10/03/2008

CMS Response to the Hurricane Emergency – Gustav/Ike
Medicare Fee-For-Service

#	Question and Answer
	Waiver of Certain Medicare Requirements
1	Question: Do the modifications and flexibilities described in Q&As in response to the existing emergency apply only to providers in the States in which the Secretary of Health and Human Services (HHS) has declared a public health emergency and FEMA or the president has made a declaration under the Stafford Act or National Emergencies Act? Answer: The waivers apply only to providers in the areas in which the Secretary has declared a public health emergency and the president has made a declaration of an emergency under the Stafford Act, and then only to the extent that the provider in question has been affected by the emergency. Note, however, that Medicare does allow for certain limited flexibilities outside the scope of the Secretary's § 1135 waiver authority as discussed in other Q&As.
2	Question: What is the duration of the waivers granted by the HHS Secretary under § 1135? Answer: In general, the length of the waiver is the duration of the emergency period, unless sooner terminated, as described in § 1135(e). However, requirements are waived only to the extent necessary to achieve the purposes of the statute. For example, if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, then the waiver of that requirement would no longer apply to that hospital. Note that if a waiver of EMTALA or HIPAA sanctions is granted, such a waiver is subject to special limits on duration.
3	Question: In addition to those services provided in the emergency area, can the § 1135 waiver authority be used to include waivers regarding benefits and services provided for evacuees from emergency areas who are receiving those services in non-emergency areas? Answer: The § 1135 waiver authority does not extend beyond the "emergency area," which is defined as the area in which there has been both a Stafford Act or National Emergencies Act declaration and a public health emergency declaration under Section 319 of the Public Health Service Act. Medicare does allow for certain limited flexibilities outside the scope of the § 1135 waiver authority as discussed in other Q&As. Some of these flexibilities may be extended to areas beyond the declared "emergency area".
4	Question: At what point will individuals no longer be treated as "emergency victims"? Is there a set period of time or does it vary by individual? Answer: Emergency policies, including those policies made possible by the § 1135 waiver authority generally do not vary by individual beneficiary. These policies apply to the geographic area(s) in which the emergencies have been declared and may apply to individual health care providers or groups or types of providers. In addition, the § 1135 waiver authority, if invoked, is geared toward requirements upon providers, not individual beneficiaries. However, the effect of a waiver may vary somewhat from individual to individual depending, not upon the waiver authority itself, but rather upon particular circumstances, e.g., whether the person was evacuated to a facility for which requirements were waived (as opposed to a facility to which the waiver did not apply).
	Advance / Accelerated Payments
1	Question: Are accelerated or advance payments available for providers whose practices and/or businesses were severely affected by the existing emergency related to the emergency? Answer: For providers who are still rendering some services or who are taking steps to be able to render services again, accelerated or advance payments may be available. Providers in this position should contact their fiscal intermediary, carrier, or MAC for details.

#	Question and Answer
2	Question: What about provider requests to delay their monthly payment of their Extended Repayment Plan (ERP)? Answer: Yes, payments may be deferred; however, the provider should contact their Medicare contractor for more information.
3	Question: Are requests for accelerated and advance payments or requests to defer 1 or 2 monthly payments of an ERP retroactive to the effective date of the Secretary's issuance of the waiver? Answer: Yes.
4	Question: Will the recoupment process for providers receiving an accelerated or advance payment be different due to a Public Health Emergency? Answer: If the provider is operating at normal capacity within the first 60 days of receiving an accelerated or advance payment, normal recovery mechanisms should apply. However, if the provider is still experiencing difficulties and the business is not running at normal capacity after an accelerated or advance payment has been issued, CMS may allow additional time to repay the accelerated or advance payment if needed. Contact your Medicare contractor for more details.
	General Billing Procedures
1	Question: On October 14, 2005, in response to Hurricane *Katrina*, CMS issued Change Request 4106, "National Modifier and Condition Code To Be Used To Identify Disaster Related Claims." May these modifiers and condition codes be used for this emergency's-related claims? Answer: Yes.
2	Question**:** What should providers do when treating a Medicare beneficiary that can not provide their Medicare health insurance claim number at the time services are rendered? Answer: Medicare beneficiaries should not be denied emergency healthcare services. During a situation where the health care needs are not an emergency, the provider should instruct the beneficiary to call the Social Security Administration at 1-800-772-1213 to obtain a new card or to order one on-line at: http://www.socialsecurity.gov/medicarecard/. Providers should hold their claims until the beneficiary receives the new card and provides them with their Medicare number. Claims can not be processed without the Medicare Number (or health insurance claim number). Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for-service claims. In general, claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year (i.e., the time limit is the second year after the year in which such services were furnished). The timely filing period should allow adequate time for the provider to receive the health insurance number and file the claim. In those situations where the beneficiary requires emergency healthcare services in a natural or manmade disaster, the provider should attempt to obtain the Medicare number from the beneficiary, beneficiary's family members, or other providers such as transferring facilities, if possible. Providers can also share patient information to the extent necessary to seek payment for these health care services. If the provider cannot obtain the Medicare number through these other individuals, providers should contact the local Medicare contractor to request the Medicare number. Individual practitioners, such as a sole proprietorship, should be prepared to furnish the following information regarding their enrollment in the Medicare program: the provider's Social Security Number, date of birth and PTAN. Organizational providers should be prepared to furnish the following information about their enrollment in the Medicare program: the name of the authorized or delegated official on file for the provider.

