The Interim Final Rule is found at: https://www.cms.gov/files/document/covid-final-ifc.pdf

Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS. ACTION: Interim final rule with comment period.
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In reading all of these CMS documents, remember that you must have supportive data as to why such waiver etc was implemented if you have not been seriously impacted in your area but you may want to use some of this info to better assist your referring hospitals and to adjust your pandemic plan. It is reported that COVID-19 is moving from cities to rural areas so not the time to lower our guards. **Hospitals' administrative team ARE responsible to read all applicable CMS documents and not take my comments as the law.**

1. One of the attachments is a list of waivers. - Use these not only to continue adjusting your pandemic plan but also to look for opportunities to grow your services if the need is there and to better assist your referring hospitals and local NHs. It is not a license to stop doing what requirements are in normal times if there is no need for such. Examples can be found throughout. Summary-covid-19-emergency-declaration-waivers- 7 final-508.pdf

My Notes regarding the most pertinent applicable to your hospitals re: SB but the entire document is a must read to understand all that is waived by CMS.

a) **3-Day Prior Hospitalization (Page 14)** 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 without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. So, the patient could come to your SB directly from your ED or referring hospital ED and not have to be admitted to their hospital if they do not meet acute criteria. Can also be admitted directly from the community. Potential scenario could be a physician performing a telecommunication call with a patient at home and based on reports and condition, the physician may want this patient to be observed closer on a scheduled by skilled staff.

   Do the referring hospitals know that you could admit a patient they would like to observe for COVID-19. The skilled service you would use is to admit them is under Observation & Management. Requires provider order. You would need to document very clearly as to what S&S you are observing for, how (assessment - what signs are you specifically looking for, V/S, O2 Sats, tolerance etc...), q. shift observation and documentation, and treatments as applicable (treatments may not be required). If symptomatic, they may be quarantined in a private room of your hospital if home is not an option.
   - Note: The qualifying hospital stay waiver applies to all SNF-level beneficiaries under Medicare Part A, regardless of whether the care the beneficiary requires has a direct relationship to COVID-19

b) **Exhausted SNF benefits -** For certain beneficiaries who recently exhausted their SNF benefits but got sick re: potential COVID before their 60 days spell of illness was over, the waiver authorizes renewed SNF coverage without first having to start a new benefit period. This will apply only for those beneficiaries 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).

This is NOT meant to extend the benefit to SB/SNF patients or LTC residents who are not prevented from ending their skilled services • Example: G-Tube fed resident, who had previously exhausted benefits and remains at a skilled level of care since then, would not qualify because they are NOT in a wellness, or custodial care window.

To determine if appropriate or not, • Determine last skilled day • Identify current skilled care needs • Are current skilled needs related to the pandemic? If so, then the waiver applies. For instance, a patient was in SB/SNF post -ortho surgery and was discharged home. 45 days later (not yet 60 days out of a part A stay), he/she needs to be admitted to SB due to skilled needs related to COVID-19.

In reviewing your charts, you identify the 3-MN or the spell of illness not followed, check to see if it was related to COVID and bill as such by identifying this to be related to COVID-19 (see below)

c) **Reporting Minimum Data Set.** For PPS SB hospitals - CMS is waiving 42 CFR 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission. This addresses late completion or late submission of the MDS. It does NOT include setting assessment reference dates (ARDs) late so, as usual, set the ARDs as per usual requirements

If you have the time to complete the MDS now, I recommend you do so because at one point they will have to be done in order to get paid and we know how complicated that would be. This was really written for LTC facilities who have been overwhelmed with the pandemic due to re-organizations they have to do in their facilities. Though, this could apply to the busy PPS hospital where the MDS Coordinator had to be re-assigned to another department for the time being due to COVID-19

Do remember that you may not bill until MDSs are accepted into the repository using an MDS transmission system such as jRaven or other system.

Note re: MDS for PPS SB hospitals – notes not necessarily referring to the waiver

- To check the MDS off as patient under isolation, it continues to meet the isolation requirements and coding (see RAI User's Manual, page O-5 Code for "single room isolation" only when all of the following conditions are met:

- The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
- Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
- The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
- The resident must remain in his/her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.)

