



Medicare FFS Response to the PHE on the COVID-19

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Note: We revised the article to add waiver information about ground ambulance services in red print at the end of the table on page 7. All other information remains the same.

Provider Types Affected

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

Provider Information Available

The Secretary of the HHS declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020, HHS authorized waivers and modifications under [Section 1135 of the Social Security Act](#) (the Act), retroactive to March 1, 2020.

CMS is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for patients affected by the emergency. You don't need to apply for an individual waiver if a blanket waiver is issued.

For more Information refer to:

- [Coronavirus Waivers and Flexibilities](#) webpage
- [Instructions](#) to ask for an individual waiver if no blanket waiver exists

Background

Section 1135 and Section 1812(f) Waivers

As a result of this PHE, apply the following to claims for which Medicare payment is based on a "formal waiver" including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The "DR" (disaster related) condition code for institutional billing, that is, claims you submit using the ASC X12 837 institutional claims format or paper Form CMS-1450.

- The “CR” (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, that is, claims you submit using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

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

When HHS declares a PHE and invokes Section 1135 authority, we have the authority to take proactive steps through 1135 waivers as well as, where applicable, authority granted under Section 1812(f) of the Act, to approve blanket waivers of certain Social Security Act requirements. These waivers help prevent gaps in access to care for patients affected by the emergency. In prior emergencies, we issued waivers for the Medicare Fee-for-Service program. To allow us to assess the impact of prior emergencies, we needed modifier “CR” and condition code “DR” for all services provided in a facility operating per CMS waivers that typically were in place, for limited geographical locations and durations of time.

For the COVID-19 PHE, we added many blanket waivers, flexibilities, and modifications to existing deadlines and timetables that apply to the whole country. See the [full list](#) of waivers and flexibilities. Due to the large volume and scope of these new blanket waivers and flexibilities, we are clarifying which need the usage of modifier “CR” or condition code “DR” when submitting claims to Medicare. The chart below identifies those blanket waivers and flexibilities for which CMS requires the modifier or condition code. Submission of the modifier or condition code isn’t needed for any waivers or flexibilities not included in this chart.

Please note that we wouldn’t deny claims due to the presence of the “CR” modifier or “DR” condition code for services or items related to a COVID-19 waiver that aren’t on this list, or for services or items that aren’t related to a COVID-19 waiver. There may be potential claims implications, like claims denials, for claims that don’t contain the modifier or condition code as identified in the below chart, but providers don’t need to resubmit or adjust previously processed claims to conform to the requirements below, unless claims payment was affected.

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

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

Waiver/Flexibility	Summary	CR	DR
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise unusable, allow the DME MACs to have the flexibility to waive replacements requirements so the face-to-face requirement, a new physician's order, and new medical necessity documentation aren't needed. Suppliers must still include a narrative description on the claim explaining the reason why they are replacing equipment and we remind them to keep documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise unusable or unavailable as a result of the emergency.	X	
Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)	Modifies the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency, plus an added period of no more than 60 continuous days after the PHE expires. On the 61st day after the PHE ends (or earlier), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least 1 day to reset the 60-day clock. Physicians and eligible physical therapists must continue to use the Q5 or Q6 modifier (as applicable) and don't need to begin including the CR modifier until the 61st continuous day.	X	
Critical Access Hospitals	Waives the requirements that Critical Access Hospitals limit the number of inpatient beds to 25, and that the length of stay, on an average annual basis, be limited to 96 hours.		X
Replacement Prescription Fills	We allow Medicare payment for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise unusable by damage due to the disaster or emergency.	X	
Hospitals Classified as Sole Community Hospitals (SCHs)	Waives certain eligibility requirements for hospitals classified as SCHs before the PHE, specifically the distance requirements and the "market share" and bed requirements (as applicable).		X

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

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

Waiver/Flexibility	Summary	CR	DR
Services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient.	During the COVID-19 PHE, hospitals may send clinical staff services in the patient's home as a provider-based outpatient department and bill and be paid for these services as Hospital Outpatient Department (HOPD) services when the patient is registered as a hospital outpatient. Hospitals should bill as if they provided the services in the hospital, including appending the PO modifier for excepted items and services and the PN modifier for non-excepted services. The DR condition code should also be appended to these claims.		X
Ground Ambulance Services: Treatment in Place	CMS waived the requirements that an ambulance service include the transport of an individual to the extent necessary to allow payment for ground ambulance services furnished in response to a 911 call (or the equivalent in areas without a 911 call system) in cases in which an individual would have been transported to a destination permitted under Medicare regulations but such transport did not occur as a result of community-wide emergency medical service (EMS) protocols due to the COVID-19 PHE.	X	

Medicare FFS, FAQs available on the [Waivers and Flexibilities webpage](#) apply to items and services for Medicare patients in the current emergency. We display these FAQs in these files:

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

Blanket Waivers Issued by CMS

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

Counseling and COVID-19 Testing

To prevent further spread of COVID-19, a key strategy includes quarantine and isolation while patients wait for test results or after they get positive test results – regardless of showing symptoms.

