CMS updated MLN Matters SE20011 (attached) with new information that pertains to SNF billing on Friday 6/26/20. This guidance will assist facilities waiting to get our DR (disaster related) claims paid. There is definite action that must taken by billers now in order to process Claims that appropriately and properly utilized the 1135 Waivers.
See pages 10 – 13 of the CMS Memo for the specific Information and Claim Instructions pertaining to SNF's. Highlights include:
CMS recognizes that disruptions arising from a Public Health Emergency (PHE) can affect coverage under the SNF benefit:

1. Prevent a beneficiary from having the 3-day inpatient qualifying hospital stay (QHS)
2. Disrupt the process of ending the beneficiary'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 beneficiaries 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 without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently 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 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).

For the QHS waiver:

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

In contrast, for the Benefit Period Waiver:

1. **To qualify for the benefit period waiver, it must be demonstrated that a beneficiary's continued receipt of skilled care in the SNF is in some way related to the PHE.** 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.

2. Would not apply to those beneficiaries 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 beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver 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."

3. In making such 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 beneficiary 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 beneficiary has actually received to what would have been furnished absent the emergency. Unless the two are exactly the same, the provider would determine that the treatment has been affected by – and, therefore, is related to – the emergency.

4. **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 establish that the COVID-19 emergency applies for the benefit period waiver under §1812(f) for each benefit period waiver claim. 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.

   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:

5. Submit a final discharge claim with patient status 01 on the last covered day.

6. Admit the beneficiary the following day (Day 101) to start the benefit waiver period.
7. Non-Prospective Payment System (PPS) Critical Access Hospitals that provide SNF-level swing bed services do not have to comply with the discharge and readmission requirements, but all other actions apply.

For admission under the benefit period waiver:

1. Complete a 5-day PPS Assessment. (The interrupted stay policy does not apply.)
2. Follow all SNF Patient Driven Payment Model (PDPM) assessment rules.

3. Include the HIPPS code derived from the new 5-day assessment on the claim.
4. The variable per diem schedule begins from Day 1.

For SNF benefit period waiver claims, include the following:

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

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

1. If you billed the discharge and readmission correctly:

1. Cancel the rejected claim to remove it from claims history. DO NOT submit an adjustment to the rejected claim.
2. Once the cancel has finalized, resubmit the initial claim.
3. If you submit a claim without COVID100 in the remarks, we cannot process it for an additional 100 benefit days.

2. If you did not previously bill for a discharge on the last covered day to start a new admission with the benefit period waiver days:

1. Cancel the paid claim that includes the last covered coinsurance benefit day.
2. Once the cancel is processed, resubmit as a final bill with patient status equal to 01.
3. Cancel the initial benefit period waiver claim that rejected for exhausted benefits. You can submit this concurrently with the cancel of the paid claim.
4. Once the rejected claim is cancelled, submit an initial bill for the benefit period waiver following the same instructions as #1 above.

Please note, as previously stated, ongoing skilled care in the SNF that is unrelated to the PHE does not qualify for the benefit period waiver. You must determine if the waiver applies in accordance with the criteria set forth above. If so:

1. Fully document in medical records that care meets the waiver requirements; this may be subject to post payment review.
2. Track benefit days used in the benefit period waiver spell and only submit claims with covered days 101 - 200.
3. Once the additional 100 days have been exhausted, follow existing processes to continue to bill Medicare no-pay claims until you discharge the beneficiary.
4. Identify no-pay claims as relating to the benefit period waiver by using condition code DR and including “BENEFITS EXHAUST” in the remarks field.

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