Division of TennCare

MEMO

Memorandum

To: Medicaid Nursing Facilities (NFs), TennCare Managed Care Organizations (MCOs)
From: Keith Gaither
Date: September 30, 2020

Subject: Payment for COVID-19 testing of Medicaid Enrollees in Nursing Facilities

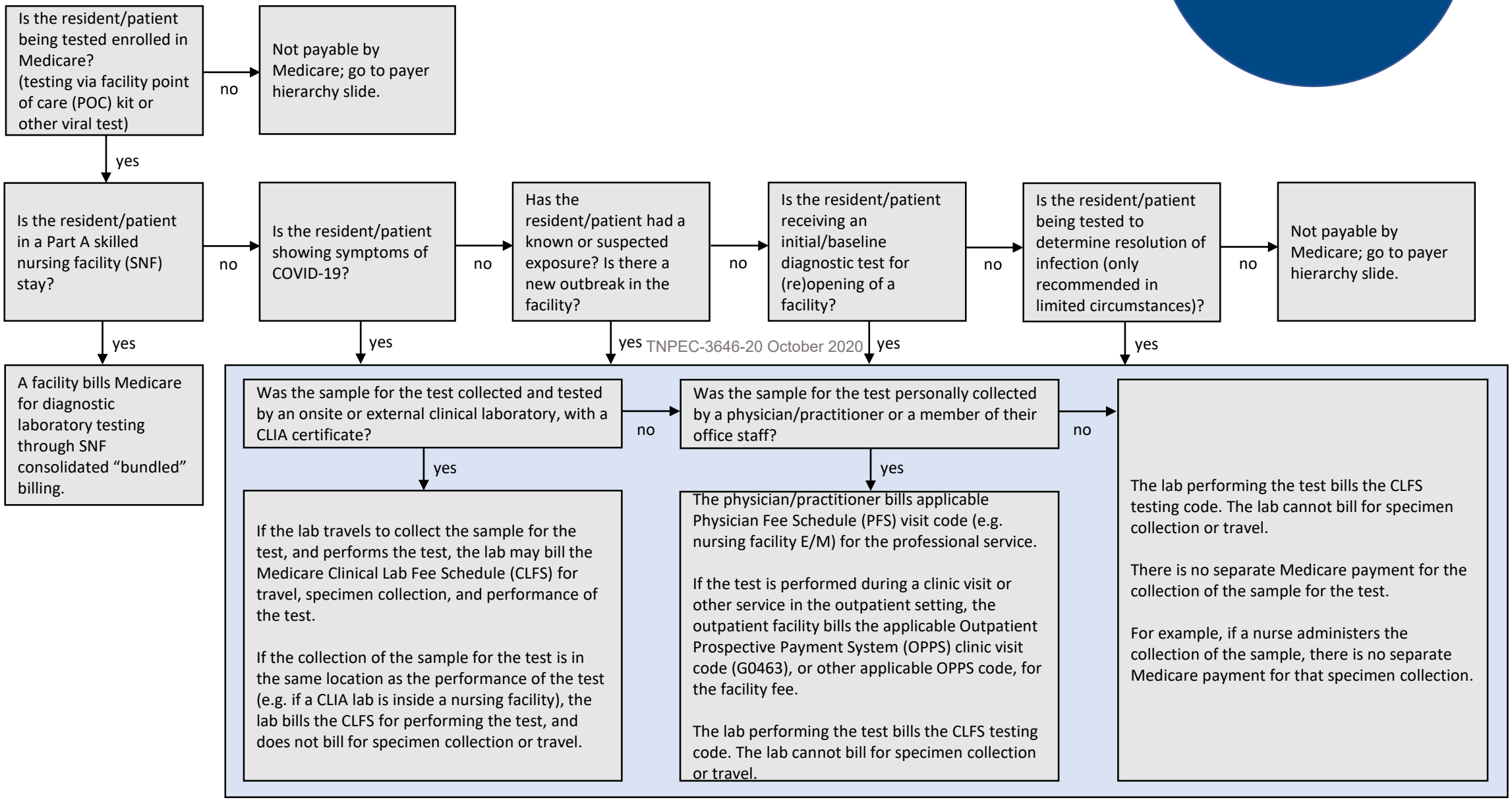
As you may be aware, on August 26, 2020, the Centers for Medicare and Medicaid Services (CMS) issued a new interim final rule that imposes new COVID testing requirements for Medicare certified Skilled Nursing Facilities (SNFs) and Medicaid certified Nursing Facilities (NFs) as part of the requirements for participation in the Medicare and Medicaid programs (see QSO-20-38-NH, available at https://www.cms.gov/files/document/qso-20-38-nh.pdf).

