Health Law Daily Wrap Up, STRATEGIC PERSPECTIVES: Medicare, other insurers cover COVID-19 testing and related services, (Mar. 18, 2020)

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The federal government and many states have provided for COVID-19 diagnostic testing with no cost-sharing and waivers to relax roadblocks to reimbursement.

The 2019 Novel Coronavirus (COVID-19) pandemic continues to escalate, posing unique challenges to health care facilities—which not only are on the front lines of treating patients, but also face the question of what services Medicare and other insurers cover, and how they will be reimbursed. However, CMS and a number of states now specifically provide coverage for COVID-19 testing, usually with no cost-sharing, and have waived requirements that would normally be an impediment to reimbursement.

**Medicare**

CMS announced that Medicare Part B will cover the diagnostic test to determine if a patient has COVID-19, with no cost-sharing. Part A will also cover medically necessary hospitalizations related to COVID-19, including for quarantine after a beneficiary would have otherwise been discharged. CMS reiterated other Part B benefits relevant to COVID-19, including imaging tests needed for treatment of lung infections.

The Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123) allows CMS to temporarily waive or modify the application of the telehealth origination site requirements of Soc. Sec. Act 1834(m)(4)(C) and the restriction in 42 C.F.R. §410.78(a)(3) on the use of a telephone. Accordingly, on March 17 CMS expanded the telehealth benefit on a temporary basis (see Medicare beneficiaries get expanded access to telehealth services during coronavirus outbreak, March 17, 2020). Beginning March 6, 2020 through the end of the public health emergency, Medicare will make payment for telehealth services furnished to beneficiaries in any health care facility and in their homes. Normal cost-sharing will apply; however, the Office of Inspector General said in a policy statement that physicians and other practitioners will not be subject to administrative sanctions for waiving or reducing cost-sharing for telehealth services.

Division G section 102 of the Families First Coronavirus Response Act (H.R. 6201), which was passed by the House on March 14, would require coverage with no cost-sharing under Medicare Part B of certain office visits related to COVID-19 testing. Section 103 would require Medicare Advantage coverage with no cost-sharing of COVID-19 testing.

CMS released new Healthcare Common Procedure Coding System (HCPCS) codes for COVID-19 tests—one for tests developed by the Centers for Disease Control and Prevention (CDC) and one for non-CDC laboratory tests—and the prices by Medicare administrative contractor (MAC) jurisdiction. Laboratories can use the codes beginning April 1 for tests provided after February 4, 2020. In addition, a new International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code for COVID-19 will be added effective with the next update on October 1 (see the CDC’s interim guidance), and the American Medical Association added a new Current Procedural Technology (CPT®) code for COVID-19 testing.

CMS also released FAQs on March 6 for providers regarding Medicare payment for laboratory tests and other services related to COVID-19.

**Parts C and D "flexibilities."** Under 42 C.F.R. §422.100(m), when a state of disaster is declared, an MA organization must:

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1. cover Parts A and B services and supplemental Part C plan benefits furnished at non-contracted facilities subject to 42 C.F.R. §422.204(b)(3), which requires facilities that furnish covered Parts A and B benefits to have participation agreements with Medicare.

2. waive, in full, requirements for gatekeeper referrals;

3. provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility; and

4. make changes that benefit the enrollee effectively immediately without the 30-day notification requirement at 42 C.F.R. §422.111(d)(3).

On March 10, CMS announced that MA organizations may also engage in permissive actions, such as waiving cost-sharing for COVID-19 tests, telehealth benefits, or other services to address the outbreak, and providing access to Medicare Part B services via telehealth in any geographic area and from a variety of places.

According to CMS, to ensure pharmacy access during a disaster or state of emergency resulting from COVID-19, Part D sponsors may relax "refill-too-soon" edits and provide maximum extended-day supply, reimburse for prescriptions obtained from out-of-network pharmacies, relax policies that discourage mail or home delivery, and waive prior authorization requirements. If a COVID-19 vaccine becomes available, it will be covered under Part D.

