

## VOLUNTARY JOINT BILLING GUIDANCE

### Care Provided in Alternate Sites During the COVID-19 Pandemic

*Updated: May 5, 2020*

America's Health Insurance Plans (AHIP) and the Healthcare Financial Management Association (HFMA) stand together with America's frontline healthcare heroes and leaders to fight against the novel coronavirus (COVID-19). The pandemic is an unprecedented crisis overwhelming the healthcare system. To increase capacity, health systems have been resourcefully utilizing alternate locations for care to meet demand. This may be the use of certain healthcare sites for a different level of care than is customary (e.g., ambulatory surgical centers, inpatient rehabilitation facilities) or the use of nontraditional temporary sites (e.g., parks, parking lots, convention centers).

To support and accommodate the expansion in care due to COVID-19, health insurance providers are affording flexibilities to their clinical providers to bill for these services furnished in alternate sites of care. However, the existing billing and coding infrastructure was not designed for this. Various international, federal and private entities have had to issue new diagnosis and billing codes as well as guidance on their use by stakeholders. Clinicians and health systems are struggling to keep up with seemingly constant changes in how they are expected to bill amid the turmoil, while health insurance plans are scrambling to make necessary changes in their billing adjudication systems.

HFMA and AHIP partnered to provide clear, useful voluntary guidance for providers to code, bill and seek payment for services rendered in temporary, alternate healthcare sites that may be used during the COVID-19 public health emergency (PHE). The voluntary guidance is intended to reduce the burdens faced by providers when billing in these unprecedented circumstances, increase the accuracy and timeliness of payment, ensure appropriate patient cost-sharing waivers are implemented and improve population health surveillance. This guidance is not binding, but rather available for voluntary use by providers and health insurance providers. However, the guidance does reflect some legal requirements of the Medicare program as well as laws such as the Health Insurance Portability and Accountability Act and the Families First Coronavirus Response Act. We have attempted to note when we are referencing a legal requirement, but are not offering legal or compliance advice and providers and health insurance providers should not rely on anything in this guidance as such. Also, nothing in this voluntary guidance is intended to address payment rates, which are the subject of arrangements between individual health insurance providers and individual providers. The intention of this voluntary guidance, developed collaboratively by hospitals and health insurance providers, is to reduce unnecessary administrative burden-related coding and billing complications that have arisen in this complex, and constantly evolving, situation.

This first set of billing scenarios focuses on inpatient hospital services and is intended to be valid for the duration of the PHE. The organizations expect soon to release outpatient service scenarios. Both will be updated as needed.

#### **Inpatient Level of Care**

Below we offer voluntary guidance on the diagnosis and billing codes to process inpatient claims associated with these alternate sites of care during the PHE. In addition, we provide a list of inpatient care scenarios to which this billing convention guidance applies as well as notes to provide context on how

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entities may apply the codes and billing conventions. As a point of clarity, while these scenarios could include services to patients with COVID-19, it is not exclusively so. Patients who do not have COVID-19 but are served in alternate locations to provide increased capacity are also included.

**Provider Number/NPI.** For all scenarios described in this voluntary guidance, a hospital's acute provider number and address should be used. The alternate site of care should use its provider number and address only in scenarios where it has separately applied for new licensure and there is a discharge and transfer between the originating hospital and the receiving facility, as noted in Table 2.

**Type of Bill.** For all guidance scenarios described herein, the claim should be billed on a 111 Type of Bill on the 837i electronic transaction.

**Condition Code.** In order to ensure appropriate flagging of COVID-19 related care, the National Uniform Billing committee (NUBC)<sup>1</sup> recommends that institutional claims for COVID-19 diagnosis or treatment should include the "DR" condition code, which is used to identify claims that are or may be impacted by specific policies related to a national or regional disaster/emergency. NUBC instructs that this should be reported in form locators 18 - 28 of the claim for these scenarios to flag the claim for special handling during the PHE, whether or not the patient has or is suspected to have COVID-19.

**Diagnosis Codes.** To identify COVID-19 cases, follow the most up-to-date CDC diagnosis coding guidance.<sup>2</sup> A synopsis is provided in Table 1 below, but this does not include the full coding hierarchy.