Health care providers who counsel patients during their medical visits have an opportunity to decrease the time between patient-testing and quarantine or isolation, especially when this counseling happens concurrent with COVID-19 testing. Working in partnership with public health personnel, you could speed the counseling, testing, and referrals for case tracing

initiation to reduce potential exposures and added cases of COVID-19. By having patients isolated 1-2 days earlier, you can reduce the spread of COVID-19 significantly. Modeling shows early isolation can reduce transmission by up to 86 percent.

Through counseling, you can discuss with patients:

- The signs and symptoms of COVID-19
- The immediate need to separate from others by isolation or quarantine, particularly while awaiting test results
- The importance of informing close contacts of the person being tested (for example, family members) to separate from the patient awaiting test results
- If the patient tests positive, the patient will be contacted by the public health department to learn the names of the patient's close contacts. The patient should be encouraged to speak with the health department
- The services that may be available to help the patient in successfully isolating or quarantining at home

This early intervention of counseling steps and isolation can reduce spread of COVID-19.

How to Bill for Counseling Services

Medicare covers these counseling services. Health care providers providing counseling services to people with Original Medicare should use existing and applicable coding and payment policies to report services, including [evaluation and management](#) visits.

When providing these services during 2020, when you spend more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) providing counseling or coordination of care, you may use that time to select the level of visit reported.

Please review the following provider resources:

- [Provider Counseling Q&A](#)
- [Provider Counseling Talking Points](#)
- [Provider Counseling Check List](#)
- [Handout for Patients to Take Home](#)

Please also review the following information from CDC:

- [Overall COVID-19 Information](#)
- [Testing](#)
- [Symptoms](#)
- [Self-Care](#)
- [Care at Home](#)

Contact Tracing:

- [Contract Tracing webpage](#)
- [Principles Contract Tracing Booklet](#)
- [Investigation Contract Tracing](#)

Billing for Professional Telehealth Distant Site Services During the PHE

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

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

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

- Place of Service (POS) equal to what it would have been had the service been provided in-person
- Modifier 95, indicating that you provided the service via telehealth

As a reminder, we aren't requiring the CR modifier on telehealth services. But, consistent with current rules for telehealth services, 2 scenarios where modifiers are needed on Medicare telehealth professional claims are:

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

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

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

[Video](#)

Teaching Physicians and Residents: Expansion of CPT Codes that You May Bill with the GE Modifier

Teaching physicians and residents: Expansion of CPT codes that you may bill with the GE modifier under [42 CFR 415.174](#) on and after March 1, 2020, for the duration of the PHE:

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

MACs automatically reprocessed claims billed with the GE modifier on or after March 1, 2020, that were denied. You don't need to do anything.

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

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients who got COVID-19 testing-related services. These services are medical visits under the HCPCS E/M categories described below when outpatient providers, physicians, or other providers and suppliers who bill Medicare for Part B services order or administer COVID-19 lab tests regardless of the HCPCS codes they use to report the tests.

Cost-sharing doesn't apply for COVID-19 testing-related services, which are medical visits that: are provided between March 18, 2020 and the end of the PHE that result in an order for or administration of a COVID-19 test; are related to providing or administering such a test or to the evaluation of an individual for purposes of determining the need for a test; and are in any of the following categories of HCPCS E/M codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital E/M services

Cost-sharing doesn't apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- RHCs
- FQHCs

We provided the CS modifier for the gulf oil spill in 2010, but we recently repurposed the CS modifier for COVID-19 purposes. Now, for services provided on March 18, 2020, and through the end of the PHE, you should use the CS modifier on applicable claim lines to show the

service is subject to the cost-sharing waiver for COVID-19 testing-related services. Don't charge Medicare patients any co-insurance and deductible amounts for those services.

