

Coverage and Payment Related to COVID-19

Medicare

Original Medicare

Diagnostic Tests

Medicare Part B, which includes a variety of outpatient services, covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. Medically necessary clinical diagnostic laboratory tests are generally not subject to coinsurance or deductible.

Medicare Part B also covers medically necessary imaging tests, such as computed tomography (CT) scans, as needed for treatment purposes for lung infections (not for screening asymptomatic patients). For those imaging tests paid by Part B, beneficiary coinsurance and deductible would apply.

If the Part B deductible (\$198 in 2020) applies to the Part B services, beneficiaries must pay all costs (up to the Medicare-approved amount) until the beneficiary meets the yearly Part B deductible. After the beneficiary's deductible is met, Medicare pays its share and beneficiaries typically pay 20% of the Medicare-approved amount of the service (except laboratory tests), if the doctor or other health care provider accepts assignment. There's no yearly limit for what a beneficiary pays out-of-pocket.

CMS issued a public health news alert on February 13¹, which has additional information about the new Healthcare Common Procedure Coding System (HCPCS) code (U0001) for health care providers and laboratories to bill for a laboratory testing patients for SARS-CoV-2. HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. This code will allow those laboratories conducting the tests to bill for the specific test instead of using an unspecified code, which means better tracking of the public health response for this particular strain of the coronavirus to help protect people from the spread of this infectious disease.

There are two new HCPCS codes for healthcare providers who need to test patients for Coronavirus. Providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the newly created HCPCS code (U0001). A second new HCPCS code (U0002) can be used by laboratories and healthcare facilities to bill Medicare as well as by other health insurers that choose to

¹ <https://www.cms.gov/newsroom/press-releases/public-health-news-alert-cms-develops-new-code-coronavirus-lab-test>

adopt this new code for such tests. HCPCS code (U0002) generally describes 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets). The Medicare claims processing system will be able to accept these codes on April 1, 2020 for dates of service on or after February 4, 2020.

Vaccines

Medicare Part B pays for certain preventive vaccines (influenza, pneumococcal, and Hepatitis B) and coinsurance and deductible do not apply to preventive vaccines. Medicare Part B also pays for other vaccines directly related to medically necessary treatment of an injury or direct exposure to a disease or condition. For example, Medicare would cover a tetanus vaccine for a beneficiary who steps on a rusty nail. For these other medically necessary vaccines, beneficiary coinsurance and deductible would apply.

Inpatient Hospital Care Services

Medicare Part A covers medically necessary inpatient hospital care. This coverage includes semi-private rooms, meals, general nursing, imaging, drugs as well as other hospital services and supplies as part of inpatient hospital treatment. Inpatient hospital treatment includes care from acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or psychiatric unit within a hospital.

Medicare beneficiaries may pay a deductible for hospital services. Under Original Medicare, for hospital inpatient services, beneficiaries pay a deductible of \$1,408 and no coinsurance for days 1– 60 of each benefit period. Beneficiaries pay a coinsurance amount of \$352 per day for days 61– 90 of each benefit period. There is a coinsurance amount per “lifetime reserve day” after day 90 of each benefit period (up to 60 days over a beneficiary’s lifetime). Beneficiaries pay all costs for each day after all the lifetime reserve days are used. In addition, inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a beneficiary’s lifetime.

Inpatient Hospital Quarantines

There may be times when beneficiaries with the virus need to be quarantined in a hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the hospital for public health reasons. Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary. Patients who would have been otherwise discharged from the hospital after an inpatient stay but are instead remaining in the hospital under quarantine would not have to pay an additional deductible for quarantine in a hospital.

If a Medicare beneficiary is a hospital inpatient for medically necessary care, Medicare will pay hospitals the diagnosis-related group (DRG) rate and any cost outliers for the entire stay, including any the quarantine time when the patient does not meet the need for acute inpatient care, until the Medicare patient is discharged. The DRG rate (and cost outliers as applicable) includes the payments for when a patient needs to be isolated or quarantined in a private room.

Ambulatory Services in a Hospital or Other Location

Medicare Part B covers medically necessary ambulatory services, including doctors' services, hospital outpatient department services, home health services, durable medical equipment, mental health services, and other medical services. Coinsurance and deductible would generally apply depending on the service.

In the event a patient is quarantined in an ambulatory setting, the existing Medicare payments for medically necessary services apply.

Telehealth and Other Communication-Based Technology Services

Beneficiaries can communicate with their doctors or certain other practitioners without necessarily going to the doctor's office in person for a full visit.

Since 2018, Medicare pays for "virtual check-ins" for patients to connect with their doctors without going to the doctor's office. These brief, virtual check-in services are for patients with an established relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to using virtual check-ins and the consent must be documented in the medical record prior to the patient using the service. The Medicare coinsurance and deductible would apply to these services.

Doctors and certain practitioners may bill for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

Medicare also pays for patients to communicate with their doctors without going to the doctor's office using online patient portals. The individual communications, like the virtual check ins, must be initiated by the patient; however, practitioners may educate beneficiaries on the availability of this kind of service prior to patient initiation. The communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable. The Medicare coinsurance and deductible would apply to these services.

In addition, Medicare beneficiaries living in rural areas may use communication technology to have full visits with their physicians. The law requires that these visits take place at specified sites of service, known as telehealth originating sites, and receive services using a real-time audio and video communication system at the site to communicate with a remotely located doctor or certain other types of practitioners. Medicare pays for many medical visits through this telehealth benefit. Certain beneficiaries, such as those needing a monthly end-stage renal disease visit or those needing treatment for substance use disorders or co-occurring mental health disorder may access telehealth services from their home without traveling to an originating site. The Medicare coinsurance and deductible would apply to these services.