**Table 1.** ICD-10 Diagnosis Codes Applicable to COVID-19

COVID-19 Status	Diagnosis Code <sup>3</sup>
<b>Confirmed</b>	For COVID-19 <b>confirmed</b> cases on or after April 1, 2020, code diagnosis <b>U07.1</b> (B97.29 prior to April 1)
<b>Suspected</b>	For COVID-19 <b>suspected, probable, possible or inconclusive</b> cases, assign code related to reason for encounter (i.e., fever) or <b>Z20.828</b> , contact with, and (suspected) exposure to other viral communicable diseases.
<b>Exposed</b>	But was ruled out after evaluation, code <b>Z03.818</b> , encounter for observation for suspected exposure to other biological agents <b>ruled out</b> .
	And the exposure was an <b>actual exposure</b> to someone who is confirmed or suspected (not ruled out) to have COVID-19, and exposed individual either tests <b>negative</b> or the test results are <b>unknown</b> , assign code <b>Z20.828</b> , contact with and (suspected) exposure to other viral communicable diseases.
<b>Asymptomatic</b>	And were screened for COVID-19 with no known exposure to the virus, and the test results are either <b>unknown or negative</b> , assign code <b>Z11.59</b> , encounter for screening for other viral diseases.

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### Applicable Billing Scenarios

Table 2 contains a listing of the scenarios to which this voluntary billing guidance applies. Given the constantly changing environment, while extensive, Table 2 is likely not comprehensive. Note that unless a specific coding or CMS document is referenced, the guidance contained in Table 2 is a product of joint efforts by HFMA and AHIP to arrive at solutions that reduce administrative uncertainty and inefficiency in this crisis and are offered for voluntary use by providers and plans. Given that many of the scenarios are treated in the same manner, the governing document will only be referenced in the guidance's initial appearance.

**Table 2.** Applicable Inpatient Billing Scenarios

<b>Inpatient Level Care (Either ICU or Routine)</b>	
Scenario	Notes
<p><b>ASC</b>—Converted surgical suite of an ambulatory surgical center (ASC) that is owned by the health system/ hospital.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only.<sup>4</sup> If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, National Provider Identifier (NPI), and contract (which contains payment terms).<sup>5</sup></li> <li>• Notation in the medical record is suggested to explain the location where patient received care.<sup>6</sup></li> </ul>
<p><b>ASC</b> — Converted surgical suite of an ASC that is not owned by the health system/hospital.</p> <p>This scenario assumes care is provided under arrangement with the ASC.</p> <p>This scenario does not entail discharge and transfer. It is analogous to moving a patient between beds in the same facility.</p> <p>This scenario assumes the ASC has a contract with the acute provider that contains payment terms.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, NPI, and health plan contract (which contains payment terms).</li> <li>• Notation in the medical record is suggested to the explain the location where patient received care.</li> </ul>

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### Inpatient Level Care (Either ICU or Routine) *(continued)*

**Freestanding ED** — Independent, freestanding emergency department (ED) enrolled temporarily as a Medicare/Medicaid hospital

This assumes the licensed, independent freestanding ED was temporarily enrolled in Medicare as a hospital for inpatient and outpatient services by creating a temporary new facility profile and certification kit in the Automated Survey Process Environment (ASPEN) and was assigned a hospital CMS Certification Number (CCN) and sent a tie-in notice and attestation form to the Medicare Administrative Contractor (MAC).

- DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.
- Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).
- Notation in the medical record is suggested to explain the location where patient received care.

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### Inpatient Routine and Ancillary Acute Care

**Excluded unit** — An excluded unit of the hospital (e.g., inpatient rehabilitation hospital (IRF), psychiatric hospital, long-term acute care facility [LTAC])

- DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.
- Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).
- Notation in the medical record is suggested to explain the location where patient received care.
- If the patient requires post-acute care (PAC) after the acute stay, the patient will be discharged from the acute stay and admitted to the IRF or LTAC.
- The post-acute stay should then be billed as it normally would for an IRF/LTAC.
- These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.

**Excluded hospital**—A freestanding IRF, psychiatric hospital, LTAC, cancer or children’s hospital.

This scenario assumes acute care is provided under arrangement (e.g., the freestanding rehab hospital acting as an extension of acute hospital that has contracted with it).

This scenario does not entail discharge and transfer. It is analogous to moving a patient between beds in the same facility.

This scenario assumes the excluded hospital has a contract with the acute provider that contains payment terms.

- DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.
- Use main campus (acute) attributes – address, NPI, and health plan contract (which contains payment terms).
- Notation in the medical record is suggested to explain the location where patient received care.
- If the patient requires PAC after the acute stay, the patient will be discharged from the acute stay provided under arrangement and admitted to the IRF or LTAC as an IRF or LTAC patient.
- The post-acute stay should then be billed as it normally would for an IRF/LTAC.
- These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.

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Inpatient Routine and Ancillary Acute Care <i>(continued)</i>	
<p><b>SNF</b> — Acute bed created in a skilled nursing facility (SNF) subprovider of the main hospital</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers will need to submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).</li> <li>• Notation in the medical record is suggested to explain the location where patient received care.</li> <li>• If the patient requires post-acute care after the acute stay, the patient will be discharged from the acute stay and admitted to the SNF, IRF or LTAC.</li> <li>• The post-acute stay should then be billed as it would be normally for an IRF/LTAC.</li> <li>• These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.</li> </ul>
<p><b>SNF</b> — Acute bed created in a freestanding SNF.</p> <p>This scenario assumes acute care is provided under arrangement (acting as an extension of acute hospital that has contracted with the SNF).</p> <p>This scenario does not entail discharge and transfer. It is analogous to moving a patient between beds in the same facility.</p> <p>This scenario assumes the SNF has a contractual arrangement with the acute provider that contains payment terms.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).</li> <li>• Notation in the medical record is suggested to explain the location where patient received care.</li> <li>• If the patient requires post-acute care after the acute stay, the patient will be discharged from the acute stay and admitted to the SNF, IRF or LTAC.</li> <li>• The post-acute stay should then be billed as it normally would normally for a SNF, IRF, or LTAC.</li> <li>• These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.</li> </ul>

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<b>Inpatient Routine and Ancillary Acute Care</b> <i>(continued)</i>	
<p><b>Nontraditional site</b> — Acute care is provided in an alternate site of care (e.g., college dorm, hotel or gymnasium) rented by or provided to the hospital for such purposes.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).</li> <li>• Notation in the medical record is suggested to explain the location where patient received care.</li> </ul>
<p><b>Field Hospital</b> — Inpatient acute care is provided in a civilian field hospital (park, parking lot, etc.) established as an extension of an existing acute care provider.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).</li> <li>• Notation in the medical record is suggested to explain the location where patient received care.</li> </ul>
<p><b>Freestanding ED</b> — Independent, freestanding emergency department (ED) affiliated with a Medicare/Medicaid hospital under the 1135 emergency waiver</p> <p>This assumes the licensed, freestanding ED and the chosen hospital obtained state approval for the freestanding ED to operate as the hospital's outpatient department (i.e., become hospital-affiliated).</p>	<ul style="list-style-type: none"> <li>• This case will be billed and handled like a transfer case.</li> <li>• The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> </ul>

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### Inpatient Routine and Ancillary Acute Care *(continued)*

**Freestanding ED** — Independent, freestanding emergency department (ED) enrolled temporarily as a Medicare/Medicaid hospital.

This assumes the licensed, independent freestanding ED temporarily enrolled in Medicare as a hospital for inpatient and outpatient services by creating a temporary new facility profile and certification kit in the Automated Survey Process Environment (ASPEN) and was assigned a hospital CMS Certification Number (CCN) and sent a tie-in notice and attestation form to the Medicare Administrative Contractor (MAC).

- This case will be billed and handled like a transfer case.
- The initial admitting hospital has a contract with the health plan, which contains payment terms.

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### Inpatient Acute Hospital Transfers

<p><b>ASC</b> — Acute bed (either routine or ICU) created in an ASC.</p> <p>This scenario assumes that the ASC is freestanding and has applied for its own acute provider number under the 1135 waiver.</p>	<ul style="list-style-type: none"> <li>Assumes the ASC is billing independently and the patient is discharged from the hospital and transferred to the ASC.</li> <li>The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> </ul>
<p><b>Excluded Unit</b> — An exempt unit on the main hospital campus (e.g., subprovider) for acute level care.</p> <p>This scenario is technically not a transfer since the patient would likely not be discharged from the admitting hospital.</p>	<ul style="list-style-type: none"> <li>DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).</li> <li>Notation in the medical record is suggested to explain the location where patient received care.</li> <li>If the patient requires post-acute care after the acute stay, the patient will be discharged from the acute stay and admitted to the IRF or LTAC.</li> <li>The post-acute stay should then be billed as it normally would for an IRF/LTAC.</li> <li>These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.</li> </ul>