**Waivers.** In response to President Donald Trump’s national emergency declaration (see *Emergency declarations; more aggressive actions to control coronavirus*, March 16, 2020), CMS announced the following blanket waivers for Medicare coverage and reimbursement:

- the three-day prior hospitalization requirement for coverage of skilled nursing facility (SNF) services (Soc. Sec. Act §1812(f)) when the beneficiary needs to be transferred as a result of an emergency/disaster;
- renewed SNF coverage for certain beneficiaries who recently exhausted their SNF benefits;
- Minimum Data Set requirements of 42 C.F.R. §483.20;
- the 25-bed and 96-hour length-of-stay limitations for critical access hospitals (CAHs);
- permitting hospitals to house acute-care patients in excluded distinct-part units because of capacity issues due to the emergency/disaster, and vice versa;
- various requirements (e.g., face-to-face encounter, new physician’s order, or medical documentation) when durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable as a result of the emergency;
- allowing long-term care hospitals (LTCHs) to exclude patient stays when the LTCH admits or discharges patients to meet the demands of the emergency from the 25-day average length-of-stay requirement;
- MACs may grant relief to home health agencies (HHAs) on the time frames related to OASIS transmission and extend the auto-cancellation date of requests for anticipated payment during emergencies; and
- various requirements pertaining to appeals.

A guidance document describes additional emergency- and disaster-related policies and procedures that may be implemented only with a section 1135 waiver, and an FAQ explains policies and procedures that may be implemented without a section 1135 waiver.

**Sequester.** The American Hospital Association, Association of American Medical Colleges, and Federation of American Hospitals urged Congress to suspend the 2 percent Medicare sequester “for at least the duration of the pandemic.”

**Medicaid and CHIP.** In a March 5 fact sheet, CMS described Medicaid and Children’s Health Insurance Program (CHIP) coverage as it relates to COVID-19. CMS also published its first set of FAQs for state Medicaid and CHIP agencies (see *Medicaid and CHIP agencies get answers relating to coronavirus concerns*, March 13, 2020).
Division G section 104 of the Families First Coronavirus Response Act would require coverage with no cost-sharing under Medicaid and CHIP of COVID-19 testing, and would temporarily increase the federal medical assistance percentage (FMAP). Similarly, states such as Michigan and New York announced that there would be no cost-sharing related to COVID-19 testing and/or treatment.

**Waivers.** CMS encouraged state Medicaid agencies to submit requests for waivers under [Soc. Sec. Act §1135](https://www.cms.gov/). The waiver request does not need to be in a specific format, but it should clearly state the scope of the issue and the impact. CMS described examples of flexibilities that states and territories may seek: (1) waiver of prior authorization requirements in fee-for-service programs; (2) permitting providers located out of state/territory to provide care to another state’s Medicaid enrollees affected by the pandemic; and (3) temporary suspension of requirements for certain pre-admission and annual screenings for nursing home residents. CMS directed state agencies to the [Medicaid and CHIP Disaster Response Toolkit](https://www.medicaid.gov/). On March 16 it [approved](https://www.healthlawdaily.com/) Florida’s request for a [section 1135 waiver](https://www.cms.gov/). 

**Private Insurance**

CMS released a [fact sheet](https://www.cms.gov/) on individual and small group health insurance coverage as it pertains to the diagnosis and treatment of COVID-19 and [FAQs](https://www.cms.gov/) on essential health benefit coverage.

A number of insurance companies have committed to covering COVID-19 tests without cost-sharing and waiving other requirements. In addition, state departments of insurance, including [Colorado](https://www.colorado.gov/) and [Connecticut](https://www.ct.gov/), have issued advisories concerning coverage of COVID-19-related services.

Division G section 101 of the Families First Coronavirus Response Act would require group health plans and health insurance issuers offering group or individual health insurance coverage to provide, with no cost-sharing during the emergency period, coverage of COVID-19 diagnostic tests and office visits, urgent care center visits, and emergency room visits that result in an order for, or administration of, such tests.

**Looking Ahead**

The COVID-19 situation has been changing day to day, even hour to hour. Stay tuned to [Health Law Daily](https://www.healthlawdaily.com/) for continuing coverage.