



# **COVID+ Report Template for In-Home Providers**

## **Technical Assistance Session, 2 of 2**

**June 12, 2020**

# Overview of Webinars

This is a two-part webinar series.

## **Last Session's Priorities:**

- Overview of Special Bulletin and confirmation of impacted providers.
- Overview of reporting tool.
- Fielding questions to inform process.

## **Today's Session:**

- FAQ responses.
- Additional Guidance on Hours.

## Refresher: Report is Referenced In Special Bulletin COVID-19 #93

- Special Bulletin COVID-19 #93 Targeted Rate Increase, Additional Hours and Associated Reporting Requirements for In-Home Personal Care Services (PCS) Providers under State Plan PCS and CAP/C and CAP/DA Waivers.
  - Additional, time-limited rate for serving COVID+ Medicaid beneficiaries.
  - Additional, time-limited increase in hours, as appropriate, for serving COVID+ Medicaid beneficiaries.
  - Recognizes “close contact” support needs of COVID+ beneficiaries in home-based settings.
- Report developed as a high level information source on provider experience.
- Attempts to harmonize with similar reporting requirements under other Bulletins/COVID response initiatives.
- Because concept is evolving, this report template should be considered preliminary.

# Refresher: Special Bulletin COVID-19 #93 Applies To the Following Services

Providers serving COVID+ Medicaid beneficiaries under the PCS; CAP/DA; CAP/C services provided below (as listed under Medicaid Fee Schedules).

## State Plan PCS

- Attendant Care (99509 HA and 99509 HB only)

## CAP/DA

- CAP In-Home Aide
- In-Home Aide Congregate Services

## CAP/Consumer Direction

- In-Home Aide
- In-Home Aide Congregate Services
- Personal Assistance Services
- Personal Assistance Congregate Services.

## CAP/Children

- In-Home Aide
- Pediatric Personal Care
- Personal Care Assistance Services
- Personal Care Assistance Congregate Services
- Pediatric Nurse Aide Congregate Services.

## Refresher: How Special Bulletin COVID-19 #93 Modifies Current Rates

RATE RESPONSE	15 minute UNIT RATE	NOTES
Pre COVID Base	Varies depending on service	
COVID Response Prior to Special Bulletin #93: (After 5% and 10% rate increase)	Varies depending on service	See Special Bulletins #32 and #88 Time-limited, not tied to serving COVID+ beneficiaries.
Today's Discussion: Special Bulletin #93: If serving COVID+ beneficiary.	Total unit rate for serving COVID+ beneficiary: \$8.25	Time –limited, applicable to COVID+ beneficiaries.
	Additional 40 hours, as appropriate for serving COVID+ beneficiaries.	

## 6/12/20 Update: How does this information get to NC Tracks for payment to providers?

- Providers serving COVID+ beneficiaries under Special Bulletin #93 are required to submit *COVID+ Report Template for In-Home Providers* (“The Report”) in order to draw down enhanced rate.
- The Report is submitted to [Medicaid.ProviderReimbursement@dhhs.nc.gov](mailto:Medicaid.ProviderReimbursement@dhhs.nc.gov) on the timelines provided in this presentation.
- The Report will activate the process for establishing a rate increase specific to the applicable NPI and locator codes.
- Technical requirements for both increased rates and increased hours are being established. This functionality should be established by mid-June and DHB will communicate this operability through its PCS, CAP/DA and CAP/C provider portals.
- Once this functionality is established, a provider’s claim for service provided to the COVID+ beneficiary will be reimbursed at COVID enhanced rate and provider will be able to bill the additional hours used to support the COVID+ beneficiary.
- If a provider has not yet submitted eligible claims, NC Medicaid recommends holding claims until technical functionality is established, following billing guidance provided.
- If a provider has submitted eligible claims with the U07.1 diagnosis code, these claims will be reprocessed once functionality is established.
- If a provider has already submitted eligible claims (for DOS 4/1/2020, forward), without U07.1 diagnosis, provider will need to resubmit with diagnosis code.