#	Question and Answer
3	Question: I am an attorney representing a Medicare beneficiary in a liability insurance (or no-fault insurance or workers' compensation) matter. My client's claim has settled. He/she has incurred additional expenses due to a public health emergency. How can I expedite CMS' determination regarding whether or not Medicare has a recovery claim against my client's settlement due to the Medicare Secondary Payer rules? Answer: If you have a client residing in states where a public health emergency has been declared, you may telephone the Medicare Secondary Payer Recovery Contractor (MSPRC) to request expedited conditional payment information and/or an expedited demand letter provided the case has settled. The demand triggers the process to quickly resolve Medicare claims and releases funds to the beneficiary. The contact person for the MSPRC is Mike Piatt; his contact number is (505) 798-7500. Please note that this assumes that you have first notified the Coordination of Benefits Contractor (COBC) of your pending case so that the matter has been established in CMS' systems as a potential recovery case. The contact person for the COBC is Jim Brandy; his contact number is (646) 458-6682. The MSPRC has no way to expedite further action until a potential recovery case has been established in CMS' systems.
4	Question: If a provider is temporarily working out of another doctor's office (within the same State) due to hurricane damage, would they need to file a Change of Address for this temporary site? Answer: Yes. In most cases, the physician or non-physician can reassign his or her benefits to the other group by completing the CMS-855R. However, if the physician or non-physician practitioner has not updated their enrollment record in more than 5 years, then the individual practitioner would need to also submit the CMS-855I. Further questions may be referred to the provider's Medicare contractor.
	Drugs & Vaccines Under Part B
1	Question: Will Medicare Part B pay for vaccinations of Medicare beneficiaries? Answer: As usual, Medicare Part B will pay for preventive Hepatitis B vaccinations for high-and intermediate-risk beneficiaries and also for influenza and pneumoccocal vaccinations for all Medicare beneficiaries. Medicare will also pay for medically reasonable and necessary vaccinations of beneficiaries against a microbial agent or its derivatives (e.g., tetanus toxin, Hepatitis A) following likely exposure in accordance with normal Medicare coverage rules.
2	Question: What can Medicare beneficiaries, who generally receive their Part B drugs at the doctor's office, do when that office is no longer in operation? Answer: If possible, patients should contact their original physician's office to determine if there is an alternate location where they can receive services. If this is not possible, then patients may find another physician. That new physician can provide the necessary Part B drugs and Medicare will pay for them since beneficiaries in original, i.e., fee-for service, Medicare can receive health care services anywhere in the country. (Note: Medicare Advantage (MA) enrollees also can get urgently needed or emergency health care services anywhere.)
	Laboratory & Other Diagnostic Services
1	Question: In situations where laboratory specimens are destroyed or compromised by a disruptive event, how will laboratories be paid? Answer: Medicare contractors may consider payment for another drawing fee, specimen transport, or test if the results have not been communicated to the patient's physician.
	Ambulance Services

#	Question and Answer
1	Question: Will Medicare pay for ambulance services for emergency evacuation situations? Answer: Medicare contractors may make payment for ambulance transports for evacuating patients from locations affected by the emergency. The regulatory requirements must be met in order for such ambulance transports to be covered (i.e., the vehicle must meet certain requirements, the crew must be certified, ambulance services must be medically necessary, the transport must be from an eligible origin and to an eligible destination, certain billing and reporting requirements must be met, and Medicare Part A payment is not made directly or indirectly for the services).
2	Question: How will ambulance services be paid when patients are moved from hospital to hospital or other approved locations? Answer: Charges for ambulance transportation will be paid according to the usual payment guidelines. Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals should be included on the inpatient claims submitted by the originating hospitals. Payment will be included in the diagnostic related group (DRG) payment amounts made to hospitals paid under the prospective payment system. Outpatient claims may be submitted as separately billable claims for ambulance charges incurred by those patients who were transported from the originating hospitals and subsequently discharged by receiving hospitals.
3	Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to the emergency, and who wishes to return to a nursing facility closer to family members or home after the emergency is over? Answer: Part B of the Medicare program covers only local ambulance transportation to and from the nearest appropriate SNF equipped to treat the beneficiary, as long as the beneficiary is not a SNF resident in a covered Part A stay whose transport would be subject to consolidated billing rules. If there are exceptional circumstances that require transport outside the locality, Medicare can pay for this transport, but only if the destination is still the nearest SNF with appropriate facilities. In any case, the ambulance transport must be medically necessary.
	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
1	Question: Does CMS provide any payments for durable medical equipment damaged during a disruptive event? Answer: Payment can be made for DME that has been repaired or replaced if the DME was damaged as part of a disruptive event related to the emergency.
2	Question: How can people with Medicare who have been displaced and who are without access to their usual suppliers get access to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) such as wheelchairs and therapeutic shoes? Answer: Beneficiaries who have access to a telephone may contact 1-800-Medicare for information regarding suppliers serving their current location. Alternatively, if beneficiaries have access to the Internet, they may go to the following medicare.gov website to obtain a directory listing suppliers by geography, proximity and name: http://www.medicare.gov/supplier/home.asp.
3	Question: Will CMS cover the cost of a generator for medical needs? Answer: While generators may be used to power durable medical equipment, they are not medical equipment, nor can they be considered medical equipment. By law, Medicare does not have the authority to pay for them.
	Mental Health Counseling
1	Question: Will Medicare help pay for counseling to help the beneficiary deal with the mental health issues associated with the emergency? Answer: Certain mental health service benefits (including counseling) may be available to Medicare beneficiaries with Part B coverage. In certain situations partial hospitalization may also be covered.