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<b>Inpatient Acute Hospital Transfers</b> <i>(continued)</i>	
<p><b>Excluded Hospital</b> — Acute hospital bills for a portion of the stay and an IRF/psychiatric hospital/LTAC bills for a portion of the stay.</p> <p>Freestanding IRF/Psychiatric/LTAC Hospital This scenario assumes that the IRF/psychiatric hospital/LTAC is freestanding and has applied for its own acute provider number under the 1135 waiver.</p>	<ul style="list-style-type: none"> <li>Assumes that the IRF/psychiatric/LTAC hospital has acquired its own acute provider number and will bill separately.</li> <li>This case should be billed and handled like a transfer case, with the contract between the plan and acute provider who discharged/transferred the patient to the receiving facility containing payment terms.</li> <li>If the patient requires post-acute care after the acute stay, the patient will be discharged from the acute stay (provided in the IRF/psychiatric/LTAC hospital) and admitted to the receiving facility.</li> <li>The post-acute stay should then be billed as it normally would for a SNF/IRF/ LTAC.</li> <li>These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.</li> </ul>
<p><b>SNF</b> — Acute bed created in a SNF subprovider of the main hospital.</p> <p>This scenario is technically not a transfer since the patient would likely not be discharged from the admitting hospital.</p>	<ul style="list-style-type: none"> <li>DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>Use main campus (acute) attributes – address, NPI and health plan contract (governs payment).</li> <li>Notation in the medical record is suggested to explain the location where patient received care.</li> <li>If the patient requires post-acute care after the acute stay, the patient will be discharged from the acute stay and admitted to the IRF or LTAC.</li> <li>The post-acute stay should then be billed as it normally would for a SNF/IRF/ LTAC.</li> <li>These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.</li> </ul>

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<b>Inpatient Acute Hospital Transfers</b> <i>(continued)</i>	
<p><b>SNF</b> — Hospital bills for a portion of the stay in an acute bed created in a freestanding SNF.</p> <p>This scenario assumes that the SNF is freestanding and has applied for its own acute provider number under the 1135 waiver.</p>	<ul style="list-style-type: none"> <li>• Assumes that the SNF has acquired its own acute provider number and will bill separately.</li> <li>• This case should be billed and handled like a transfer case, with contract between the plan and acute provider who discharged / transferred the patient to the receiving facility containing payment terms.</li> <li>• If the patient requires post-acute care after the acute stay, the patient will be discharged from the acute stay (provided in the SNF) and admitted to the SNF/IRF/ LTAC.</li> <li>• The post-acute stay should then be billed as it normally would for a SNF/IRF/ LTAC.</li> <li>• These cases/discharges should follow normal PAC transfer rules unless these are suspended by a subsequent CMS waiver.</li> </ul>
<p><b>Acute bed in a civilian field hospital (park, parking lot, etc.)</b>—The field hospital functions like a unit/floor of the hospital where the patient is currently admitted.</p> <p>This scenario is technically not a transfer since the patient would likely not be discharged from the admitting hospital.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate DX code.</li> <li>• Use main campus (acute) attributes – address, NPI and health plan contract (governs payment).</li> <li>• Notation in the medical record is suggested to explain the location where patient received care.</li> </ul>
<p><b>Acute bed in a civilian field hospital (park, parking lot, etc.)</b> — The field hospital was established by a separate hospital with its own acute provider number.</p>	<ul style="list-style-type: none"> <li>• This case should be billed and handled like a transfer case.</li> <li>• The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> </ul>

