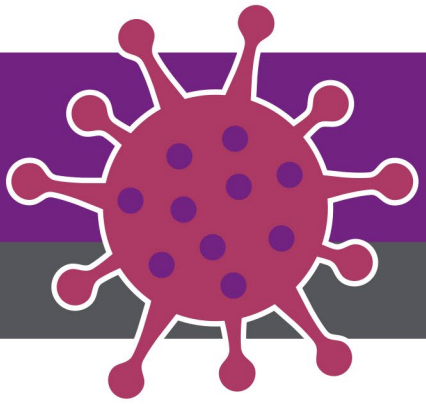
CORONAVIRUS DISEASE 2019
(COVID-19)

New COVID-19 Policies for Inpatient Reimbursement
Article SE20015 Updated 8/17/2020



Trinity Health

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COVID-19 Response Team Owner: David Bittner, Finance
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On April 15, 2020, CMS released MLN Matters article, SE20015, with subsequent revisions on April 27 and August 17, 2020. The purpose of the CMS article is to provide guidance and instructions to providers related to reimbursement increases pursuant to treating beneficiaries as stipulated in the CARES Act Sections 3710 and 3711, issued by the federal government in response to the COVID-19 pandemic. These payment variances are designed to temporarily supplement normal reimbursement provisions in order to promote operational sustainability during crises.

The August 17, 2020 update to CMS MLN SE20015 releases updated policies that require specific diagnostic testing documentation to be contained within the applicable inpatient medical record supporting the reported ICD-10-CM diagnosis, U07.1 for patients with covid-19 for the 20 percent increase MS-DRG reimbursement to be applicable.

The instruction is effective for admissions occurring on or after September 1, 2020; however, the MS-DRG software updates will not be released until October 2020 and further instructions for reporting are expected.

Medical records must include a positive COVID-19 testing result and the documentation must be:

- Molecular or antigen tests only (Reference: COVID-19 Lab Test CDM Communication)
- Performed during the hospitalization or up to 14 days prior to admission
- Documentation from outside laboratories or other testing organizations must be scanned into the current admission, on-file, and included in routine Release of Information procedures
- Testing that occurs prior to 14 days of admission may be considered applicable on a case-by-case basis if complex medical factors are present within medical record documentation

The guidance states that CMS will continue to reimburse all claims with COVID-19 U07.1 at the increased rate. However, via claims processing, facilities will indicate when the 20% increase should be applied to a particular claim or when the institution is expecting reimbursement at the regular MS-DRG rate.

- It is anticipated that CMS will develop new Condition Codes, Value Codes or Remarks Comments to indicate to the MACs that the documentation requirements have been met for positive tests or a method to indicate the current admission does not contain the required documentation of positive test results.

CMS will recoup additional funds paid if lab result documentation is not present in the medical record during medical record documentation review audits.

Reference: https://www.cms.gov/files/document/SE20015.pdf

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