#	Question and Answer
	Hospital Services – General
1	Question: I was scheduled for surgery at my hospital next week, but my hospital is unable to get to me. I already had all my tests done. Can I have the surgery at another hospital? Will I have to have the tests done again? Answer: If your physician has re-established his practice near you, you can contact him/her at the new location. However, if you cannot locate your physician, you will need to see another physician who will want to perform his/her own evaluation. If the test results are available, repeat tests may not be necessary. If the test results are not available, they will need to be repeated. A new physician may also have differing criteria as to who is eligible for surgery. Those criteria do vary among health care providers.
2	Question: Patients are taken to a second facility for chemotherapy services because of inadequate staff at the original facility due to the emergency. How should this be billed? Answer: For inpatients, the originating medical facility must bill for these services as part of the original inpatient stay and reimburse the second facility for the use of their chemotherapy services. It is important that this occur so that claims are not submitted with overlapping dates of service. If the originating facility is not able to operate, the receiving facility may bill Medicare, beginning with the date they assumed responsibility for the inpatient. If the services were rendered in an outpatient setting at both facilities, both facilities may bill for their own services as long as the dates of services do not overlap. Specifically, each facility may bill for the particular dates on which they serviced the beneficiary by providing chemotherapy. All facilities need to use the specific line item dates of service for each beneficiary encounter.
	Hospital Services – Acute Care
1	Question: Will a hospital be eligible for additional payment for rendering services to patients that remain in the hospital due to the fact that they continue to need medical care but at less than an acute level and those services are unavailable at any SNFs in the area because of the emergency? Answer: A physician may certify or recertify the need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF, but no bed is available in a participating SNF. Medicare will pay the DRG rate and any cost outliers for the entire stay until the Medicare patient can be moved to an appropriate facility.
2	Question: Are prospective payment providers going to be paid using a special payment method? If not, is there a special DRG that IPPS providers will be reimbursed for this situation? Answer: Normal prospective payment procedures apply to those hospitals reimbursed under the inpatient prospective payment system.
3	Question: Due to the unexpected emergent nature of the PPS hospital evacuation, there was not time to work out a financial arrangement with the receiving health care institution. Are PPS hospitals responsible to reimburse the receiving hospital for full charges or how can assistance be provided if problems arise with post evacuation payment negotiations? Answer: Financial agreements between providers are a private matter between those two parties. CMS cannot dictate the terms of these agreements or interfere in providers' negotiations. If the facilities are unable to work out a financial arrangement, CMS may consider allowing each facility to bill for the services it provided. CMS will make these considerations on a case-by-case basis.
4	Question: Can a bed in a psychiatric unit be used for acute care patients admitted during the emergency period? Answer: Yes, beds in a psychiatric unit can be used for acute care; however, it should be fully documented in hospital records and for cost reporting purposes. In addition, the acute portion of the hospital should bill for all Medicare-covered services; the psychiatric unit should record the services/charges as non-Medicare.

#	Question and Answer
5	Question: During an emergency situation, if acute care beds are all in use, can a hospital use its hospital-based SNF beds to provide acute care? Answer: Under the 1812(f) waiver that is in effect, a hospital can discharge more stable patients to a SNF. In this situation, the 3-day prior hospital stay requirement and benefit period requirements will be relaxed, and the beneficiary's care will be reimbursed at the appropriate SNF PPS rate. If it would be impractical or clinically inappropriate to discharge hospital patients to SNF-level care, a hospital may expand its inpatient bed capacity by obtaining a CMS waiver and placing some hospital patients into its hospital-based SNF. All waivers are directed to the Dallas Regional Office for approval. They can be sent to RODALDSC@cms.hhs.gov <mailto:RODALDSC@cms.hhs.gov> . If approved, the hospital must inform its FI/MAC. The hospital will be responsible for documenting that those patients admitted to the hospital-based SNF need a hospital level of care. The hospital will need to provide adequate RN staffing in the SNF to make sure that every patient needing a hospital level of care has immediate RN availability at the bedside. High acuity hospital patients or patients who need special equipment or special treatments should not be placed in the SNF. Care must also be taken not to place hospital patients into the SNF, if those patients place the SNF patients at risk (behavior problems, communicable infections). The hospital should bill at the IPPS rate for the stay. The hospital would need to keep good records for billing and for cost reporting reasons. Since the hospital and its hospital-based SNF share a cost report, costs would need to be appropriately attributed.
6	Question: Can a hospital that does not have either a hospital-based SNF or a swing bed unit use its acute care beds to provide SNF level care? Answer: No. Both hospital-based SNFs and swing beds have different conditions of participation, and, even when an 1135 waiver is in effect, can only be established after an on-site survey. During an emergency, CMS has very limited survey capability, and could not conduct surveys quickly enough to be useful. If the 1812 (f) waiver of the 3-day prior hospital stay is in effect, the hospital should make every effort to place patients in free-standing SNFs.
7	Question: Are there any additional payments for hospitals' capital costs as a result of the unanticipated capital expenditures they face due to emergencies? Answer: Under the existing regulations for short-term acute care hospitals under the inpatient hospital prospective payment system (PPS), there is an Extraordinary Circumstances Exception provision under the capital PPS that provides an additional payment if a hospital incurs unanticipated capital expenditures in excess of $5 million (net of proceeds from other funding sources, including insurance, litigation and government funding (e.g., FEMA aid)) due to extraordinary circumstances beyond the hospital's control (such as a hurricane or flood). For most hospitals, the additional payments are based on 85 percent of Medicare's share of allowable capital costs attributed to the extraordinary circumstance. There may be an offset to this amount based on a comparison of the hospital's cumulative capital PPS Medicare payments to a specified percent of its Medicare allowable costs over the past 10 years.