Use these HCPCS codes for billing:

- [Health care practitioners](#)
- [Outpatient Prospective Payment System \(OPPS\)](#)
- [RHCs and FQHCs](#)
- CAHs: use OPPS codes
- Method II CAHs: use the OPPS list or the health care practitioner list, as appropriate.

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

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

- Any location that is an alternative site determined to be part of a hospital, CAH, or SNF
- CMHCs
- FQHCs
- RHCs
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location providing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility isn't available
- Patient's home

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

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

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

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

To identify and pay for specimen collection for COVID-19 testing, we provide 2 Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a home health agency, any specimen source

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

These codes are billable by clinical diagnostic laboratories.

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

We instructed MACs and notified Medicare Advantage plans to cover COVID-19 laboratory tests for nursing home residents and patients. This instruction follows the CDC recent update of COVID-19 [testing guidelines for nursing homes](#) that give recommendations for testing of nursing home residents and patients with symptoms consistent with COVID-19 as well as for asymptomatic residents and patients who have been exposed to COVID like in an outbreak. Starting on July 6, 2020, and for the duration of the PHE, consistent with sections listed in the CDC guidelines titled, "Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel," original Medicare and Medicare Advantage plans cover diagnostic COVID-19 lab tests:

Diagnostic Testing

- Testing residents with signs or symptoms of COVID-19
- Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2, including close and expanded contacts (for example, an outbreak in the facility)
- Initial (baseline) testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 is part of the recommended reopening process
- Testing to determine resolution of infection

Original Medicare and Medicare Advantage Plans don't cover non-diagnostic tests.

SNF Benefit Period Waiver - Provider Information

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

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

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

Using the authority under section 1812(f) of the Social Security Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services (including SNF-level swing-bed services in rural hospitals and CAHs) without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19. Also, for certain patients who recently exhausted their SNF benefits, the waiver authorizes a one-time renewal of benefits for an added 100 days of Part A SNF coverage without first having to start a new benefit period (this waiver will apply only for those patients who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

For the QHS waiver:

- All patients qualify, regardless of whether they've SNF benefit days remaining
- The patient's status of being "affected by the emergency" exists nationwide under the current PHE. (You don't need to verify individual cases.)

In contrast, for the Benefit Period Waiver:

- Patients who exhaust their SNF benefits can get a renewal of SNF benefits under the waiver *except* in one particular scenario: that is, those patients who are receiving ongoing skilled care in a SNF that is unrelated to the emergency, as discussed below. To qualify for the benefit period waiver, a patient's continued receipt of skilled care in the SNF must in some way be related to the PHE. One example would be when a patient who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube. We would also note that patients who don't themselves have a COVID-19 diagnosis may nevertheless be affected by the PHE (for example, when disruptions from the PHE cause delays in obtaining treatment for another condition).
- Wouldn't apply to those patients who are receiving ongoing skilled care in the SNF that is *unrelated to the emergency* - a scenario that would have the effect of prolonging the current benefit period and precluding a benefit period renewal even under normal circumstances. For example, if the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the patient can't renew his or her SNF benefits under the Section 1812(f) waiver as it's this continued skilled care in the SNF rather than the emergency that is preventing the patient from beginning the 60 day "wellness period."

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

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

Billing Instructions

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

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

To bill for the benefit period waiver:

- Submit a final discharge claim on day 101 with patient status 01, discharge to home
- Readmit the patient to start the benefit period waiver

For ALL admissions under the benefit period waiver (within the same spell of illness)

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

For ALL SNF benefit period waiver claims, include the following (within the same spell of illness):

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

Note: Providers may use the added 100 SNF benefit days at any time within the same spell of illness. Claims must contain the above coding for ALL benefit period waiver claims.

Example: If a benefit waiver claim was paid using 70 of the added SNF benefit days and the patient either was discharged or fell below a skilled level of care for 20 days, the patient may subsequently use the remaining 30 added SNF benefit days as long as the resumption of SNF care occurs within 60 days (that is, within the same spell of illness).

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

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

CAH Swing-bed providers don't have to follow 1 and 2 since they aren't paid according to the SNF PPS. They must submit separate claims for the one-time benefit period waiver claims with the DR condition code. These claims shouldn't contain both benefit period waiver days and non-benefit period waiver days.

Please note, as previously stated, ongoing skilled care in the SNF that is **unrelated** to the PHE doesn't qualify for the benefit period waiver. You must decide if the waiver applies following the criteria set forth above. If so:

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

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

Note: You must abide by all other SNF billing guidelines. CAH Swing bed providers aren't subject to PPS and so aren't required to send assessments.

