CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10361	**Date: September 17, 2020**
	Change Request 11925

NOTE: This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 10300, dated August 14, 2020, is being rescinded and replaced by Transmittal 10361, September 17, 2020 to remove business requirement 11925.6. All other information remains the same.

SUBJECT: Update to the Implementation of the Increased Payments for COVID-19 Discharges Under the Inpatient Prospective Payment System (IPPS) Under Section 3710 of the CARES Act

I. SUMMARY OF CHANGES: This change request prospectively updates the implementation of section 3710 of the CARES Act to require that a positive laboratory test be documented in the patient's medical record for the increased payment for COVID-19 discharges under the Inpatient Prospective Payment System (IPPS).

EFFECTIVE DATE: September 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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EFFECTIVE DATE: September 1, 2020
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IMPLEMENTATION DATE: October 5, 2020

I. GENERAL INFORMATION

A. Background: In response to the declaration of the Novel Coronavirus Disease, (COVID-19) outbreak as a public health emergency, the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law 116-136) provides a temporary payment policy for certain IPPS claims, effective for hospital discharges occurring on or after January 27, 2020 through the duration of the COVID-19 public health emergency period.

B. Policy: Section 3710 of the CARES Act directs the Secretary to increase the weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 public health emergency period. CMS implemented the provisions of section 3710 of the CARES Act in Change Request (CR) 11764 (Transmittal 10058; April 24, 2020). CR 11764 established that discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes: B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020 and on or before March 31,2020; and U07.1 (COVID-19) for discharges occurring on or after April 1, 2020 through the duration of the COVID-19 public health emergency period. (Additional instructions will be issued once the COVID-19 public health emergency period has concluded.)

To address potential Medicare program integrity risks, effective with **admissions occurring on or after September 1, 2020**, claims eligible for the 20 percent increase in the Medicare Severity-Diagnosis Related Group (MS-DRG) weighting factor will also **be required to have a positive COVID-19 laboratory test** documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission.

The Pricer will continue to apply an adjustment factor to increase the MS-DRG relative weight that would otherwise be applied by 20 percent when determining IPPS operating payments for discharges that report the ICD-10-CM diagnosis code U07.1 (COVID-19). CMS may conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the additional payment resulting from the 20 percent increase in the MS-DRG relative weight will be recouped.

For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. For example, a copy of a positive test result that was obtained a week before the admission from a local government run testing center can be added to the patient's medical record. In the

rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement.

A hospital that diagnoses a patient with COVID-19 consistent with the ICD-10-CM Official Coding and Reporting Guidelines but does not have evidence of a positive test result can decline, at the time of claim submission, the additional payment resulting from the application of the 20 percent increase in the MS-DRG relative weight at the time of claim payment to avoid the repayment. To do so, the hospital will inform its Medicare Administrative Contractor (MAC), and the MAC will notate the claim internally with the appropriate coding for processing. The presence of that MAC internal claim processing coding on a claim with the ICD10-CM diagnosis code U07.1 (COVID-19) will result in the 20 percent increase in the MS-DRG relative weight not being applied to the claim by the Pricer. To notify MACs that there is no evidence of a positive COVID-19 laboratory test documented in the patient's medical record, providers may enter a Billing Note NTE02 "No Pos Test" on the electronic claim 837I or a remark "No Pos Test" on a paper claim.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11925.1	Medicare contractors shall be aware of new payer-only condition code "ZA" processing on inpatient claims effective for admissions on or after September 1, 2020.	X								HIGLAS, IDR
11925.2	Medicare contractors shall append payer-only condition code "ZA" on or after October 5, 2020, to an IPPS claim with an admission date on or after September 1, 2020, upon notification from an IPPS hospital that a positive test result is not included in the patient's medical record.	X								
11925.2.1	For finalized claims, Medicare contractors shall adjust the claim to add the new payer-only condition code "ZA".	X								
11925.2.1.1	MACs shall initiate this adjustment within 10 business days from notification.	X								
11925.3	Medicare contractors shall be aware of the temporary instructions to notify MACs on the 837I that there is no evidence of a positive laboratory test documented in the patient's medical record. When in the judgment of the provider, providers may provide this	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	notification to MACs by using Loop 2300 Billing Note NTE02 “No Pos Test” or a remark “No Pos Test” on a DDE or paper 11X claim.									
11925.4	Medicare contractor shall add payer-only condition code “ZA” when Billing Note NTE02 value “No Pos Test” is submitted in the 837I Loop 2300 as NTE*ADD* No Pos Test~ or remark “No Pos Test” on a DDE or paper 11X claim is present.	X				X				
11925.4.1	The Medicare Contractor shall not send condition code “ZA” to the BCRC.					X				
11925.5	Pricer shall **NOT** increase the MS-DRG weighting factor by 20 percent on an IPPS claim when condition code “ZA” is present.									IPPS Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Michele Hudson, 410-786-5490 or michele.hudson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0