#	Question and Answer
8	Question: How do Inpatient PPS hospitals apply for the Capital PPS Extraordinary Circumstances Exception payments? Answer: To receive payments under the Capital PPS Extraordinary Circumstances Exception provision, a hospital that may be eligible for such payments must make an initial written request to its CMS Regional Office (RO) within 180 days after the occurrence of the extraordinary circumstance causing the unanticipated expenditures for a determination by CMS. If necessary, additional supporting information and documentation may be sent after the 180 day period provided that an initial written request was made to the appropriate RO in a timely manner. A complete written request should include an explanation with supporting documentation of the circumstances that led to the unanticipated capital expenditure, the estimated amount of the expenditure, and the sources and amounts of any anticipated reimbursement from other sources (including insurance, litigation and government funding (e.g., FEMA)) directly related to the capital expenditure. The RO will evaluate the completed request and forwards its recommendation to the CMS Administrator for a decision based on the nature of the circumstances, any recovered proceeds from other parties, and the amount of financial loss documented by the hospital.
	Hospital Services – EMTALA
1	Question: Are hospitals required to comply with all of the requirements of EMTALA during the emergency period in the emergency area? Answer: Generally, yes. However, the Secretary has the authority not to impose sanctions on a hospital located in the emergency area during the emergency period if the hospital redirects or relocates an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfers an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. These waivers shall be limited to a 72-hour period beginning upon implementation of a hospital emergency or disaster protocol and are not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.
2	Question: If a hospital remains open during the emergency period and is operating at or in excess of its normal operating capacity and cannot get sufficient staff, may the hospital shut down its emergency department (ED) without violating EMTALA? Answer: Under these circumstances, EMTALA would not prohibit the hospital from closing its ED to new patients if it no longer had the capacity to screen and treat individuals (in effect, going on diversion). The hospital should follow any applicable State and local notice requirements and its own previously established plan for public notification when it goes on diversionary status. The hospital would continue to have an EMTALA obligation to individuals undergoing examination or treatment in its ED at the time it stops accepting new emergency patients. In addition, in spite of the "closure" if an individual comes to such a hospital and requests examination or treatment for an emergency medical condition, the hospital would be obligated by EMTALA to act within its capabilities to provide screening and, if necessary, stabilization.
	Hospital Services – Critical Access Hospitals (CAH)
1	Question: Critical access hospitals (CAHs), which are normally limited to 25 beds and to a length of stay of not more than 96 hours, may need to press additional beds into service or extend lengths of stay to respond to the emergency. Will CMS enforce these limits? Answer: CMS will not count any bed use that exceeds the 25-bed or 96-hour average length of stay limits if this result is clearly identified as relating to the emergency. CAHs must clearly indicate in the medical record where an admission is made or length of stay extended to meet the demands of the emergency.

#	Question and Answer
2	Question: Does a Critical Access Hospital (CAH) get paid differently depending on whether it is a new admission or a transfer of a patient that is evacuated from an area undergoing an emergency? Answer: No. A CAH will receive 101 percent of reasonable costs for all Medicare patients irrespective of whether the patient was discharged from a hospital in an emergency area and then admitted to the CAH or transferred from that hospital.
	Hospital Services – Long Term Care Hospitals (LTCH)
1	Question: Generally, a hospital must have an average Medicare inpatient length of stay of greater than 25 days in order to be classified as a long-term care hospital (LTCH). If a long-term care hospital (LTCH) admits a patient solely to meet the demands of the emergency, will the patient's stay be counted towards the greater than 25-day average Medicare inpatient length of stay calculation in 42 CFR 412.23(e)(3)(i)? Answer: If a LTCH admits a patient solely in order to meet the demands of the emergency, the patient's stay will not be included for purposes of the average length of stay calculation in 412.23 (e)(3)(i). LTCHs must clearly indicate in the medical record where an admission is made to meet the demands of the emergency.
	Inpatient Rehabilitation Facilities (IRF)
1	Question: If an inpatient rehabilitation facility (IRF) provider cannot file the Patient Assessment Instrument (PAI) within the specified time frame, they will be imposed a 25% penalty. The Fiscal Intermediary Shared System (FISS) auto applies the penalty, and currently there is not an override/bypass in FISS. Does CMS have a workaround for this, as the only way we see getting around the penalty is for the provider to bill with an "artificial" PAI date that is within 28 days of the patient's discharge date? Answer: IRF payment policy allows for a waiver of the penalty in 412.614(e). Do not put an inaccurate date on the claim for the transmission of the IRF PAI. Medicare contractors have the authority to override the penalty in certain circumstances.
2	Question: The disruption to the hospital system caused by the emergency and its aftermath may require some hospitals to use any available bed to care for patients that have been transferred from the affected areas, or to treat the large number of people requiring hospital care. If an inpatient rehabilitation facility (IRF) admits a patient solely in order to meet the demands of this emergency, will the patient be included in the hospital's or unit's inpatient population for purposes of calculating the applicable compliance thresholds in 42 Code of Federal Regulations (CFR) § 412.23(b)(2) ("the 60 percent rule")? Answer: In order to meet the demands of the emergency, CMS will modify enforcement of the requirements specified in 42 CFR § 412.23(b)(2), which is the regulation commonly referred to as the "60 percent rule." If an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such, the patient will not be included in the hospital's or unit's inpatient population for purposes of calculating the applicable compliance thresholds outlined in § 412.23(b)(2). In the case of an admission that is made solely to meet the demands of the emergency, a facility should clearly identify in the inpatient's medical record by describing why the patient is being admitted solely to meet the demands of the emergency. In addition, during the applicable waiver time period, the exception described in this answer would also apply to facilities not yet classified as IRFs, but that are attempting to attain classification as an IRF. An institutional provider would use the "CR" (catastrophic/disaster related) modifier to designate any service line item on the claim that is disaster related. If all of the services on the claim is disaster related, the institutional provider should use the "DR" (disaster related) condition code to indicate that the entire claim is disaster related.