□ In section O of the MDS, it has been determined that the time it takes a therapist to DON and DOFF their PPE can be counted in the therapy time the patient has received based on set-up time

□ In billing acute or SB on the UB04, it should include the Condition Code DR if related to COVID to ensure that the MAC appropriately reviews the information and not needlessly deny.

d) **Detailed Information Sharing for Discharge Planning for Hospitals and CAHs** is waived for now. This refers to the Freedom of Choice letter where you must provide options to the patient for post-acute discharge including quality data. Patients may not have choices under a pandemic depending on the situation in your area. See multiple bullets on this topic in the list of waivers.

e) **Waiver for Telehealth Services** - This is an opportunity for rural hospitals if not already using such or are limited in this service regardless of whether you have COVID-19 patients or not. This helps to continue communication with patients during these stay-at-home requirements – see other documents for more details. Also see the bullet on Telemedicine – is there an opportunity for you to improve patient care and allow you to take patients you may not otherwise taken if telemedicine was not available.

f) **Emergency Medical Treatment & Labor Act (EMTALA)**. CMS is waiving the enforcement of section 1867(a) of the Act. This will allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to **screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19**, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan.
Is this not an opportunity to add this service for our service area? (see other documents re: lab testing for instance)

g) Expanded Ability for Hospitals to Offer Long-term Care Services ("Swing-Beds") for Patients Who do not Require Acute Care but do Meet the Skilled Nursing Facility (SNF) Level of Care Criteria as Set Forth at 42 CFR 409.31. (New since 4/30 Release) – In other words, this means that a PPS hospital without SB could apply for such(including urban hospitals) – My question to CMS was - : how do you think those

PPS hospital will learn PDPM (payment system), learn how to complete MDSs and be set-up to transmit all for just COVID-19 period – Their response was that this was a good question and they would refer to somebody else. In Thursday's call, the CMS person responding to questions on the subject seemed to say that there would be a shorten version of the MDS but the others did not agree or deny. They reportedly plan to offer education on the subject for PPS hospitals wanting to now offer SB for the pandemic period. Also, those hospitals must demonstrate that this was a need in their area.

Have you rural PPS and CAHs reached out to larger PPS hospitals w/out SB to explain your bed availability and type of patients you can admit etc…

h) **Potential need to add to existing SB rural PPS and CAH hospitals** – again if that is an issue with lack of beds. It even allows CAHs to go above the 25 beds. You must follow the process for waivers with your CMS office. WVHA may be a resource for you.

This is another opportunity for you to grow your services if the need is greater that your SB number. Given the low reported # of COVID patients in WV, this may not be the case.

i) **CAH Length of Stay**. CMS is waiving the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation for number of beds and length of stay at 42 CFR §485.620.

Therefore, if your patient still meets criteria for acute care, there is no need to hurry their discharge to your SB.

j) **LTC Residents transferred to Hospitals** - CMS allows for hospitals to use their beds to temporarily "house" asymptomatic LTC residents that must be moved out of their facility. The nursing facility and the hospital must enter an "under arrangements" written contract. The nursing facility will continue to bill for the resident and pass through the per diem.

Do you have available capacity in your PPS or CAH? Is there a need for this service in your area? If so, please refer to WVHA or CMS office for more state specific details.

2. **Telehealth Video: Medicare Coverage and Payment of Virtual Services**

CMS updated a video that answers common questions about the expanded Medicare telehealth services benefit during the COVID-19 public health emergency. New information includes how CMS adds services to the list of telehealth services, additional practitioners that can provide telehealth services, and the distant site services that Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can provide. Further, the video includes information about audio-only telehealth services, telehealth services that hospitals, nursing homes and home health agencies can provide, along with how to correctly bill for telehealth services. – see https://youtu.be/Bsp5tIFnYHk

3. Coverage and Payment Related to COVID-19 Medicare

03052020-medicare-covid-19-fact-sheet.pdf **(see attachment)**

Posted 3/23/20 – good basic on what is covered. At a minimum, the Business Office and Care Manager should review.

