



Oklahoma State Department of Health
Creating a State of Health

FAQs
Nursing Home Reimbursements
Updated April 22, 2020

Please address questions related to Medicare/Medicaid billing during the emergency declaration period to the appropriate agency:

Medicare: Oklahoma MAC COVID Hotline for Medicare Provider Enrollment Relief and Frequently Asked Questions (FAQs), Novitas Solutions, Inc., at 1-855-247-8428
Hours of Operation Monday - Friday: 8:30 AM – 4:00 PM EST.

Medicaid: OHCA Medicaid Finance Unit at 405-522-7294 or 405-522-7098.

Both agencies have webpages dedicated to provide information for [CMS Coronavirus Waivers and Flexibilities](#) and [OHCA Coronavirus/COVID-19 Web Alerts](#). The [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#) was last updated on 04/21/20.

1. Transfer or discharge a resident (either COVID positive or negative) to the care of another facility for cohorting purposes

Q: How does reimbursement work if we transfer or discharge a resident (either COVID positive or negative) to the care of another facility for cohorting purposes?

A: There are 3 types of cohort dedicated facilities and 2 options for Medicare reimbursement as described below.

The cohort facility may be dedicated to providing services and agree to accept each specific resident for:

1. Residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19;
2. Residents without symptoms of a respiratory infection or confirmed to not have COVID-19;
or
3. Residents without symptoms of a respiratory infection that must be observed for any signs or symptoms of respiratory infection over 14 days.

Transferring Facility Bills Medicare/Medicaid and Reimburses the Receiving Facility

When a LTC resident is transferred to a receiving facility, with provision of services “under arrangement,” the transferring facility need not issue a discharge, and will continue to bill Medicare for services. The transferring facility is responsible for reimbursing the receiving facility for care provided during the emergency declaration. In this case, certain transfer and discharge requirements are waived if the transferring facility obtains written or verbal confirmation the receiving facility agrees to the arrangement. A verbal confirmation must be documented with the date, time and person the receiving facility communicated/confirmed agreement.

Certain transfer and discharge requirements are waived when transferring residents to another facility, such as a COVID-19 isolation and treatment location, with the provision of services “under arrangements,” as described on pages 11 and 12 of the [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#).

Receiving Facility Bills Medicare/Medicaid

If the LTC facility does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare/Medicaid billing purposes. The LTC facility should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual to submit a discharge bill to Medicare/Medicaid. The COVID-19 isolation and treatment facility should then bill Medicare/Medicaid appropriately for the type of care it is providing for the beneficiary.

4/16/20 OHCA confirmed Medicare billing instructions above apply to Medicaid billing also.

[QSO-20-25-NH issued 04/13/20](#) addresses Long Term Care Facility Transfer Scenarios.

2. Medicaid Public Health Emergency (PHE) billing/reimbursement questions

Q: If a nursing home or ICF/IID has a Medicaid Public Health Emergency (PHE) billing/reimbursement questions, who can they call?

A: Call the Oklahoma Health Care Authority (OHCA) at:
405-522-7294 OHCA Finance
405-522-7098 OHCA Finance
800-522-0114 Select Option 1 – Denied Claims
800-522-0114 Select Option 3, then Option 1

3. Accelerated/Advanced Payments under the 1135 Blanket Waiver

Q: Is there a recommendation or FAQ for advanced payments under the 1135 Blanket Waiver provisions?

A: For Medicare billing inquiries, the facility should contact the Medicare Administration Contractor (MAC) Hotline at the toll-free telephone number at the top of this document. Likewise, Medicaid billing questions should be directed to the Oklahoma Health Care Authority (OHCA) Finance Unit (telephone number at the top).

Advance Payments with repayment beginning 120 days after issuance (extended from the 90 day deadline for beginning date of repayment) is addressed in the updated (04/21/20) [LTC Facility SNF and/or NF Waiver Document](#).

Accelerated/Advance Payments: *In order to increase cash flow to providers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/ advance payment is a payment intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the public health emergency to any Medicare provider/ supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/ accelerated payments begins at 90 days, however for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process here: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.*

4. Funding for Extra Staff?

Q: Is there a recommendation or FAQ for funding extra staff?

A: A skilled nursing facility (SNF) may accept Federal, State, or local government resources (e.g., supplies and staffing assistance) to help with the COVID-19 emergency and still bill Medicare. Although Medicare usually doesn't allow payment for services that are paid for by a governmental entity, there is an exception for services furnished as a means of controlling infectious diseases (see 42 CFR 411.8(b)(4)).

In addition, [Blanket Waivers for Health Care Providers](#) includes the following waiver to assist in potential staffing shortages:

Physician Visits. *42 CFR 483.30(c)(3). CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. We are modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a*

physician, and who is licensed by the State and performing within the state's scope of practice laws.

Note to Facilities. *These actions will assist in potential staffing shortages, maximize the use of medical personnel, and protect the health and safety of residents during the PHE. We note that we are not waiving the requirements for the frequency of required physician visits at § 483.30(c) (1). As set out above, we have only modified the requirement to allow for the requirement to be met by an NP, physician assistant, or clinical nurse specialist, and via telehealth or other remote communication options, as appropriate. In addition, we note that we are not waiving our requirements for physician supervision in § 483.30(a)(1), and the requirement at § 483.30(d) (3) for the facility to provide or arrange for the provision of physician services 24 hours a day, in case of an emergency. It is important that the physician be available for consultation regarding a resident's care.*

5. Medicare Funding for Personal Protective Equipment And Supplies

Q: Does Medicare pay health care providers such as hospices, hospitals, and skilled nursing facilities (SNFs) separately for personal protective equipment and supplies necessary to prevent the spread of infectious disease?

A: Not directly. Medicare payments for health care services include payment for the supplies necessary to appropriately provide the service, including any personal protective equipment and supplies appropriate for the patient's condition and treatment. However, there are not separate payments for those supplies. Additional resources for infection control, such as supplies or staffing assistance, may be made available from other local, state, or federal government agencies.

A physician who has to self-quarantine can be recruited to provide care virtually, or oversee care delivered by other clinicians through interactive video/audio conferencing. And Medicare will pay for providers who are licensed in one state to provide care in a different state if they are needed. Health systems can provide care options that use population management strategies like triaging based on COVID status as well as clinical status, employing doctors, nurses and other staff to better manage high patient volumes. Clinicians who are not fully employed during the emergency can be repurposed to provide care in other areas.

According to the [FEMA Fact Sheet dated 3/19/20](#), FEMA will not duplicate assistance provided by HHS, CDC, or other federal agencies.