#	Question and Answer
3	Question: In addition to suspending the "60 percent rule" during the emergency, will the Medicare admission criteria for inpatient rehabilitation found (IRF) in Section 110 of the Medicare Benefits Policy Manual, such as the 3-hour rule, also be temporarily suspended? Answer: CMS recognizes that it may become necessary for patients who are not rehabilitation candidates to be admitted to IRFs due to the emergency. In these instances, CMS would not apply the IRF specific criteria (e.g., the 3-hour rule) to any review of claims. IRFs should clearly document in the patient's medical record that the patient was admitted solely to meet the demands of the emergency.
4	Question: What billing and Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument (PAI) procedures should be used when an IRF evacuates a Medicare beneficiary to another IRF? Answer: An IRF may evacuate beneficiaries for short periods of time to another IRF without formally releasing (i.e., "discharging") the patient. The transferring IRF should make arrangements to reimburse the receiving IRF. In this case, the transferring IRF retains overall responsibility for the patient's care, and should make sure that the necessary medical documentation is transferred with the patient. Then, the receiving IRF can continue to treat the patient in accordance with the established plan of care. The transferring IRF also retains responsibility for completing the IRF-PAI, and for billing the entire stay to CMS. This procedure is most appropriate when the evacuating IRF expects to bring the patient back within a reasonable period of time. When an evacuating facility formally discharges patients to another IRF, the evacuating facility should consider the expected duration of the evacuation, and the amount of time the patient has already been in the evacuating facility. First, if the evacuation is for 3 days or less, payment for the patient's entire IRF length of stay (both in the evacuating facility and in the receiving facility) is made to the evacuating facility based on the patient's initial case mix group (CMG) assignment. When the patient has completed his or her entire rehabilitation episode stay and is discharged, the evacuating IRF is responsible for billing the claim and completing and transmitting the IRF-PAI information according to the special payment provisions for interrupted stays that are outlined in 42 CFR § 412.624(g) and § 412.618(a)(1). Second, if the beneficiary is transferred to another IRF for more than 3 days, the evacuating facility should be aware that the IRF short-stay transfer policy may apply. Under the IRF short-stay transfer policy specified in 42 CFR § 412.624(f), the transferring IRF receives a reduced per diem payment for patients who are transferred to another institutional site of care (such as, for example, another IRF, a SNF, or an acute care hospital) after having stayed in the IRF for less than the average length of stay for the patient's assigned CMG. This situation does not affect the receiving IRF's payment, which would be subject to all of the normal IRF payment provisions outlined in 42 CFR § 412.624, including the full CMG payment amount if applicable. The patient must be formally discharged from the evacuating facility and then admitted to the receiving IRF Both IRFs will need to meet all applicable IRF-PAI requirements Finally, if the discharged beneficiary had been a patient in the evacuating IRF for a number of days at least equal to the average length of stay for the patient's assigned CMG and was transferred to another IRF for more than 3 days, .the patient must still be formally discharged from the evacuating facility and then admitted to the receiving IRF. Both IRFs will need to meet all applicable IRF-PAI requirements and are subject to all of the normal IRF payment provisions outlined in 42 CFR § 412.624, including reimbursement for both IRFs at the full CMG payment amount if applicable Please note that for all the situations described above, the requirements for timely transmission of the IRF-PAI will be relaxed. During this emergency period, the penalty for late submission of the IRF-PAI specified in 42 C.F.R. § 412.614(e) will be waived.
	Skilled Nursing Facility (SNF)

#	Question and Answer
1	Question: Is CMS waiving the skilled nursing facility (SNF) benefit's 3- day qualifying hospital stay requirement for those beneficiaries affected by the emergency situation? Answer: Yes. Section 1812(f) of the Social Security Act (the Act) confers the administrative authority to grant SNF coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program costs and does not alter the SNF benefit's "acute care nature" (that is, its orientation toward relatively short-term and intensive care). Under this authority, CMS has issued a temporary waiver of the SNF benefit's qualifying hospital stay requirement for those beneficiaries who are evacuated or transferred as a result of the emergency situation. In this way, beneficiaries who may have been discharged from a hospital early to make room for more seriously ill patients will be eligible for Medicare Part A SNF benefits. In addition, beneficiaries who had not been in a hospital or SNF prior to being evacuated, but who now need skilled nursing care, will be eligible for Medicare Part A SNF coverage. CMS's waiver of the requirement for a 3-day hospital stay is limited to the time period during which the Secretary's Waiver or Modification of Requirements under Section 1135 of the Social Security Act remains in effect.
2	Question: When a SNF evacuates patients to another SNF or hospital as part of an emergency plan, who should bill for the services? Answer: If the evacuation is for less than 30 days, the initial SNF can transfer the patients to another facility "under arrangements." The transferring SNF need not issue a formal discharge in this situation, as it is still considered the provider and should bill Medicare for each day of care. The SNF is then responsible for reimbursing the provider that accepted the patients during the emergency period. For specific instructions on the procedures to be followed, please review the detailed survey and certification instructions at http://www.cms.hhs.gov/SurveyCertEmergPrep/04_Resources.asp#TopOfPage.
3	Question: Is CMS temporarily relaxing the requirements for establishing a new spell of illness for beneficiaries who have a renewed need for skilled nursing facility (SNF) services as a direct result of the dislocations and trauma related to the emergency situation? Answer: Yes. A new SNF Part A benefit period will be available to any beneficiary recently discharged from a nursing home who has not had the time to establish a new benefit period. The Part A SNF coverage is available to any beneficiary who has experienced trauma through dislocation or evacuation in connection with this emergency, regardless of the location of the SNF that provides the care. Therefore, in this situation, the admitting SNF does not need to be located in the emergency area. Part A coverage will be available as long as the beneficiary requires skilled care, up to 100 days. Full coverage will be available for the first 20 days. The daily Medicare coinsurance will be applied from days 21-100. CMS's policy to provide a new benefit period will apply only during the time period in which the Secretary's Waiver or Modification of Requirements under Section 1135 of the Social Security Act remains in effect.
4	Question: Our SNF was affected by the emergency and, as a consequence, some of our patients were transferred to other providers. I have not submitted my claims for the month of the transfer. What is the correct patient status code that should be used? Answer: Those affected providers that are aware of the location of their former resident's transfer should include the correct patient status code for the transfer (i.e., patient status code "03" = transfer to SNF). If not aware of the exact transfer, providers should use patient status code "01" (discharged to home or self care) in order to bypass any potential overlapping claim situations. Providers should include "Hurricane Emergency" on their remarks page prior to submitting the claim to Medicare.