In response to the new CMS rule becoming effective, the Tennessee Board for Licensing Health Care Facilities took quick action to waive provisions of Emergency Rules, Tenn. Comp. R. & Regs. § 1200-08-06-.06(j) *et. seq.*, for any Tennessee licensed SNF/NF that is certified by CMS and is required to comply with the provisions of the 42 C.F.R. §483.80(h) COVID-19 Testing. This waiver of state requirements is effective October 1, 2020. In addition, funding previously provided by the Tennessee Department of Health to cover the costs of state-mandated COVID testing is also discontinued on this date.

In an effort to ensure that Medicaid NFs and TennCare MCOs are able to access payment for COVID testing provided to Medicaid-eligible residents, as appropriate, TennCare is providing the guidance attached and below to Medicaid contracted NFs and MCOs. The attached document was developed by CMS to identify when testing services provided to a Medicare beneficiary may be billed to Medicare and the process for doing so. TennCare will apply the same policies with regard to Medicaid payment for COVID testing for Medicaid enrollees. COVID 19 testing for the resident is not part of the Medicaid per diem payment for Medicaid NF services.

TennCare remains the payer of last resort for services including COVID-19 testing. For patients with both Medicare and TennCare coverage or TennCare and other commercial coverage, the nursing facility should bill Medicare or the commercial coverage for tests. If a patient only has TennCare coverage, the nursing facility should bill the patient's MCO. The MCO should reimburse these claims at 100% of the current Medicare fee schedule. The MCO should include these claims in their request sent to TennCare for reimbursement of COVID-19 related expenditures.

MEDICARE PAYMENT FOR COVID-19 VIRAL TESTING: Skilled Nursing Facility/Nursing Facility



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PAYMENT FOR COVID-19 TESTING:
Payer Hierarchy: Medicare

Medicare

- Medicare is the primary payer for most Medicare covered testing for beneficiaries enrolled in Medicare, including Medicare-Medicaid dually eligible individuals.
    - For dually eligible individuals, Medicaid may cover additional testing (beyond what is covered by Medicare) based on Medicaid policy.
    - There are some uncommon instances where Medicare could be the secondary payer for a Medicare covered service, discussed here: https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance
- Medicare covers the following diagnostic viral testing for nursing home residents and patients:
    - Testing residents with signs or symptoms of COVID-19
    - Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2 including close and expanded contacts (e.g., there is an outbreak in the facility)
    - Initial (baseline) testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 as part of the recommended reopening process
    - Testing to determine resolution of infection
- Medicare coverage is consistent with the CDC Testing Guidelines for Nursing Homes, Diagnostic Testing section, available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html.
- Medicare does not cover non-diagnostic tests (i.e., testing done for public health surveillance purposes).
- Given that conditions and circumstances may be similar in some other congregate living settings, such as intermediate care facilities for individuals with intellectual disabilities, assisted living facilities, and group homes, Medicare Administrative Contractors have the discretion to apply the coverage and payment criteria for nursing homes to other appropriate settings during the public health emergency.
- Medicare will make payment for one diagnostic test per resident/patient without an order from a physician, practitioner, pharmacist, or other authorized health care professional. All subsequent tests require such an order.
- States should contact the Contractor Medical Directors at their local MAC for specific guidance on coverage and payment for Medicare services. Contact information for the Medicare A/B Contractor Medical Directors for each jurisdiction is here: https://www.cms.gov/files/document/cmd-public-directory-june-2020.pdf

PAYMENT FOR COVID-19 TESTING:
Payer Hierarchy: Medicaid and the Uninsured

Medicaid

- Providers should contact the state Medicaid agency and/or contracted Medicaid managed care plan for information on testing coverage, payment, and coding for Medicaid beneficiaries. Medicaid pays after most other payers.
- The Families First Coronavirus Response Act (FFCRA) (Public Law No. 116-127), and Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law No. 116-136), added a new optional Medicaid eligibility group for uninsured individuals, effective March 18, 2020.
    - Individuals eligible for the new group ("COVID-19 testing group") receive a limited benefit package of services related to testing and diagnosis of COVID-19 that are rendered during the public health emergency period.
    - Additional information on eligibility, covered benefits, and federal medical assistance percentage (FMAP) for the new COVID-19 testing group is available here: https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf and here: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Health Resources and Services Administration (HRSA) COVID-19 Claims Reimbursement to Health Care Providers and Facilities Testing and Treatment of the Uninsured Program

