MDS Alert

Billing and Reimbursement: Understand This Important PHE Billing Clarification

Know what to do with 'DR' code modifier.

Facilities have been scrambling to understand how to utilize properly some of the federal waivers enacted due to the COVID-19 public health emergency (PHE). The Centers for Medicare & Medicaid Services (CMS) has released an update with specific instructions for long-term care facilities on how to bill claims under two waivers.

"This is the guidance we've been waiting on to get our DR claims paid. There is definite action that you must take now," says **Judy Wilhide Brandt, RN, BA, CPC, QCP, RAC-MTA, DNS-CT,** principal for **Wilhide Consulting Inc.** in Virginia Beach, Virginia.

Background: CMS has issued waivers for certain regulations to help beneficiaries maintain steady access to care, despite the PHE. "In previous emergencies, CMS issued a limited number of waivers for the Medicare Fee-for-Service program. In order to allow CMS to assess the impact of prior emergencies, CMS has required the use of modifier 'CR' and condition code 'DR' for all services provided in a facility operating pursuant to CMS waivers that typically were in place, for limited geographical locations and durations of time," says a recent MLN Matters document "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)."

The two waivers that affect facility billing are related to qualifying hospital stays (which CMS has given the acronym QHS) and a benefit period waiver. While the QHS waiver and its billing instructions are pretty straightforward, the benefit period waiver is a little more complicated.

Follow These Steps for QHS Waiver

If you have a resident who is a Medicare beneficiary with benefit days available, but the resident didn't have a three-day qualifying stay, the QHS waiver may make sense.

For the QHS waiver: "All beneficiaries qualify, regardless of whether they have SNF benefit days remaining," CMS says. "The beneficiary's status of being 'affected by the emergency' exists nationwide under the current PHE. (You do not need to verify individual cases.)"

To bill for the QHS waiver, simply include the "DR" condition code on the claim.

Plus, you don't need to reach out to your Medicare Administrative Contractor (MAC) to figure out any necessary documentation for the QHS waiver. However, you may need to for the benefit period waiver, Brandt says.

Use These Guidelines for Benefit Period Waiver

You can use the benefit period waiver if you can demonstrate that a beneficiary's continued skilled care in a skilled nursing facility (SNis related to the PHE, CMS says.

To utilize the benefit period waiver, you're basically disrupting the process of ending the beneficiary's current benefit period to renew their benefits, Brandt says.

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You might pursue this waiver if the resident in question doesn't have benefit days available because they didn't have a 60-day wellness period. "In CMS regulatory language, when they talk about ending the current benefit period, they're not talking about the days you're billing to Part A. The benefit period ends, in regulatory language, when they qualify for a new 100 days. Ending the current benefit period means they did not achieve a 60-day wellness period, which is what has to happen to renew the benefit," Brandt explains.

Even though CMS notes that basically everyone is affected by the PHE for the QHS waiver, you have to do a little more legwork the benefit period waiver. However, the resident does not necessarily need to have a COVID-19 diagnosis to qualify.

"One example would be when a beneficiary who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube. We would also note that beneficiaries who do not 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," CMS says.

A beneficiary whose skilled care is not affected by the PHE, like a resident who required a feeding tube before the pandemic and still needs that level of care, doesn't qualify, "as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60-day 'wellness period,'" CMS says.

To make that determination, providers should compare the course of treatment that the beneficiary received to what the beneficiary would have received if the pandemic weren't occurring. "Unless the two are exactly the same, the provider would determine that the treatment has been affected by - and, therefore, is related to - the [public health] emergency," CMS says.

Include This Paperwork

For the benefit period waiver, providers need to include documentation demonstrating the beneficiary's qualifications.

"In this situation, we would also ask those providers to work with their respective MACs to provide any documentation needed to establish that the COVID-19 emergency applies for the benefit period waiver under §1812(f) for each benefit period waiver claim," CMS says.

To bill for the benefit period waiver, submit a final discharge claim with patient status 01, and then readmit the beneficiary (Day 101) to start the benefit period waiver, CMS says.

You need to include this information as well, CMS says:

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

For admission under the benefit period waiver, you need to complete a 5-day PPS assessment - the interrupted stay policy does not apply. Once you've completed the assessment and are ready to submit, make sure you're following the regular Patient-Driven Payment Model (PDPM) assessment rules, and add the HIPPS code from the new 5-day assessment to the claim. The variable per diem schedule begins Day 1.

However, the agency acknowledges that facilities may be scrambling a bit with paperwork, assessments, and submissions, more generally.

"Additionally, we also recognize that during the COVID-19 PHE, some SNF providers may have not yet submitted the PPS assessments for the benefit period waiver. In these limited circumstances, providers may utilize the Health Insurance Prospective Payment System (HIPPS) code that was being billed when the beneficiary reached the end of their SNF benefit period," CMS says.

As of publication, the most up-to-date bulletin can be found here: www.cms.gov/files/document/se20011.pdf.

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