Beneficiary Notice Delivery Guidance in Light of COVID-19

If you're treating a patient with suspected or confirmed COVID-19, we encourage you to be diligent and safe while issuing the following beneficiary notices to patients receiving institutional care:

- Important Message from Medicare (IM)_CMS-10065
- Detailed Notices of Discharge (DND)_CMS-10066
- Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
- Detailed Explanation of Non-Coverage (DENC)_CMS-10124
- Medicare Outpatient Observation Notice (MOON)_CMS-10611
- Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
- Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)_CMS-10055
- Hospital Issued Notices of Non-Coverage (HINN)

Due to concerns related to COVID-19, current notice delivery instructions give flexibilities for delivering notices to patients in isolation. These procedures include:

- Hard copies of notices may be dropped off with a patient by any hospital worker able to enter a room safely. A contact phone number should be provided for a patient to ask questions about the notice, if the individual delivering the notice is unable to do so. If you can't drop off a hard copy of the notice, you can deliver notices to patients by email if the patient has access in the isolation room. Annotate the notices with the circumstances of the delivery, including the person delivering the notice, and when and where you sent the email.
- Notice delivery may be made via telephone or secure email to patient representatives who are offsite. Annotate the notices with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where you sent the email.

We encourage you to review all of the specifics of notice delivery, as in [Chapter 30 of the Medicare Claims Processing Manual](#).

More Information

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

For more information, review the [current emergencies webpage](#).

Providers may also want to view the [Survey and Certification FAQs](#).

For more information, contact your [MAC](#).

Document History

Date of Change	Description
May 12, 2021	We revised the article to add waiver information about ground ambulance services in red print at the end of the table on page 7. All other information remains the same.
November 9, 2020	We revised the article to clarify the billing instructions in the SNF Benefit Period Waiver - Provider Information section. All other information remains the same.
October 16, 2020	We revised the article to clarify the HCPCS codes that Critical Access Hospitals (CAHs) should use in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. Also, we clarified the Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information section to show the SNF waiver applies to swing-bed services in rural hospitals and CAHs. All other information remains the same.
August 26, 2020	We revised the article to add information about the HCPCS codes for OPPS, RHC, FQHC, and CAH billers in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. All other information remains the same.
August 20, 2020	We revised the article to add information about the HCPCS codes in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. All other information remains the same.
July 30, 2020	We revised the article to add the section, "Counseling and COVID-19 Testing." All other information remains the same.
July 24, 2020	We revised the article to add clarifying language to the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section to show it applies to lab tests regardless of the HCPCS codes used to report those tests. All other information remains the same.

Date of Change	Description
July 17, 2020	We revised the article to: - Update information on CDC nursing home patients or /residents testing - Add clarifying language to the SNF Benefit Period Waiver - Provider Information section All other information remains the same.
July 8, 2020	We revised the article to add a row at the end of the Waiver/Flexibility table (page 7) to discuss services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient. Also, we added the section on Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier. All other information remains the same.
July 1, 2020	We revised the billing instructions on page 12 of this article. Changes include instructions to readmit the patient on day 101 to start the SNF benefit period waiver. All other information remains the same.
June 26, 2020	We revised the article to add the section, "Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information" and related billing instructions. All other information remains the same.
June 19, 2020	We revised the article to add the section, "Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients." All other information remains the same.
June 1, 2020	We revised the article to add a section on Clarification for Using the "CR" Modifier and "DR" Condition Code. All other information remains the same.
April 10, 2020	Note: We revised this article to: <ul style="list-style-type: none"> • Link to all the blanket waivers related to COVID-19 • Provide place of service coding guidance for telehealth claims • Link to the Telehealth Video for COVID-19 • Add information on the waiver of coinsurance and deductibles for certain testing and related services • Add information on the expanded use of ambulance origin/destination modifiers • Provide new specimen collection codes for clinical diagnostic laboratories billing • Add guidance about delivering notices to patients. All other information is the same.
March 20, 2020	We revised the article to add a note in the Telehealth section to cover _ modifiers on telehealth claims and to explain the DR condition code isn't needed on telehealth claims under the waiver. All other information is the same.
March 19, 2020	We corrected a typo in the article. One of the e-visit codes was incorrectly stated as 99431 and we corrected it to show 99421.

Date of Change	Description
March 18, 2020	We revised this article to include information about the Telehealth waiver. All other information remains the same.
March 16, 2020	Initial article released.

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