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CMS: Hospitals Need Proof of Positive COVID-19 Test to Get 20% Medicare MS-DRG Bonus

By Nina Youngstrom

Starting Sept. 1, hospitals will lose the 20% Medicare bonus for treating inpatients with COVID-19 unless there's proof of a positive COVID-19 lab test, CMS said in an Aug. 17 *MLN Matters* (SE20015 Revised).[1] A presumptive positive test based on the physician's diagnosis of symptoms won't be good enough to generate the additional money. The positive test results must be in the medical records, and hospitals could face post-payment reviews later, CMS said. The challenge with this requirement is there's no way at the moment for hospitals to indicate on claims for COVID-19 when it was diagnosed and treated without a positive test, and they may have to hold claims until that's sorted out, experts say. They also may have to track down documentation of tests that were performed outside the hospital shortly before admission.

The coding guidelines haven't changed, and physicians will continue to diagnose patients with COVID-19 based on their clinical judgment (with or without a positive test), and hospitals will assign MS-DRGs the usual way, said Leslie Slater, a specialist leader with Deloitte Risk and Financial Advisory in New York City. What's new is when there's no documentation of the test results, no test was performed or it's negative (whether or not the physician believes it's a false negative), the Medicare Pricer software won't apply the 20% increase to claims with ICD-10 U07.1 (COVID-19) for admissions starting Sept. 1.

"Coders still code as they have been. We would still code the presumptive diagnosis as COVID," Slater said. "But if the hospital doesn't have documentation of the positive test result, that claim will not qualify for the 20% increase."

The 20% bonus comes from Sec. 3710 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[2] But apparently CMS is worried that hospitals are pushing the envelope because the *MLN Matters* states a positive lab test is necessary "to address potential Medicare program integrity risks." And antibody tests aren't proof enough for the 20% bonus. "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." Hospitals may enter the results of tests administered elsewhere before the admission (e.g., at a government-run center) into the medical record.

"It's not a positive development. It gives you the sense they are pulling back on some of the CARES Act benefits to hospitals," said Amanda Hayes-Kibreab, with King & Spalding in Los Angeles. "But practically, we have to see. At this point, it's not clear how big of an impact it will have on reimbursement." It would have been a gut punch in the first months of the pandemic, when tests were harder to come by, she said. But the picture has changed. "We have heard from clients that most patients with COVID-19-related symptoms are able to get tested now, so it may not have as significant an impact as it might have earlier on."

An Operational Problem Is Looming

Hospitals should take note of a few things. For one, the date is timed to admissions, not discharges, which is

unusual, Slater said. Also, the test result report has to be documented in the admission encounter, regardless of where it was performed. "Hospitals have to have the physical evidence of the lab result," she said. When patients have the test done outside the hospital, they must bring the piece of paper to have it scanned into the medical record, she said. For the most part, the test can't be older than 14 days prior to admission, although CMS left a window cracked open for complex situations.

Slater said it will require a form of contact tracing, with the hospital reaching out to a physician or family member to get test results when a sick patient is admitted with COVID-19 unless the test was never performed. Or the hospital may have to repeat the test.

The false negatives also are a concern. "No test is 100% sensitive, meaning it has no false negatives. In the midst of a pandemic, a patient presenting with typical symptoms and an X-ray compatible with COVID-19 whose initial test is negative will be treated for COVID-19, including strict isolation with use of full personal protective equipment for all caregivers," said Ronald Hirsch, M.D., vice president of R1 RCM. "The absence of a negative test does not lessen the need for that care nor lower its cost to the hospital. Repeating the test, especially with the ongoing testing shortage, simply to prove the infection exists also does not make sense."

The *MLN Matters* explains that when hospitals identify COVID-19 claims without the positive test result, they can decline the 20% bonus at the time of claim submission by informing the MAC. "The MAC will notate the claim with MAC internal claim processing coding for processing. The Pricer software will not apply the 20 percent increase to the claim when that MAC internal claim processing coding is present on a claim with the ICD-10-CM diagnosis code U07.1 (COVID-19). The updated Pricer software package reflecting this change will be released in October 2020, and additional operational guidance will be provided in implementation instructions in the near future."

But there's an operational problem here, Slater said. "There's no way for hospitals to put any kind of indication on the uniform bill, like a condition code, to inform a Medicare administrative contractor this claim doesn't qualify for 20%," she said. Without some kind of condition code or modifier, all the claims will look the same to the MACs, and they could all be paid the 20% bonus regardless of whether patients had positive COVID-19 lab tests.

Until that guidance comes down from the MACs on how to bill the claims, Slater suggested hospitals hold them.

Concurrent Review Is a Best Practice

In light of the fact that reimbursement for claims with a COVID-19 principal or secondary diagnosis will soon be bifurcated, Slater said the best practice is concurrent review of claims by clinical documentation improvement and case management departments. When positive test results are AWOL, she suggested working with the medical staff to decide when to perform a new or repeat COVID-19 test. "Someone has to make sure test results are in the medical record," she noted. "Coders can be another stop gap." If the test results are there and they meet CMS's 14-day requirement, claims are good to go.

Hirsch also raised the question of whether CMS can unilaterally scale back a payment increase authorized by Congress in the CARES Act. Hayes-Kibreab said it looks like the language of Sec. 3710 gives the Secretary of HHS "pretty wide authority to determine how to identify a COVID-19 diagnosis." According to Sec. 3710, "For discharges occurring during the emergency period described in section 1135(g)(1)(B),[3] in the case of a discharge of an individual diagnosed with COVID-19, the Secretary shall increase the weighting factor that would otherwise apply to the diagnosis-related group to which the discharge is assigned by 20 percent. The Secretary shall identify a discharge of such an individual through the use of diagnosis codes, condition codes, or other such means as may be necessary."

"It's frustrating, though," Hirsch said, because COVID-19 can be accurately diagnosed without a positive test.

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1 CMS, "New COVID-19 Policies for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act," *MLN Matters*, SE20015 Revised, August 17, 2020, https://go.cms.gov/3kVP2Kr.
2 Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, 134 Stat. 281, 422 (2020), https://bit.ly/2xMtITW.
342 U.S.C. § 1320b–5(g)(1)(B) .