#	Question and Answer
5	Question: Our SNF has received beneficiaries transferred from another SNF provider affected by this emergency. I have submitted my claims to Medicare for the month after the transfer but I am receiving an overlap with the prior month's claim previously sent by the affected SNF. How can I get my claim paid? Answer: Receiving providers should make sure they include remarks indicating "Hurricane Emergency" on any claims affected by this emergency. The receiving provider should contact their FI or MAC for assistance with these overlap situations. FIs and MACs shall identify the overlap and develop the claim accordingly, including working with other FIs that might service the affected SNF. If the transferring provider submitted its "transfer-month" claim with a patient status of "30" (still patient) but the patient was actually transferred in that month, the FI/MAC shall adjust the claim or work with the transferring provider's servicing FI/MAC to have the claim adjusted and use an appropriate patient status code to indicate a transfer.
6	Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to the emergency and who wishes to return to a nursing facility closer to family members or home after the emergency is over? Answer: Part B of the Medicare program covers only local ambulance transportation to and from the nearest appropriate SNF facility, as long as the beneficiary is not a SNF resident in a covered Part A stay whose transport would be subject to consolidated billing rules. If there are exceptional circumstances that require transport outside the locality, Medicare can pay for this transport, but only if the destination is still the nearest SNF with appropriate facilities. In any case, the ambulance transport must be medically necessary.
7	Question: How should a facility bill for a beneficiary who was classified into rehabilitation Resource Utilization Group, Version III (RUG-III) group prior to the emergency when the facility is no longer able to provide therapy services as a result of the dislocations associated with the emergency? Answer: As explained in the Long-Term Care Facility Resident Assessment Instrument User's Manual, the RUG-III category stays in place for the Minimum Data Set (MDS) coverage period (e.g., the 5-day assessment can be used to bill from Day 1 up through Day 14, etc.) as long as the MDS was coded accurately. Payment will continue to be made at the assigned rehabilitation RUG level until the end of the covered time frame or until an Other Medicare-required assessment (OMRA) is completed. The OMRA must be completed 8 – 10 days after all therapies have been discontinued.
8	Question: A provider has residents who are returning to an evacuated facility. If a resident previously exhausted the 100 day benefit period, remained at a skilled level of care, (status code 30 no code 22), was not discharged but was evacuated for a few days and now is back in the facility still requiring skilled care, does that Medicare beneficiary receive any additional days? Answer: No. The intent of the section 1812(f) waiver was to provide additional benefits for a beneficiary who, at the time of the disaster, had exhausted the 100 days of SNF benefits available in the current benefit period and was in the process of establishing a new benefit period. A new benefit period is established after a period of 60 consecutive days elapses during which the beneficiary is not receiving skilled care in a SNF. In the situation described above, because the beneficiary at the time of the disaster is still receiving *skilled* care in the SNF after exhausting the 100 days of SNF benefits, he or she would not be in the process of establishing a new benefit period at that point and, consequently, would not qualify for additional coverage under the section 1812(f) waiver.