Medicare also pays doctors for certain non-face-to-face care management services and remote patient monitoring services. The Medicare coinsurance and deductible would apply to these services.

Requests for Prescription Refills

For Part B drugs, when considering whether to pay for a greater-than-30-day-supply of drugs, in general, Medicare and its contractors, known as Medicare Administrative Contractors or MACs, will, on a case-by-case, basis, consider each request and make decisions locally.

In general, local Medicare contractors will take into account the nature of the particular Part B drug (including Part B immunosuppressive drugs), the patient's diagnosis, the extent and likely duration of disruptions to the drug supply chain during an emergency, and other relevant factors that would be applicable when making a determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.

Emergency Ambulance Transportation

Medicare covers ground ambulance transportation when beneficiaries need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services when transportation in any other vehicle could endanger the beneficiary's health. A ground ambulance emergency transportation may temporarily stop at a doctor's office without affecting the coverage status of the transport in certain circumstances, however, in general the physician's office is not a covered destination. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if the beneficiaries needs immediate and rapid ambulance transportation that ground transportation can't provide.

Should a facility which would normally be the nearest appropriate facility be unavailable during an emergency, Medicare may pay for transportation to another facility so long as that facility is the nearest facility that is available and equipped to provide the needed care for the illness or injury involved.

In some cases, Medicare may pay for limited, medically necessary, nonemergency ambulance transportation if the doctor writes an order stating that ambulance transportation is medically necessary. For example, beneficiaries may need a medically necessary nonemergency ambulance transport to a dialysis facility when they have End-Stage Renal Disease. There is a current Medicare model testing prior authorization for individuals receiving scheduled, non-emergency ambulance transportation for 3 or more round trips in a 10-day period or at least once a week for 3 weeks or more in certain states.

The Medicare coinsurance and deductible would apply to these Part B services.

Medicare pays for ambulance transports under the Ambulance Fee Schedule. This payment amount includes a base rate payment (level of service provided) plus a separate payment for mileage to the nearest appropriate facility and also cover both the transport of the beneficiary to the nearest appropriate facility and all medically necessary covered items and services (such as oxygen, drugs, extra attendants, and electrocardiogram testing) associated with the transport.

Medicare Advantage (Part C) and Part D

Medicare Advantage (also known as “Part C”) is an “all in one” alternative to Original Medicare. Medicare Advantage plans cover Medicare Part A and Part B services, and usually prescription drugs covered under Medicare Part D. These plans also may offer extra benefits Original Medicare doesn’t cover. Medicare Part D, also called the Medicare prescription drug benefit, is an optional federal-government program to help Medicare beneficiaries pay for prescription drugs not covered under Part B through prescription drug insurance.

Medicare Advantage Coverage

Medicare Advantage plans must cover all medically necessary Part A and B services covered under Original Medicare for all enrollees. Medicare Advantage plans can also cover items and services beyond those covered by Original Medicare, such as vision, dental, and over-the-counter products, among other things. These items and services are typically referred to as “supplemental benefits.”

Medicare Advantage Cost Sharing - “Surprise Billing”

Medicare Advantage plan enrollees are generally protected from “surprise billing” which is when an enrollee receives unexpected bills from out-of-network providers. Surprise billing most commonly occurs when patients either receive care from an out-of-network provider they had reasonably assumed was in-network or received out-of-network care in an emergency when they had limited, if any, ability to choose their provider. When Medicare Advantage enrollees obtain plan-covered services (e.g., covered under the plan’s normal rules, or when an HMO

arranges for or directs out of network care) in an HMO, PPO, or Regional PPO, they may not be charged or held liable for more than plan-allowed cost-sharing.

Additionally, CMS advises Medicare Advantage (MA) organizations that they may waive or reduce enrollee cost-sharing for Novel Coronavirus (COVID-19) laboratory tests effective immediately provided that MA organizations waive or reduce cost-sharing for all plan enrollees on a uniform basis. Specifically, CMS will exercise its enforcement discretion regarding the administration of MA organizations benefit packages as approved by CMS in conjunction with implementing a voluntary waiver or reduction of cost-sharing for COVID-19 laboratory tests as described. CMS consulted with the Office of Inspector General (OIG) and OIG advised that should an MA organization choose to voluntarily waive or reduce enrollee cost-sharing for COVID-19 laboratory tests, as approved by CMS in this advisory, such waivers or reductions would satisfy the safe harbor to the Federal anti-kickback statute set forth at 42 CFR 1001.952(l).

Nothing in this guidance speaks to the arrangements between MA organizations and their contracted providers or facilities.

Telehealth and other Communication Based Technology Services

Medicare Advantage plans may provide their enrollees with access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries' homes. With this flexibility, it is possible that beneficiaries in Medicare Advantage plans can receive clinically appropriate services for treatment of COVID-19 via telehealth.

Part D Coverage

Each Part D Sponsor that offers prescription drug coverage must provide a standard level of coverage to ensure beneficiaries have adequate access to Part D drugs. Many Part D Sponsors offer plans with different levels of coverage many of which exceed CMS's minimum requirements.

Vaccines

Under current law, once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine.

Prior Authorization

Consistent with flexibilities available to Medicare Advantage Organizations and Part D Sponsors with respect to other items and services, MAOs and Part D Sponsors may choose to waive plan prior authorization requirements that otherwise would apply to tests or services related to COVID-19.