## 6/12/20 Update: Guidance for Additional Hours: PCS

- Providers may bill up to 40 additional hours needed to support COVID-19+ beneficiaries.
- The additional hours may be used to support the current PCS services authorized.
- Providers should appropriately document additional time spent on PCS Services per clinical coverage policy 3L.
- Additional questions may be sent to [PCS\\_Program\\_Questions@dhhs.nc.gov](mailto:PCS_Program_Questions@dhhs.nc.gov)

## **6/12/20 Update: Guidance for Additional Hours: CAP/DA and CAP/C**

- The provider agency notifies the assigned case manager of the request to seek the enhanced rate.
- The case manager arranges an MDT meeting to review additional assistance with ADLs and IADLs to identify the need for more hours.
- The case manager will revise the service plan to add the MDT's recommended hours of in-home aide or pediatric nurse aide services.
- The local approval authority approves additional hours before a CAP service authorization is provided with the approved hours.



# Refresher: Additional Information about Rate Applicability and Billing

## Rate Applicability

- Rates and Reporting are currently time-limited.
  - Currently available through June 30, 2020, may be extended beyond, subject to budget availability and continued emergency declarations.
- Special Bulletin #93 and report are not applicable to retainer payments related waiver programs under Appendix K.

## 6/12/20 Update: Additional Information about Rate Applicability and Billing

**Q: Cases started in March. Would it be fair to go back to March instead of April 1?**

*A: At this time, rate adjustments under Special Bulletin 93 apply only to applicable dates of service of April 1, 2020 or later.*

**Q: Is the rate increase for case manager fees only for COVID positive patients or everyone?**

*A: Case manager fees are not covered under Special Bulletin 93.*

**Q: Can an agency request funding if that beneficiary had COVID-19 but has currently recovered?  
Are we still required to do reporting if that beneficiary has recovered?**

*A: Yes. An agency may retroactively submit information on COVID+ beneficiaries served with dates of service of 4/1/2020 or later in accordance with the guidance provided in Special Bulletin 93, subsequent technical assistance session, and the applicable Clinical Coverage Policy, even if that beneficiary has since recovered.*

**Q: Must providers wait for the official rate letter before assigning patient rates and hours?**

*A: No. The rate adjustment and hour reimbursement process under Special Bulletin 93 are activated with the submission of the COVID+ Report template, reflecting those Medicaid beneficiaries currently served who are COVID+. The rate letter will follow this submission.*

## 6/12/20 Update: Additional Information about Rate Applicability and Billing

**Q: Please explain how the hardship advance is different from the COVID rate.**

*A: A hardship advance enables an eligible provider to receive interim payments for services being rendered for recipients impacted by COVID environments. These payments are based upon a specific two months of prior Medicaid payments, and increased by 25 percent to allow for increased staffing and PPE costs. Once the interim advances are released to the provider, all subsequent claims that process to pay are first applied to pay back the interim payments. Once the advance is fully repaid, paid claims resume their normal payment to the provider. For additional information, please email.*

*[Medicaid.Hardships@dhhs.nc.gov](mailto:Medicaid.Hardships@dhhs.nc.gov)*

*The COVID-related rate adjustments reflected in Special Bulletin 93 (and others) are time-limited rate increases tied to the requirements established in the applicable Special Bulletin. These COVID-related rates are provided through claims reimbursement, not advances.*

## Refresher: How Reports Are Used

- Activates NPI-specific, COVID-rate availability.
- Provide high-level information on how increased rates are being used by organizations.
- Provide insight into COVID experience and service “pathways” of Medicaid beneficiaries.
- Will be used to inform any lookback analysis.
  - Are beneficiaries for whom provider is claiming reflected on the report?
- Providers can use this report to communicate additional information that may be helpful about the COVID experience.

