisms should apply. However, if the provider is still experiencing difficulties and the business is not running at normal capacity after an accelerated or advance payment has been issued, CMS may allow additional time to repay the accelerated or advance payment if needed. Contact your Medicare contractor for more details.</p>

Question Number	Question and Answer
X-26	<p>Question: I am an attorney representing a Medicare beneficiary in a liability insurance (or no-fault insurance or workers' compensation) matter. My client's claim has settled. He/she has incurred additional expenses due to a public health emergency. How can I expedite CMS' determination regarding whether or not Medicare has a recovery claim against my client's settlement due to the Medicare Secondary Payer rules?</p> <p>Answer: If you have a client residing in a State where a public health emergency has been declared, you may telephone the Medicare Secondary Payer Recovery Contractor (MSPRC) to request expedited conditional payment information and/or an expedited demand letter provided the case has settled. The demand triggers the process to quickly resolve Medicare claims and releases funds to the beneficiary. The contact number is (505) 798-7500. Please note that this assumes that you have first notified the Coordination of Benefits Contractor (COBC) of your pending case so that the matter has been established in CMS' systems as a potential recovery case. The contact number for the COBC is (646) 458-6682. The MSPRC has no way to expedite further action until a potential recovery case has been established in CMS' systems.</p>

Y – Medicare FFS Appeals

Question Number	Question and Answer
Y-1	<p>Question 1: Can beneficiaries in affected areas receive an extension to file an appeal?</p> <p>Answer: Yes, for good cause, affected beneficiaries may receive extensions to file appeal requests. Beneficiaries in affected areas should indicate they were impacted by a hurricane in their appeal requests.</p> <p>Updated: 9/14/17</p>
Y-2	<p>Question 2: What happens if the Medicare contractor needs additional documentation to support a pending appeal, but the provider/supplier is in an affected area?</p> <p>Answer: Medicare contractors will work with the provider/supplier to obtain the necessary documentation.</p> <p>Updated: 9/14/17</p>
Y-3	<p>Question 3: What if providers/suppliers in affected areas are unable to file appeals within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination?</p> <p>Answer: For good cause, Medicare contractors may accept late appeal requests from providers/suppliers. Providers/suppliers in affected areas should indicate they were impacted by a hurricane in their appeal requests.</p> <p>Updated: 9/14/17</p>
Y-4	<p>Question 4: What if providers/suppliers in affected areas are unable to receive RAs for an extended period of time, which can impact their ability to file timely appeals?</p> <p>Answer: For good cause, Medicare contractors may accept late appeal requests from providers/suppliers. Providers/suppliers in affected areas should indicate they were impacted by a hurricane in their appeal requests.</p> <p>Updated: 9/14/17</p>