



New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act

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Note: We revised this article to add guidance on how providers notify their MAC when there is no evidence of a positive laboratory test documented in the patient's medical record. All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for Inpatient Prospective Payment System (IPPS) hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) who bill Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article describes certain provisions of the Coronavirus Aid, Relief, and Economic Security (CARES) Act that relate to IPPS hospitals, LTCHs, and IRFs. These provisions are Sections 3710 and 3711 of the CARES Act.

BACKGROUND

Section 3710 of the CARES Act

Inpatient Prospective Payment System (IPPS) Hospitals - Section 3710 of the CARES Act directs the Secretary to increase the weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 Public Health Emergency (PHE) period. Discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes:

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period.

Providers may refer to the following ICD-10-CM coding guidance for coding encounters related to COVID-19:

- For discharges on or after April 1, 2020, the ICD-10-CM Official Coding and Reporting Guidelines are at <https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf>
- For discharges prior to April 1, 2020, the ICD-10-CM Official Coding Guideline – Supplement is at <https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Guidance-Interim-Advice-coronavirus-feb-20-2020.pdf>.

To implement this temporary adjustment, Medicare's claims processing systems will apply an adjustment factor to increase the Medicare Severity-Diagnosis Related Group (MS-DRG) relative weight that would otherwise be applied by 20 percent when determining IPPS operating payments for discharges described above.

CMS implemented the provisions of Section 3710 of the CARES Act in CR 11764. The MLN Matters article related to that CR is available at <https://www.cms.gov/files/document/mm11764.pdf>.

To address potential Medicare program integrity risks, effective with **admissions occurring on or after September 1, 2020**, claims eligible for the 20 percent increase in the MS-DRG weighting factor will also **be required to have a positive COVID-19 laboratory test** documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission.

For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. For example, a copy of a positive COVID-19 test result that was obtained a week before the admission from a local government-run testing center can be added to the patient's medical record. In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement.

The Pricer will continue to apply an adjustment factor to increase the MS-DRG relative weight that would otherwise be applied by 20 percent when determining IPPS operating payments for discharges that report the ICD-10-CM diagnosis code U07.1 (COVID-19). CMS may conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the additional payment resulting from the 20 percent increase in the MS-DRG relative weight will be recouped.

A hospital that diagnoses a patient with COVID-19 consistent with the ICD-10-CM Official Coding and Reporting Guidelines but does not have evidence of a positive test result can decline, at the time of claim submission, the additional payment resulting from the application at the time of claim payment of the 20 percent increase in the MS-DRG relative weight to avoid the repayment. To do so, the hospital will inform its MAC and the MAC will notate the claim with MAC internal claim processing coding for processing. The Pricer software will not apply the 20 percent increase to the claim when that MAC internal claim processing coding is present on a claim with the ICD-10-CM diagnosis code U07.1 (COVID-19). The updated Pricer software package reflecting this change will be released in October 2020.

To notify your MAC when there is no evidence of a positive laboratory test documented in the patient's medical record, enter a Billing Note NTE02 "No Pos Test" on the electronic claim 837I or a remark "No Pos Test" on a paper claim.

Section 3711 of the CARES Act

Inpatient Rehabilitation Facilities (IRFs) - Intensity of Therapy Requirement ("3-Hour Rule") - As required by Section 3711(a) of the CARES Act, during the COVID-19 PHE, the Secretary is waiving § 412.622(a)(3)(ii) relating to the criterion that Medicare Part A Fee-For-Service patients treated in IRFs receive at least 15 hours of therapy per week. This waiver supersedes the clarification of § 412.622(a)(3)(ii) provided in the interim final rule with comment titled, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC).

Long Term Care Hospitals (LTCHs) - Site Neutral Payment Rate Provisions - As required by Section 3711(b) of the CARES Act, during the COVID-19 PHE, the Secretary is waiving Section 1886(m)(6) Social Security Act (the Act) relating to certain site neutral payment rate provisions for LTCHs.

Section 3711(b)(1) of the CARES Act waives the payment adjustment under Section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a Discharge Payment Percentage (DPP) for the period that is at least 50 percent during the COVID 19 PHE period. Under this provision, for the purposes of calculating an LTCH's DPP, all admissions during the COVID-19 PHE period will be counted in the numerator of the calculation, that is, will be counted as discharges paid the LTCH Prospective Payment System (PPS) standard Federal payment rate.

Section 3711(b)(2) of the CARES Act provides a waiver of the application of the site neutral payment rate under Section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that are in response to the PHE and occur during the COVID-19 PHE period. To implement this provision, the claims processing systems will be updated to pay all LTCH cases admitted during the COVID-19 PHE period the LTCH PPS standard Federal rate, effective for claims with an admission date occurring on or after January 27, 2020.

ADDITIONAL INFORMATION

View the [complete list](#) of coronavirus waivers.

Review information on the current emergencies webpage at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

The following articles provide updates to payment policy for COVID-19 claims.

- [MM11742](#) – The article is based on CR 11742 that updates the LTCH Pricer software used in Original Medicare claims processing. The CR also includes new payment policy for the Novel Coronavirus Disease, COVID-19
- [MM11764](#) – The article is based on CR 11764 which updates the FY 2020 IPPS Pricer software used in Original Medicare claims processing. It includes new payment policy for individual diagnosed with COVID-19.

DOCUMENT HISTORY

Date of Change	Description
September 11, 2020	We revised this article to add guidance on how providers notify their MAC when there is no evidence of a positive laboratory test documented in the patient's medical record. All other information is unchanged.
August 17, 2020	We revised the article to add an update regarding the implementation of Section 3710 of the CARES Act for IPPS hospitals to address potential Medicare program integrity risks. All other information remains the same.
April 27, 2020	We revised this article to add references to related MLN Matters Articles MM11764 and MM11742 in the Additional Information Section. The article release date was also updated.
April 15, 2020	Initial article released.

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