- This program provides reimbursement directly to eligible providers for COVID-19 testing and treatment services furnished to uninsured individuals. Reimbursement is generally made at the Medicare payment rate.
- To access these funds, providers must enroll in the program as a provider participant, sign the terms and conditions of the program, check patient eligibility, and submit patient information. Once they have done so, they can submit claims for direct reimbursement for COVID-19 testing and treatment services furnished to uninsured individuals on or after February 4, 2020.
- Providers must verify and attest that to the best of the provider's knowledge at the time of claim submission, the patient was uninsured at the time the services were provided. If the provider subsequently receives reimbursement for any items from other coverage, the provider must return the payment that duplicates other reimbursement to HRSA.
- Individuals who are enrolled in a state's Medicaid program under the new optional Medicaid COVID-19 testing group are not considered uninsured for purposes of provider payment of COVID-19 testing services through this HRSA program. However, providers can attest to the HRSA program terms and conditions for COVID-19 treatment services provided to individuals enrolled in the new optional Medicaid COVID-19 testing group.
- Additional information is available here: https://www.hrsa.gov/coviduninsuredclaim/frequently-asked-questions

PAYMENT FOR COVID-19 TESTING:
Private Insurance

Private Insurance

- Section 6001 of the Families First Coronavirus Response Act (FFCRA) generally requires group health plans and health insurance issuers to provide benefits for certain items and services related to testing for the detection or the diagnosis of COVID-19 when those items or services are furnished on or after March 18, 2020, and during the public health emergency.
- Under FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements.
- Section 3201 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act amended section 6001 of the FFCRA to include a broader range of diagnostic tests that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements.
- Section 3202(a) of the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)
- Additionally, during the public health emergency, section 3202(b) of the CARES Act requires providers of diagnostic tests for COVID-19 to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website or face potential enforcement action including civil monetary penalties.
- Health insurance issuers and group health plans must cover COVID-19 diagnostic testing as determined medically appropriate by the individual's health care provider, consulting CDC guidelines as appropriate.
- Health insurance issuers and group health plans are not required to cover non-diagnostic tests (i.e., testing done for public health surveillance purposes) without cost-sharing.
- Additional information is available here, including information on which tests are required to be covered: https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf

PAYMENT FOR COVID-19 TESTING: Additional Funding Sources

CDC Preparedness and Response Supplemental Funding, and CARES Act Funding Distribution to States and Localities in Support of COVID-19 Response

- The Centers for Disease Control and Prevention (CDC) awarded funds and provided guidance to state and local jurisdictions to help them access this funding through existing cooperative agreement mechanisms.
- Jurisdictions may use this funding for a variety of activities including:
  - Enhancing testing capacity.
  - Establishing or enhancing the ability to aggressively identify cases, conduct contact tracing and follow up, as well as implement appropriate containment measures.
  - Controlling COVID-19 in high-risk settings and protect vulnerable or high-risk populations.
  - Improving morbidity and mortality surveillance.
  - Working with healthcare systems to manage and monitor system capacity.
- Additional information is available here: https://www.hhs.gov/about/news/2020/04/23/updated-cdc-funding-information.html

Provider Relief Fund

- HHS is making payments to facilities and providers to provide financial relief in response to the COVID-19 pandemic.
- Funds must be used for increased healthcare related expenses or lost revenue attributable to coronavirus. They may not be used for expenses or lost revenue that have been reimbursed from other sources or that other sources are obligated to reimburse.
- This funding is for a broad range of unreimbursed expenses, and does not change Medicare or Medicaid coverage or coordination of benefits.
- Additional information on eligibility, payment formulas, and distribution timeline, is available here: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html

PAYMENT FOR COVID-19 TESTING: Medicare Coding and Billing

Key Medicare Clinical Lab Fee Schedule (CLFS) Codes

- **87426** (Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])
- **P9603** (Per mile travel allowance)
- **P9604** (Per Flat-Rate Trip Basis Travel Allowance)
- **G2023** (Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source)
- **G2024 (**Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source)
- Information on additional COVID-19 test codes and pricing is available here: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf
- CLIA and coding guidance: https://www.cms.gov/files/document/admin-info-20-06-clia.pdf