4. **COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing**

COVID_FFS-Inclusive_FAQs-updated_ 6 FINAL_5.01.20 (1).pdf (see attachment or website below)

Ensure that your billing department stay alert to billing information during this pandemic.
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

It covers Q&A in the following area:

a) Payment for Specimen Collection for Purposes of COVID-19 Testing (p 1-3)
b) Lab
   - Diagnostic Laboratory Services (p 4)
   - Diagnostic Laboratory Services - Serology Testing (p 5-6)
   - High Throughput COVID-19 Testing (p 7)
c) Hospital Services (p7-13)
d) Ambulance Services (p 14-20)
e) Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (p 21-23)
f) Medicare Telehealth (Please note that these FAQs do not include flexibilities that might be exercised under the CARES act) 1 (p 24-31)
g) Physician Services (p32-35)
h) Home Infusion Services (p 35-36)
i) Accountable Care Organizations (ACO) (p 36-38)
j) Cost Reporting (p 39)
k) Opioid Treatment Programs (OTPs) (p 39)
l) Inpatient Rehabilitation Facility Services (p 40)
m) Skilled Nursing Facility Services – applies to SB (p 40-41)
n) General Billing Requirements (p 41-42)
o) Home Health (p 42-44)
p) Drugs & Vaccines under Part B (p 44-45)
q) National Coverage Determinations (NCD) (p.45-47)
r) Medicare Payment to Facilities Accepting Government Resources (p 48)
s) Oxygen (p 48)
t) Temporary Department of Defense Sites & Military Treatment Facilities (MTFs) (p 48-49)
u) Hospice (p 49-50)
v) Ambulatory Surgical Centers (ASC) (p 50-53)

5. CMS Permits Outpatient Services in the Home (Hospitals Without Walls)

Could our hospital OP department benefit from this CMS allowance?

- Tuesday, May 5th, 2020 - CMS most recent COVID-19 Interim Final Rule with Comment (IFC) provides flexibility for hospital outpatient departments (HOPD) to provide services to their patients to their home. During the COVID-19 public health emergency (PHE), a patient's home may be considered an off-site location of a hospital department. **Only registered outpatients may receive services in the home by the HOPD.** Be sure to follow instructions on how to apply for the patient's home to be home OP department.
- The HOPD may bill for services of registered outpatients provided in the patient's home by the HOPD clinical staff. The services provided must require the staff be present in the home, such as wound care, drug administration etc., and cannot be provided via telecommunications.
- However, the services of the physician/practitioner providing care in the HOPD may conduct a visit with the patient via telehealth and bill it as an HOPD visit.
- The HOPD services may not be provided to patients in the home that are under a home health plan of care. However, a home health agency may not open a patient to services if the HOPD is providing outpatient services in the home.

6. CMS COVID-19 Focused Infection Control Survey for Acute & Continuing Care

How are we doing with our Infection Prevention and Control? Both resources should help you to determine if you would be ready for a survey under COVID-19 which as replaced the regular surveys for the time being.

This website from Joint Commission covers what to expect from CMS surveys during these COVID-19 times. https://www.jointcommission.org/resources/news-and-multimedia/webinars/coronavirus-webinar-replays/cms-covid-19-focused-infection-control-survey-for-acute-and-continuing-care/
Click on the "Slide Deck" in website above for a quick review.
Also see one of my attachment for NH survey NH IC Survey - QSO-20-14-NH - REVISED 3-13-2020.pdf

7. ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020

See attachments in email COVID-19-Coding guidelines-final.pdf and

[Updated April 28] AHIMA and AHA FAQ: ICD-10-CM Coding for COVID-19

AHIMA & AHA Covid ICD10 Coding Updated April 28.docx

8. CMS Live Conference calls

Ensure that your hospital is on the email list from CMS alerting you to weekly conference calls for different audiences which gives an opportunity for Q&A session.

If you have remaining questions after looking over everything, you can always write an email to: Covid-19@cms.hhs.gov

CMS COVID-19 Stakeholder Engagement Calls

CMS hosts varied recurring stakeholder engagement sessions to share information related to the agency's response to COVID-19. These sessions are open to members of the healthcare community and are intended to provide updates, share best practices among peers, and offer attendees an opportunity to ask questions of CMS and other subject matter experts.

Past & future calls recordings and transcripts are posted on the CMS podcast page at:

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

CMS COVID-19 Office Hours Calls (Tuesdays and Thursdays at 5:00 – 6:00 PM Eastern) are more pertinent to hospital IP and OP as well as SB. Yes, time consuming but helpful for the administration team and Billing Office.