#	Question and Answer
9	Question: Bed-bound patients are evacuated from their homes in the disaster area to a hospital, because it has the only available beds. Can Medicare pay for days that such patients spend in the hospital receiving SNF-level care? What if the patient requires neither acute nor SNF-level care? Answer: A set of Provider Survey and Certification – Declared Public Health Emergencies – All Hazards Frequently Asked Questions (FAQs) is available online at www.cms.hhs.gov/SurveyCertEmergPrep/Downloads/AllHazardsFAQs.pdf. FAQ #J-2 indicates that it is indeed possible for SNF services to be furnished on the premises of a hospital, either through the creation of a Medicare distinct part SNF or (for certain small rural hospitals) under a Medicare swing-bed agreement; however, this FAQ also indicates that a survey would be required in order to establish either of those two configurations. Although §1135 of the Social Security Act (the Act) permits the waiver of certain certification requirements when the Secretary has declared a Public Health Emergency and the President has declared an emergency or major disaster, survey requirements for establishing a distinct part unit or a swing bed are not being waived at this time. Without a waiver of these requirements, there is no authority under which Medicare can pay for the inpatient hospital stay of a beneficiary who does not require a hospital level of care. Similarly, there is no Part A hospital benefit for patients who need a lower level of care than SNF care; i.e., NF-level or custodial care. In this situation, the beneficiary must look to other sources of assistance, such as the Federal Emergency Management Agency (FEMA, see regulations at 44 CFR, Part 206) or other special disaster relief aid.
10	Question: During an emergency, can SNFs place Medicare patients needing a SNF level of care in NF-only or non-certified beds? Answer: A SNF may expand its inpatient bed capacity by obtaining a CMS waiver and placing hospital beneficiaries needing a SNF level of care in an NF-only or non-certified bed. All waivers are directed to the Dallas Regional Office for approval. They can be sent to RODALDSC@cms.hhs.gov <mailto:RODALDSC@cms.hhs.gov>. If approved, the SNF must inform its FI/MAC. The SNF must document the need for the Medicare level of care, and complete and transmit the necessary MDS assessments. Then, the facility will be reimbursed at the SNF PPS rate.
11	Question: Can MDS or RUG III classification system requirements used for determining SNF PPS reimbursement amounts be waived or modified during an emergency situation to allow for increased payment? Answer: No. Specifically, • The Group Therapy requirements for four or fewer residents per supervising therapist and/or the limitation of group therapy time to 25% of each resident's total therapy time per discipline apply as usual. • The Assessment Reference Date (ARD) time frames, including the use of grace days, may not be extended to capture therapy time or other services for a later time period so that the case can be classified into a higher RUG III payment group. For example, Medicare 5-day assessments must be completed using an ARD of days 1-8. You cannot substitute services provided on day 9 to classify the patient into a higher RUG III group. • The RUG III requirement that at least one therapy discipline must be provided for at least 5 days during the assessment period cannot be waived in order to classify the resident into one of the higher paying Very High or Ultra High rehabilitation groups. For these groups, patients must have received therapy where the total minutes of care are within a specified range and at least one therapy discipline is provided at least 5 days a week. **NOTE:** In certain instances, it may be appropriate to complete a new assessment to reflect changes in the patient's condition that impact care planning or when all therapies have been discontinued. Please consult the MDS Manual for instructions.
	Home Health Services

#	Question and Answer
1	Question: How will payments be processed for home health agencies (HHAs)? Answer: CMS will advise the FI or MAC to facilitate payment for home health services for beneficiaries who have been displaced due to the emergency. The FI or MAC will work with the HHAs that have transferred or received patients to ensure that claims are processed timely and issues are addressed quickly.
2	Question: What adjustments or flexibility is allowed related to Medicare requirements for completion of the OASIS assessment process? Answer: As indicated in Survey and Certification Memo 05-43, and in the time period indicated in the statutory waiver invoked by the HHS Secretary under § 1135 of the Social Security Act, CMS may modify certain timeframe and completion requirements for OASIS. In this emergency situation, an abbreviated assessment can be completed to assure the patient is receiving proper treatment and to facilitate appropriate payment. For those Medicare approved HHAs serving qualified home health patients in the public health emergency areas determined by the Secretary, the following modifications to the comprehensive assessment regulation at 42 CFR § 484.55 may be made. These minimal requirements will support reimbursement when billing is resumed and help ensure appropriate care is provided. • The Start of Care assessment (RFA 1) may be abbreviated to include the Patient Tracking Sheet and the payment items. • The Resumption of Care assessment (RFA 3) and the Recertification assessment (RFA 4) may be abbreviated to the payment items. HHA should maintain adequate documentation to support provision of care and payment. • The OASIS transmission requirements at 42 CFR 484.20 are suspended for those Medicare approved HHAs that are serving qualified home health patients in the affected areas. • The Discharge assessment (RFA 8 or RFA 9) and the Transfer assessment (RFA 6, RFA 7) are suspended during the waiver period. HHAs should maintain adequate documentation to support provision of care and payment.
3	Question: Can the "residence" component of the homebound requirements be suspended by allowing the delivery of home health services at any site of temporary residence during the crisis? Can this include a residence that is a nursing facility or hospital provided the patient is otherwise not at such level of care when the patient is using the facility as a medical shelter? Answer: The Social Security Act stipulates that beneficiaries must be confined to the home in order to be eligible to receive home health services. A beneficiary's home is any place in which a beneficiary resides that is not a hospital, skilled nursing facility (SNF), or nursing facility as defined in § 1861(e)(2), § 1819(a)(1), or § 1919(a)(1) of the Social Security Act, respectively. Under these temporary extraordinary circumstances, place of residence can include services provided at temporary locations like a family member's home, a shelter, a community facility, a church, or a hotel. A hospital, SNF, or nursing facility as defined above would not be considered a temporary residence.
4	Question: Can the application of Partial Episode Payment (PEP) be suspended for patients displaced to other home health agencies (HHAs) due to the emergency? Answer: Normal prospective payment procedures will apply. We believe it crucial that home health agencies remain responsible for home health beneficiaries, up until a PEP situation is determined. The PEP appropriately truncates the previous episode, and allows for a subsequent episode to be established with each home health agency being reimbursed for the services provided.

#	Question and Answer
5	Question: If a home health agency (HHA) affected by the emergency is unable to submit within 60 days the final claims for home health episodes that are already begun, Medicare will automatically cancel the request for anticipated payment (RAP) for those episodes. The recovery of the RAP payments will decrease already strained cash flow for this agency. Will CMS waive the requirement to submit final home health claims within 60 days of the end of the episode? Answer: CMS is instructing the Regional Home Health Intermediaries (RHHIs) and MACs to temporarily cease to automatically cancel the RAPs of HHAs in the region affected by the emergency. The RHHIs/MACs will identify all HHAs located within the areas affected by the emergency. RAPs for these agencies will be assigned a new cancellation date to be specified. This will allow an additional 60-90 days for the HHAs to resume submission of final claims.
6	Question: How should home health agencies (HHAs) that have received patients that were displaced by the emergency, code their claims for these new admissions. Answer: HHAs should use source-of-admission code "B" (indicating transfer from another HHA) on their requests for anticipated payment (RAPs) for these patients. The use of this code will ensure that Medicare systems do no reject the RAP due to the overlapping home health episode at the prior HHA. This is standard coding procedure for all transfers under the home health prospective payment system, so no other special indicators are needed on these RAPs.
	Hospice
1	Question: What is a hospice agency's responsibility in the event of a disaster? Answer: A hospice agency, as indicated in 42 CFR § 418.100(b), "Disaster Preparedness," must have a written plan to be followed in the event of a internal or external disaster, including care of casualties arising from such a disaster. We note that this provision does not necessarily address all public health emergencies.
2	Question: If a hospice provider cannot provide care for its patients, can these patients transfer to another hospice provider? Answer: Under CMS regulations at 42 C.F.R. § 418.30(a), a Medicare beneficiary may transfer from one hospice agency to another hospice for any reason once per election period. If a Medicare beneficiary has already utilized this one-time right to transfer but needs to move again because of the public health emergency, § 1861(dd)(5)(D) of the Act provides for a hospice agency to arrange with another hospice for the delivery of services in extraordinary circumstances. We would not deem a change in hospice under these circumstances to be a voluntary transfer under 42 C.F.R. § 418.30 (i.e., a beneficiary would still be entitled to transfer voluntarily after a transfer for "extraordinary circumstances").
3	Question: In the event that the originating hospice is able to resume provision of services to their patients, may patients be transferred back to the originating hospice? Answer: CMS believes that patients should be provided with the choice of resuming care from the originating hospice or continuing with the existing hospice provider. If the beneficiary remains with the "host"/replacement hospice at the end of the emergency period, we would consider this a transfer under our regulations at 42 CFR § 418.30. If a beneficiary uses the services of an alternate hospice agency for a short period of time due to extraordinary circumstances such as a natural disaster, neither the departure from nor return to the original hospice agency would be considered a "transfer" within the meaning of 42 CFR § 418.30.

#	Question and Answer
4	Question: Will the hospice inpatient and aggregate payment caps be waived for FY 2008? Answer: No. Because these caps are not conditions of participation or program participation provisions within the meaning of Section 1135 of the Act, we do not believe that sufficient statutory authority exists to permit CMS to waive these payment caps.
5	Question: How should a hospice that temporarily receives a patient from another hospice handle administration of that patient's care plan if the patient arrives with no alternate care-giver information, and/or the admissions officer believes that the patient may be legally incompetent to make health care decisions for him/herself? Answer: Under CMS rules, the health and safety of the patient always comes first. The receiving hospice should complete an assessment of the patient to identify immediate needs and establish a plan of care with the interdisciplinary group (IDG). The receiving hospice should make every effort to contact the original hospice and/or attending physician to discuss the previously implemented plan of care and, if necessary, to determine if the patient is legally competent. If the receiving hospice has access to the plan of care established by the original hospice every attempt should be made to follow the plan if the needs of the patient are such that the original plan will provide the appropriate interventions.
6	Question: Who can speak/sign paperwork on behalf of the patient (including discharge and transfer decisions)? Answer: A person's legal authority to make healthcare decisions on behalf of another is a matter of state law; hospices should confer with their counsel to determine whether their state law has provisions which address health care decision-making in emergency/extraordinary circumstances. If the hospice patient can not speak or sign paperwork the receiving hospice should make arrangements to get permission for treatment and care pursuant to state requirements.
7	Question: If a hospice patient is transferred out of the impacted area due to emergency evacuation by ambulance, and admitted to Hospice Inpatient Respite Care several hours away for safety, who is responsible for the ambulance bill to the destination, and the return trip? Answer: The emergency waiver authority under section 1135 of the Social Security Act (Act) does not affect how Medicare hospice services are covered. Specifically, as in non-emergency situations, those services and items covered pursuant to 1861(dd)(1)(I) of the Act (which authorizes coverage of "any other item or service which is specified in the plan of care and for which payment may otherwise be made…") would continue to be covered pursuant to existing standards of coverage and payment. Generally speaking, if the ambulance transfer was medically necessary, and if the patient's plan of care described that the patient's terminal illness required ambulance transfer, the hospice would be responsible for the ambulance bill. In a scenario where ambulance transport arrangements are made by a patient's family, and the ambulance transport needs are not documented in the hospice plan of care, the patient would be responsible for the ambulance bill.
	Stark
1	Question: What is the process for requesting and receiving a Stark waiver (waiver of sanctions under section 1877(g) of the Act)? Answer: Stark waivers under authority of section 1135 of the Act are granted only upon request and only on a case-by-case basis. A specific request, detailing the proposed financial relationship between the referring physician(s) and the entity should be mailed to CMS at the following address, CMS, Division of Technical Payment Policy, ATTN: Request for Section 1135 Stark Waiver, Rm C4-25-02, Woodlawn, MD 21244-1850, or by e-mailing the request to donald.romano@cms.hhs.gov, or lisa.ohrin@cms.hhs.gov. A determination will then be made by CMS to approve or deny the request. Unless and until a determination is made approving a request, parties must comply with all physician self-referral (Stark) rules