CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services

Andy Beshear
Governor

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Eric C. Friedlander
Acting Secretary

Lisa D. Lee
Commissioner

April 30, 2020

TO: Nursing Facility PT 12
Provider Letter A-262

RE: COVID-19 Approval of Add-On to Facility Per Diem

Dear Nursing Facility Provider:

The Department for Medicaid Services (DMS) is committed to supporting providers during these extraordinary times due to the COVID-19 virus outbreak. Today, the Center for Medicare and Medicaid Services (CMS) approved our request to provide an add-on to the facility's per diem room and board rate for individuals who are diagnosed with COVID-19.

To qualify for the COVID-19 add-on of $270, the resident must be documented as having a positive COVID-19 diagnosis, starting with the date the test result is received. The ICD diagnosis code U07.1 must be submitted on the claim, along with the revenue code 550, for the days the resident remains COVID-19 positive. The traditional routine revenue code should also be billed for all nursing facility stay days to receive the standard case mix reimbursement. DMS will utilize the CMS guidance and definitions for the qualifications necessary to bill diagnosis code U07.1. The add-on rate is effective April 1, 2020 and through the emergency period.

Providers should maintain documentation, lab results, symptom tracking, and other medical records for the residents to assist with any post payment review. Please see the attached Frequently Asked Questions related to the $270 add-on for additional guidance.

In addition, due to the difficulty in obtaining documents required to determine eligibility for some patients, DMS is implementing a temporary process for Medicaid long-term care eligibility determinations during the COVID-19 State of Emergency. Effective April 24, 2020 client statement will be accepted verification for income and resources for Long Term Care applications. This includes applications for Nursing Facility and Waiver coverage.

Procedures for transfer of resources are not changing. Individuals will continue to be subject to transfer of resource penalties, if a prohibited transfer of resources has occurred.

By accepting client statement for income and resources, applications should only pend for receipt of the Level of Care (LOC) record. Current processes for requesting an LOC should be followed.

Please note, that although verification of income and resources is not being required, it is important that correct income and resources are reported to ensure an accurate eligibility determination. Verification will be requested at a later date and applicants should expect to receive a Request for Information (RFI) in approximately 6 months. All requested verification must be provided when requested or benefits will stop for failure to verify.

Additionally, it is important to understand that when all verification is processed if the member is determined ineligible for Medicaid, benefits will stop.

We believe this change will result in expedited Medicaid enrollment for individuals you are currently serving who are waiting on an eligibility determination.

In addition, effective April 1, 2020 DMS will be increasing the bed reservation days to 30 per calendar year through the state of emergency. All other requirements related to bed reservation days remains unchanged.

Thank you for your continued commitment to Kentucky's most vulnerable population during these unprecedented times. Please contact me if you have questions related to the policy directives outlined in this letter.

Thank you,

Lisa D. Lee, Commissioner

Enclosure

cc: Lee Guice, Director, Division of Policy and Operations
Jacob Wilson, Administrative Branch Manager, Division of Fiscal Management
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Kentucky Department for Medicaid Services
Provider Type 12
Nursing Facility Reimbursement – COVID-19 Additional Per Diem Payment
Frequently Asked Questions (FAQ) for Nursing Facility Providers
Updated 4/8/2020

Question 1: Is Kentucky Medicaid offering additional reimbursement for nursing facilities that care for residents testing positive for COVID-19?

Answer 1: Yes, if a resident has an active documented positive diagnosis of COVID-19, DMS will reimburse nursing facilities a separate per diem payment for the length of time that the resident's diagnosis remains active. Lab results (both positive and negative) should be maintained in the resident's medical record documentation. This additional payment will be made to nursing facilities that are currently being paid under the case mix standard price system. At this time those providers reimbursed on a cost-based or flat rate are not eligible for the additional payment.

Question 2: What is the additional amount per day that will be paid for COVID-19 positive residents?

Answer 2: An amount of $270 per day will be paid to the nursing facility, when a claim is submitted in accordance with the guidance below, for residents that have an active documented positive diagnosis of COVID-19 during the length of the resident's COVID-19 diagnosis.

Question 3: How does a nursing facility bill for the COVID-19 additional payment?