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<b>Inpatient Acute Hospital Transfers</b> <i>(continued)</i>	
<p><b>Acute bed created in a hotel/dormitory</b> —The hotel/dormitory functions like a unit/floor of the hospital where the patient is currently admitted.</p> <p>This scenario is technically not a transfer since the patient would likely not be discharged from the admitting hospital.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).</li> <li>• Notation in the medical record is suggested to explain the location where patient received care.</li> </ul>
<p><b>Acute bed created in a hotel/dormitory</b> —The hotel/dormitory hospital was established by a separate hospital with its own acute provider number.</p>	<ul style="list-style-type: none"> <li>• This case will be handled like a transfer case, including billing.</li> <li>• The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> </ul>
<p><b>Acute bed created in a freestanding ED owned by the hospital that originally admitted the patient</b> — This scenario assumes the freestanding ED does not acquire its own acute provider number under the 1135 waiver.</p> <p>The case is technically not a transfer since the patient would likely not be discharged from the admitting hospital.</p>	<ul style="list-style-type: none"> <li>• DR code denotes care provided in a designated disaster area only. If the discharge is specifically COVID-19, providers should submit the appropriate diagnosis code.</li> <li>• Use main campus (acute) attributes – address, NPI and health plan contract (which contains payment terms).</li> <li>• Notation in the medical record is suggested to explain the location where patient received care.</li> </ul>
<p><b>Acute bed created in a freestanding ED not owned by the hospital</b> —This scenario assumes that the freestanding ED applied for its own acute provider number under the 1135 waiver.</p>	<ul style="list-style-type: none"> <li>• This case should be handled like a transfer case, including billing.</li> <li>• The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> </ul>

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<b>Inpatient Acute Hospital Transfers</b> <i>(continued)</i>	
<b>Acute bed in military hospital</b>	<ul style="list-style-type: none"> <li>• This case should be handled like a transfer case, including billing.</li> <li>• The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> <li>• Transfer language in contracts between plans and hospitals likely exists that should be sufficient to cover these scenarios.</li> </ul>
<b>Independent, freestanding emergency department (ED) affiliated with a Medicare/Medicaid hospital under the 1135 emergency waiver</b> — This assumes the licensed, freestanding ED and the chosen hospital obtained state approval for the freestanding ED to operate as the hospital's outpatient department (i.e., become hospital-affiliated)	<ul style="list-style-type: none"> <li>• This case should be handled like a transfer case, including billing.</li> <li>• The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> <li>• Transfer language in contracts between plans and hospitals likely exists that should be sufficient to cover these scenarios.</li> </ul>
<b>Independent, freestanding emergency department (ED) enrolled temporarily as a Medicare/Medicaid hospital</b> — This assumes the licensed, independent freestanding ED temporarily enrolled in Medicare as a hospital for inpatient and outpatient services by creating a temporary new facility profile and certification kit in the Automated Survey Process Environment (ASPEN) and was assigned a hospital CMS Certification Number (CCN) and sent a tie-in notice and attestation form to the Medicare Administrative Contractor (MAC).	<ul style="list-style-type: none"> <li>• This case should be handled like a transfer case, including billing.</li> <li>• The initial admitting hospital has a contract with the health plan, which contains payment terms.</li> <li>• Transfer language in contracts between plans and hospitals likely exists that should be sufficient to cover these scenarios.</li> </ul>

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### Testing for Inpatients

<p><b>Patient is tested in the ED and is subsequently admitted</b> — The test and ED visit would be rolled into the inpatient stay.</p>	<ul style="list-style-type: none"> <li>The CARES Act does not waive cost sharing for inpatient services. The test HCPCS code is not included on the claim. The testing cost is incorporated into the cost of inpatient treatment.<sup>7</sup></li> </ul>
<p><b>Patient is tested as a result of a direct inpatient admission.</b></p>	<ul style="list-style-type: none"> <li>The CARES Act does not waive cost sharing for inpatient services. The test HCPCS code is not included on the claim. The testing cost is incorporated into the cost of inpatient treatment.<sup>8</sup></li> </ul>

<sup>1</sup> NUBC Guidance: Claims for COVID 19 Treatment. Available at:

[https://www.nubc.org/system/files/media/file/2020/03/NUBC%20Announcement%20for%20COVID-19%20claims\\_1.pdf](https://www.nubc.org/system/files/media/file/2020/03/NUBC%20Announcement%20for%20COVID-19%20claims_1.pdf)

<sup>2</sup> Centers for Disease Control and Prevention. "ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020." Available at: <https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf>

<sup>3</sup> Current as of April 28, 2020

<sup>4</sup> MLN Matters. "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)." Available at: <https://www.cms.gov/files/document/se20011.pdf>

<sup>5</sup> CMS. "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," p. 7 Available at: <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>

<sup>6</sup> CMS. "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," p. 7 Available at: <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>

<sup>7</sup> CMS. "FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42." Available at: <https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf>

<sup>8</sup> CMS. "FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42." Available at: <https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf>