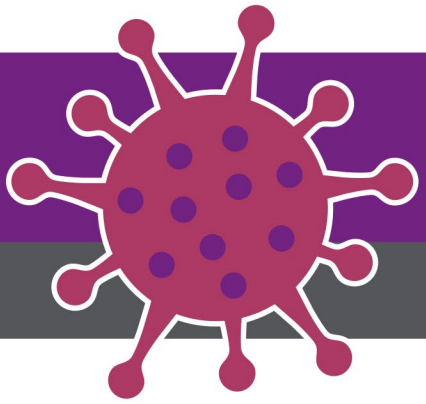
CORONAVIRUS DISEASE 2019
(COVID-19)

Revenue Excellence FAQs for Elective Procedure Ramp Up



Trinity Health

Audience: Patient Access Registration Teams
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COVID-19 Response Team Owner: Katie Taylor/Ian Sullivan
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What's Changed: Additional FAQ

This document is intended to provide guidance to Revenue Excellence, as they are directed by their clinical leadership to ramp up elective procedures. If your question is not addressed below, please reach out to both Katie Taylor (Katie.taylor@sjhsyr.org) and Ian Sullivan (Ian.sullivan@trinity-health.org) for additional guidance.

FAQ Release 9/13/2020

Q: When COVID-19 testing is required prior to the procedure, should the appropriate COVID-19 ICO code be applied as the payer of last resort? (Answer updated from original 5/19/2020 response)

A: The patient is not liable for the pre-procedure COVID-19 testing and the COVID-19 ICO code should **not** be added to the testing encounter per the 'COVID-19 – Registration Protocols'.

The COVID-19 ICO should not be added to the elective procedure encounter under any circumstances, including situations where the testing is combined with the elective procedure encounter for billing purposes.

FAQ Release 6/11/2020

Q: How should the pre-procedure COVID-19 testing be billed to the payer?

A: The following table is intended to be a guideline as to how the pre-procedure COVID-19 testing should be billed. In general, the pre-procedure COVID-19 test should be billed as a carve out service, unless the charge should be combined based on governmental billing guidelines for combination of accounts (ie. Three Day Rule).

The below table may need to be modified at the local level based on local payer contracts and billing guidelines.

Pre-procedure Testing Time Frame	Type of Account	Payer	Claim Type	Combine with OP?	Combine with IP?
Rapid Test Same Day of Service	Hospital Account	Governmental Payers	UB	Yes	Yes
Rapid Test Same Day of Service	Hospital Account	Non Governmental Payers	UB	No	No
Testing within 3 days of Procedure	Hospital Account	Governmental Payers	UB	No	Yes
Testing within 3 days of Procedure	Hospital Account	Non Governmental Payers	UB	No	No
Testing 3+ days of Procedure	Hospital Account	Governmental Payers	UB	No	No
Testing 3+ days of Procedure	Hospital Account	Non Governmental Payers	UB	No	No

FAQ Release 5/19/2020

Q: How should the COVID-19 pre-procedure testing be billed to the insurance? Should the testing be billed separate from the procedure?

A: Billing for pre-procedure COVID-19 testing will be determined by the RHMs national and local Managed Care contract terms. We will be working with Payer Strategy to review requirements for national contracts (currently Humana). RHMs should work with their local Payer Strategy team, to determine the appropriate coverage and billing requirements by payer. More guidance will be issued at a later date.

FAQ Release 4/28/2020

Q: During the COVID-19 pandemic, there has been an option to obtain verbal consents or deliver CMS notices utilizing alternate means for patients with suspected or confirmed COVID-19. Will this option to obtain verbal consents be available for elective procedures?

A: The waiver that allowed facilities to obtain verbal consents was specific to patients with suspected or confirmed COVID-19, per Collection of Patient Verbal Consent guidance. Facilities must utilize standard procedures to obtain consents and deliver CMS notices and are unable to utilize verbal consent under the COVID-19 waiver.

Q: If a patient claims financial hardship due to COVID-19, should Patient Access colleagues waive POS collections and pursue collections after services are rendered?

A: All normal self pay collection activity should resume with elective surgeries, including collection of patient responsibility, screening for Medicaid, and screening for Financial Assistance. Benefit Advocates should work with patients to provide both financial assistance and Medicaid enrollment support, in accordance with local Financial Assistance Policies. If a patient does not qualify for financial assistance or Medicaid benefits, copay/deductible/coinsurance should be collected per normal operating procedures.

If the elective surgery cannot be postponed due to the medical necessity of the case, the procedure should proceed with appropriate escalation to Benefit Advocacy for additional support.

Q: As insurance benefits have changed for many patients, it is understood that payer enrollment information may not be up-to-date. What is the recommended workflow to ensure that providers have the most up-to-date insurance information?

A: It is recommended that prior to scheduling and authorizing any elective surgery, the patient should be contacted directly to verify insurance benefits and discuss any changes in coverage. This process will allow providers to obtain the most current information and obtain the most up-to-date authorization and/or patient responsibility information.

Q: For RHMs where COVID-19 testing is required prior to the procedure, should Patient Access colleagues be collecting copays?

A: Patient Access colleagues are advised not to collect copays or deductibles on pre-operative COVID-19 Testing. Copays and deductibles for the elective procedure should be collected per normal operating procedures.

Q: What are some additional ways that we can help protect Revenue Excellence colleagues and promote infection control in the workplace?

A: As colleagues return to work, it is imperative that we continue good hygiene and infection control practices. Some additional safety practices that RHMs have put in place are:

- Plexiglass barriers at registration
- Allowing patients to keep the pen used to sign documents
- Utilizing tablets or a computer screen for electronic patient signature and sterilizing the tablet/screen after every use
- Access to hand sanitizer at each station
- Providing PPE to each colleague