CMS Response to the Midwest Floods Emergency

Questions and Answers
About
Medicare Fee-For-Service

#	Question and Answer
	Waiver of Certain Medicare Requirements
1	Question: Do the modifications and flexibilities described in Q&As in response to the existing emergency related to the floods apply only to providers in the States in which the Secretary of Health and Human Services (HHS) has declared a public health emergency and FEMA or the president has made a declaration under the Stafford Act or National Emergencies Act? Answer: The waivers apply only to providers in the areas in which the Secretary has declared a public health emergency and the president has made a declaration of a major disaster under the Stafford Act (currently Iowa and Indiana), and then only to the extent that the provider in question has been affected by the emergency. Note, however, that Medicare does allow for certain limited flexibilities outside the scope of the Secretary's § 1135 waiver authority as discussed in other Q&As.
2	Question: What is the duration of the waivers granted by the HHS Secretary under § 1135? Answer: In general, the length of the waiver is the duration of the emergency period, unless sooner terminated, as described in § 1135(e). However, requirements are waived only to the extent necessary to achieve the purposes of the statute. For example, if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, then the waiver of that requirement would no longer apply to that hospital. Note that if a waiver of EMTALA or HIPAA sanctions is granted, such a waiver is subject to special limits on duration.
3	Question: In addition to those services provided in the emergency area, can the § 1135 waiver authority be used to include waivers regarding benefits and services provided for evacuees from emergency areas who are receiving those services in non-emergency areas? Answer: The § 1135 waiver authority does not extend beyond the "emergency area," which is defined as the area in which there has been both a Stafford Act or National Emergencies Act declaration and a public health emergency declaration under Section 319 of the Public Health Service Act. Medicare does allow for certain limited flexibilities outside the scope of the § 1135 waiver authority as discussed in other Q&As. Some of these flexibilities may be extended to areas beyond the declared "emergency area".
4	Question: At what point will individuals no longer be treated as "flood victims"? Is there a set period of time or does it vary by individual? Answer: Emergency policies, including those policies made possible by the § 1135 waiver authority generally do not vary by individual beneficiary. 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. In addition, the § 1135 waiver authority, if invoked, is geared toward requirements upon providers, not individual beneficiaries. However, the effect of a waiver may vary somewhat from individual to individual depending, not upon the waiver authority itself, but rather upon particular circumstances, e.g., whether the person was evacuated to a facility for which requirements were waived (as opposed to a facility to which the waiver did not apply).
	Advance / Accelerated Payments
5	Question: Are accelerated or advance payments available for providers whose practices and/or businesses were severely affected by the existing emergency related to the floods? 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.

#	Question and Answer
	General Billing Procedures
6	Question: What guidance does CMS have for filing claims during the existing emergency related to the floods? Answer: CMS will be preparing guidance for program billing shortly.
	Drugs & Vaccines Under Part B
7	Question: Will Medicare Part B pay for vaccinations of Medicare beneficiaries? Answer: As usual, Medicare Part B will pay for preventive Hepatitis B vaccinations for high-and intermediate-risk beneficiaries and also for influenza and pneumoccocal vaccinations for all Medicare beneficiaries. Medicare 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.
8	Question: What can Medicare beneficiaries, who generally receive their Part B drugs at the doctor's office, do when that office is no longer in operation? 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.)
	Laboratory & Other Diagnostic Services
9	Question: In situations where laboratory specimens are destroyed or compromised by a disruptive event, how will laboratories be paid? Answer: Medicare contractors may consider payment for another drawing fee, specimen transport, or test if the results have not been communicated to the patient's physician.
	Ambulance Services
10	Question: Will Medicare pay for ambulance services for emergency evacuation situations? Answer: Medicare contractors may make payment for ambulance transports for evacuating patients from locations affected by the emergency. 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).
11	Question: How will ambulance services be paid when patients are moved from hospital to hospital or other approved locations? 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.

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12	Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to the flooding, and who wishes to return to a nursing facility closer to family members or home after the disaster is over? 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.
	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
13	Question: Does CMS provide any payments for durable medical equipment damaged during a disruptive event? Answer: Payment can be made for DME that has been repaired or replaced if the DME was damaged as part of a disruptive event related to the flooding.
14	Question: How can people with Medicare who have been displaced and who are without access to their usual suppliers get access to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) such as wheelchairs and therapeutic shoes? Answer: Beneficiaries who have access to a telephone may contact 1-800-Medicare for information regarding suppliers serving their current location. Alternatively, if beneficiaries have access to the Internet, they may go to the following medicare.gov website to obtain a directory listing suppliers by geography, proximity and name: http://www.medicare.gov/supplier/home.asp.
	Mental Health Counseling
15	Question: Will Medicare help pay for counseling to help the beneficiary deal with the mental health issues associated with the emergency? 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.
	Hospital Services – General
16	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 have to have the tests done again? 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.
17	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? 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.

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	Hospital Services – Acute Care
18	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? 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.
19	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? Answer: Normal prospective payment procedures apply to those hospitals reimbursed under the inpatient prospective payment system.
20	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? 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.
21	Question: Can a bed in a psychiatric unit be used for acute care patients admitted during a disaster? Answer: Yes, beds in a psychiatric unit can be used for acute care; however, it should be fully documented in hospital records and for cost reporting purposes. In addition, the acute portion of the hospital should bill for all Medicare-covered services; the psychiatric unit should record the services/charges as non-Medicare.
	Hospital Services – EMTALA
22	Question: Are hospitals required to comply with all of the requirements of EMTALA during the emergency period in the emergency area? Answer: Generally, yes. However, the Secretary has the authority not to impose sanctions on a hospital located in the emergency area during the emergency period if the hospital redirects or relocates an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfers an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. These waivers shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol and are not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.
23	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? Answer: Under these circumstances, EMTALA would not prohibit the hospital from closing its ED to new patients if it no longer had the capacity to screen and treat individuals (in effect, going on diversion). The hospital should follow any applicable State and local notice requirements and its own previously established plan for public notification when it goes on diversionary status. The hospital would continue to have an EMTALA obligation to individuals undergoing examination or treatment in its ED at the time it stops accepting new emergency patients. In addition, in spite of the “closure” if an individual comes to such a hospital and requests examination or treatment for an emergency medical condition, the hospital would be obligated by EMTALA to act within its capabilities to provide screening and, if necessary, stabilization.
	Hospital Services – Critical Access Hospitals (CAH)

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24	Question: Critical access hospitals (CAHs), which are normally limited to 25 beds and to a length of stay of not more than 96 hours, may need to press additional beds into service or extend lengths of stay to respond to the crisis. Will CMS enforce these limits? Answer: CMS will not count any bed use that exceeds the 25-bed or 96-hour average length of stay limits if this result is clearly identified as relating to the emergency. CAHs must clearly indicate in the medical record where an admission is made or length of stay extended to meet the demands of the crisis.
	Hospital Services – Long Term Care Hospitals (LTCH)
25	Question: Generally, a hospital must have an average Medicare inpatient length of stay of greater than 25 days in order to be classified as a long-term care hospital (LTCH). If a long-term care hospital (LTCH) admits a patient solely to meet the demands of the emergency, will the patient's stay be counted towards the greater than 25-day average Medicare inpatient length of stay calculation in 42 CFR 412.23(e)(3)(i)? Answer: If a LTCH admits a patient solely in order to meet the demands of the crisis, the patient's stay will not be included for purposes of the average length of stay calculation in 412.23 (e)(3)(i). LTCHs must clearly indicate in the medical record where an admission is made to meet the demands of the crisis.
	Inpatient Rehabilitation Facilities (IRF)
26	Question: If an inpatient rehabilitation facility (IRF) provider cannot file the Patient Assessment Instrument (PAI) within the specified time frame, they will be imposed a 25% penalty. The Fiscal Intermediary Shared System (FISS) auto applies the penalty, and currently there is an override/bypass in FISS. Does CMS have a workaround for this, as the only way we see getting around the penalty is for the provider to bill with an "artificial" PAI date that is within 28 days of the patient's discharge date? Answer: IRF payment policy allows for a waiver of the penalty in 412.614(e). Do not put an inaccurate date on the claim for the transmission of the IRF PAI. Medicare contractors have the authority to override the penalty in certain circumstances.
27	Question: The disruption to the hospital system caused by the flooding and its aftermath may require some hospitals to use any available bed to care for patients that have been transferred from the affected areas, or to treat the large number of people requiring hospital care. If an inpatient rehabilitation facility (IRF) admits a patient solely in order to meet the demands of this crisis, will the patient be included in the hospital's or unit's inpatient population for purposes of calculating the applicable compliance thresholds in 42 Code of Federal Regulations (CFR) § 412.23(b)(2) ("the 60 percent rule")? Answer: In order to meet the demands of the crisis, CMS will modify enforcement of the requirements specified in 42 CFR § 412.23(b)(2), which is the regulation commonly referred to as the "60 percent rule." If an IRF admits a patient solely to respond to the crisis and the patient's medical record properly identifies the patient as such, the patient will not be included in the hospital's or unit's inpatient population for purposes of calculating the applicable compliance thresholds outlined in § 412.23(b)(2). In the case of an admission that is made solely to meet the demands of the crisis, a facility should clearly identify in the inpatient's medical record by describing why the patient is being admitted solely to meet the demands of the crisis. In addition, during the applicable waiver time period, the exception described in this answer would also apply to facilities not yet classified as IRFs, but that are attempting to attain classification as an IRF. An institutional provider would use the "CR" (catastrophic/disaster related) modifier to designate any service line item on the claim that is disaster related. If all of the services on the claim is disaster related, the institutional provider should use the "DR" (disaster related) condition code to indicate that the entire claim is disaster related.