Answer 3: The nursing facility provider will bill their normal routine accommodation codes and be paid the case mix per diem rates for those dates of service. On the same claim on the detail lines, the nursing facility provider will use Revenue Code 550 – Other Skilled Nursing – to bill for the COVID-19 additional payment, and additionally have the U07.1 diagnosis recorded in any position on the claim in the diagnosis fields. The number of units should equal the number of days that the resident was in the nursing facility and also had an active documented diagnosis of COVID-19. The initial date of service for the COVID-19 days must also be included on the detail lines on the claim.

For example, for the month of April billing, assume a resident is in a nursing facility the entire month of April, and has an active documented positive diagnosis of COVID-19 from April 21-May 7. The nursing facility should bill 30 units of the normal routine revenue code and 10 units of Revenue Code 550 (for April 21-30), the additional COVID-19 units will be billed with the month of May billing. The 30 units will be multiplied by the facility's standard case mix adjusted per diem rate and the 10 units will be multiplied by the $270 add-on to determine final reimbursement.

Kentucky Department for Medicaid Services
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Question 4: When can I bill the COVID-19 positive Revenue and Diagnosis Code?

Answer 4: The Revenue Code will be available to use in billing beginning with dates of service April 1, 2020 until the end of the current national emergency declaration.

Providers will utilize the Revenue Code on claims billed based on the dates that the resident has an active documented positive diagnosis of COVID-19, starting with the date the test result is received. Additionally, the resident's medical record should document symptoms (for example, temperature and respiratory evaluations). The COVID-19 end date on the claim shall follow CDC guidelines as follows:

- Resident has had no fever for at least 72 hours without the use medicine that reduces fevers (resident temperature should be documented daily in the medical record);
- Other symptoms have improved (for example, cough or shortness of breath have improved); and
- At least 7 days have passed since symptoms first appeared or a negative test result has been obtained. Once symptoms have improved, DMS expects the provider to obtain a follow-up test to ensure the results are negative. The COVID-19 payment will end when the negative test results are obtained.

These dates are based on the current definition for meeting ICD diagnosis code U07.1, located at the following websites:

- https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf; and
- https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf.

DMS will apply CDC and CMS' instructions for when the diagnosis code of U07.1 – COVID-19 – can be used, which states the following:

- Effective with services on and after April 1, 2020, a confirmed diagnosis of COVID-19 (2019 novel coronavirus disease) should be reported with diagnosis code U07.1, COVID-19. Assignment of this code is applicable to positive COVID-19 test results and presumptive positive COVID-19 test results.

- A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC). CDC confirmation of local and state tests for COVID-19 is no longer required.

- If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter (such as fever) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

Question 5: Which claims are eligible for the COVID-19 additional payment?

Answer 5: The additional payment using the COVID-19 Revenue Code is appropriate for days that a nursing facility resident is in the facility with an active documented positive COVID-19 diagnosis. The appropriate diagnosis code of U07.1 must be coded on the claim.

Question 6: Will claims be reviewed that are paid with the new COVID-19 code?

Answer 6: Yes, a post payment review will be conducted to ensure that only those residents maintaining an active documented positive COVID-19 diagnosis were paid the additional payment of $270 per day.

Question 7: How will claims be reviewed?

Answer 7: Post payment reviews will include a variety of analysis, but will include comparing the diagnosis found on the Minimum Data Set (MDS) to the claims paid under the COVID-19 new billing code. The medical record should support a positive test result through a lab report and demonstrate the presence or absence of COVID-19 symptoms (fever, cough, shortness of breath, for example).

Question 8: Should providers put the COVID-19 diagnosis on the Minimum Data Set (MDS)?

Answer 8: Yes, if the resident has been diagnosed with COVID-19 (ICD code U07.1), this should appear as one of the diagnosis codes on the applicable MDS assessments (Medicare PPS, Admission, Significant Change, Quarterly, etc.) in either Section I0020B or I8000.

Question 9: Will DMS recoup payments for residents that are found as not having the COVID-19 positive diagnosis U07.1 during the dates billed on the claim?

Answer 9: Yes, payment recoupments will be pursued for paid claims that lack sufficient documentation to support an active documented positive COVID-19 diagnosis

Question 10: When will post-payment review of these claims occur?

Answer 10: The timing of the post-payment review will be determined at a later date, dependent upon the length of the national emergency period. It is anticipated these post-payment review activities would occur after the national emergency declaration has been lifted.