# Refresher: Additional Reporting Clarifications

## Who completes this report?

- Expected to be submitted by in-home/personal care provider/financial management providers for consumer-directed beneficiaries.
  - NOT CAP case manager.
- Reporting provider = individual NPI
- If there are multiple locator codes applicable under a single NPI, please note locator codes on face sheet and on beneficiary line under “Comments”
- Parent organization are encouraged to all reports in one email submission.

## Who and What Are Tracked on the Report?

- Tracking is necessary for COVID+ Medicaid beneficiaries only (not all COVID+ clients provider may be serving.).
- Reporting beneficiaries for whom providing billable service. If claiming the COVID+ rate for serving the beneficiary, the beneficiary should be on the report.
- Report does not track hours but if provider provides additional hours to beneficiary, beneficiary should be included on report.
- Billable days listed should be supported by U07.1 diagnosis on claim.

## 6/12/20 Update: Additional Reporting Clarifications

**Q: Do we need to send in the report if there are no COVID case to date?**

*A: No.*

**Q: When you say "location" do mean patient residence address?**

*A: No. If a provider has multiple service locations under one NPI, these locations will be identified through location-specific "locator codes" in NCTracks. If a provider has multiple locator codes in NCTracks under the same NPI, please include the locator codes applicable to beneficiaries reflected in the provider's COVID+ Report Template.*

**Q: In column P, if a client comes back home and service resumes, is it required that they are still considered COVID+ or is this intended for any return home?**

*A: Column P is Date Services Resumed (if admitted to a facility and returned home during the reporting month, if applicable). Thank you for noting this return in Column P, regardless of COVID status. Days which the beneficiary is served but not COVID+ should be excluded from the count under Column J ( Total Days During Reporting Month Diagnosis Code U07.1 Applied to Claim .Please include total days provider served client and also included U07.1 code on the claim within reporting month.).*

## Refresher: When is an Individual Recovered?

Once an individual person is *recovered*, do not include on list.

For more information about “recovery” standard, please see: CDC guidance on Discontinuation of Transmission-Based Precautions for additional information <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

## Confirming Attestation

*For each beneficiary for whom the provider has claimed the COVID+ rate for more than 14 days (regardless of reporting month), provider attests that beneficiary's symptoms have been re-assessed and U07.1 continues to be appropriate.*



## Update 6/12/2020: COVID Diagnosis

**Q: Are we to have paper trail with the date and positive test of COVID from doctor?**

*A: The provider should retain documentation of a COVID+ diagnosis consistent with the CDC criteria. Please see CDC ICD-10 diagnosis criteria U07.1 for specific guidance. The COVID positive determination must be made under appropriate testing criteria or otherwise made by a clinician with appropriate authority to diagnose. This is a medical diagnosis and should be documented by the resident's medical provider.*

**Q: Will they need a doctor note saying they have COVID-19?**

*A: Please review CDC guidance on U07.1 ICD-10 code application. The provider should retain documentation consistent with this guidance.*

**Q: Are we eligible if a doctor just has patient to self quarantine and doesn't test. For example, they were exposed but wasn't tested and told to quarantine for 14 days?**

*A: Under Special Bulletin 93, the beneficiary must have a confirmed COVID diagnosis consistent with the CDC's guidance.*

**Guidance  
Available Here**

[ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020](#)

## Reporting Submission Timing

- May apply back to April 1, if reporting can be appropriately provided.
- Bulletin indicated: Should submit April and May detail: no later than June 10<sup>th</sup>
- Recommending hold report submission until Friday, June 19 and submit by encrypted email (zixmail appreciated) to:  
[Medicaid.ProviderReimbursement@dhhs.nc.gov](mailto:Medicaid.ProviderReimbursement@dhhs.nc.gov)
- June reporting will be due July 5, 2020.

## For Additional Information

- [Medicaid.ProviderReimbursement@dhhs.nc.gov](mailto:Medicaid.ProviderReimbursement@dhhs.nc.gov)
- Materials related to this effort will soon be available here.
  - <https://medicaid.ncdhhs.gov/about-us/covid-19-guidance-and-resources/providers>