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28	Question: In addition to suspending the "60 percent rule" during the flood, will the Medicare admission criteria for inpatient rehabilitation found (IRF) in Section 110 of the Medicare Benefits Policy Manual, such as the 3-hour rule, also be temporarily suspended? Answer: CMS recognizes that it may become necessary for patients who are not rehabilitation candidates to be admitted to IRFs due to the flood. In these instances, CMS would not apply the IRF specific criteria (e.g., the 3-hour rule) to any review of claims. IRFs should clearly document in the patient's medical record that the patient was admitted solely to meet the demands of the crisis.
	Skilled Nursing Facility (SNF)
29	Question: Our SNF was affected by the flooding and, as a consequence, some of our patients were transferred to other providers. I have not submitted my claims for the month of the transfer. What is the correct patient status code that should be used? 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 "Iowa or Indiana Flooding" on their remarks page prior to submitting the claim to Medicare.
30	Question: Our SNF has received beneficiaries transferred from another SNF provider affected by the flooding. 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? Answer: Receiving providers should make sure they include remarks indicating "Iowa or Indiana Flooding" on any claims affected by this disaster. 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. 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.
31	Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to the flooding and who wishes to return to a nursing facility closer to family members or home after the disaster is over? 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.
32	Question: How should a facility bill for a beneficiary who was classified into rehabilitation Resource Utilization Group, Version III (RUG-III) group prior to the emergency when the facility is no longer able to provide therapy services as a result of the dislocations associated with the flooding? Answer: As explained in the Long-Term Care Facility Resident Assessment Instrument User's Manual, the RUG-III category stays in place for the Minimum Data Set (MDS) coverage period (e.g., the 5-day assessment can be used to bill from Day 1 up through Day 14, etc.) as long as the MDS was coded accurately. Payment will continue to be made at the assigned rehabilitation RUG level until the end of the covered time frame or until an Other Medicare-required assessment (OMRA) is completed. The OMRA must be completed 8 – 10 days after all therapies have been discontinued.
	Home Health Services

#	Question and Answer
33	Question: How will payments be processed for home health agencies (HHAs)? Answer: CMS will advise the FI or MAC to facilitate payment for home health services for beneficiaries who have been displaced due to the flooding. The FI 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.
34	Question: What adjustments or flexibility is allowed related to Medicare requirements for completion of the OASIS assessment process? Answer: As indicated in Survey and Certification Memo 05-43, and in the time period indicated in the statutory waiver invoked by the HHS Secretary under § 1135 of the Social Security Act, CMS may modify certain timeframe and completion requirements for OASIS. In this emergency situation, an abbreviated assessment can be completed to assure the patient is receiving proper treatment and to facilitate appropriate payment. For those Medicare approved HHAs serving qualified home health patients in the public health emergency areas determined by the Secretary, the following modifications to the comprehensive assessment regulation at 42 CFR § 484.55 may be made. These minimal requirements will support reimbursement when billing is resumed and help ensure appropriate care is provided. • The Start of Care assessment (RFA 1) may be abbreviated to include the Patient Tracking Sheet and the payment items. • The Resumption of Care assessment (RFA 3) and the Recertification assessment (RFA 4) may be abbreviated to the payment items. HHA should maintain adequate documentation to support provision of care and payment. • The OASIS transmission requirements at 42 CFR 484.20 are suspended for those Medicare approved HHAs that are serving qualified home health patients in the affected areas. • The Discharge assessment (RFA 8 or RFA 9) and the Transfer assessment (RFA 6, RFA 7) are suspended during the waiver period. HHAs should maintain adequate documentation to support provision of care and payment.
35	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 the crisis? 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? 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)(2), § 1819(a)(1), or § 1919(a)(1) of the Social Security Act, respectively. Under these temporary extraordinary circumstances, 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.
36	Question: Can the application of Partial Episode Payment (PEP) be suspended for patients displaced to other home health agencies (HHAs) due to the flooding? 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.

#	Question and Answer
37	Question: If a home health agency (HHA) affected by the flooding 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 episode? Answer: CMS is instructing the Regional Home Health Intermediaries (RHHIs) and MACs to temporarily cease to automatically cancel the RAPs of HHAs in the region affected by the flood. The RHHIs/MACs will identify all HHAs located within the areas affected by the flood. 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.
38	Question: How should home health agencies (HHAs) that have received patients that were displaced by the flooding, code their claims for these new admissions. Answer: HHAs should use source-of-admission code "B" (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 no 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.