Charles N. Kahn III
President and CEO

May 2, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Thomas J. Engels
Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857

Subject: HRSA COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured

Dear Secretary Azar and Administrator Engels:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care across settings in both urban and rural areas. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services.

The FAH and our member hospitals deeply appreciate the efforts across the Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA) to provide support to hospitals and health care providers in response to the novel coronavirus (COVID-19) pandemic. We applaud the speed in which HHS has responded in implementing Title V of the *Families First Act* that provides $1 billion for the Public Health and Social Services Emergency Fund (PHSSEF) to cover COVID-19 testing and testing-related services provided to uninsured and certain underinsured individuals. In addition, the *Paycheck*

Protection Program Increase Act of 2020 provides up to an additional $1 billion to cover testing costs for the uninsured. Any individuals who may be infected with COVID-19 should not delay testing and/or accessing care due to concerns about potential costs or cost-sharing. Fully funding this effort is critical to assuring access to services for the uninsured and underinsured.

On April 22, HRSA went live with the *COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured* website and hosted two educational webinars for health care providers on April 29th and 30th. During these webinars, HRSA and its contractor United Health Services (UHS) indicated that the program would begin accepting claims from providers beginning May 6th. Despite many questions being sent by providers to HRSA and UHS in advance of those webinars regarding the proper coding of claims to qualify for reimbursement, FAH members remain deeply concerned with the coding instructions issued by HRSA. They conflict with well-established national coding guidelines, and, if applied, undermine the intent of Congress in establishing this important program.

Specifically, restrictive language regarding the proper coding of claims on the HRSA website is inconsistent with both CMS guidance and national coding guidelines regarding identification of patients testing for or treating of COVID-19. If not corrected prior to May 6, the majority of claims representing COVID-19 testing and treatment would be rejected and ineligible for reimbursement under this program. FAH members have tested and treated for COVID-19 thousands of uninsured patients across the country, but are holding tens of thousands of claims for reimbursement pending clarification of this issue. ***It is imperative that HRSA take the corrective action that is clearly needed in order to ensure timely and accurate payment. We urge you to move quickly to update the HRSA website and guidance to ensure that all uninsured claims submitted by providers with either a COVID-19 or COVID-19 related diagnosis (based on national coding guidelines) be reimbursed under this program regardless of whether or not COVID-19 or COVID-19 related codes are in the primary diagnosis position. Absent this immediate clarification, HRSA should briefly delay claims submission and processing until the issues are corrected.***

HRSA Guidance is Inconsistent with National Coding Guidelines and CMS Guidance

FAH is deeply concerned that the current HRSA coding guidance on the website, the FAQs, and patient examples of claims eligible for payment provided during the educational webinars on April 29 and 30 misstate the appropriate diagnosis code by stating that reimbursement will only be made for testing and services "with a primary COVID-19 diagnosis." In response to provider concerns, HRSA updated its website on May 1 with a link to CMS Medicare Learning Network (MLN) Matters 11764 that references the related CR Transmittal R10058CP that identifies the population eligible for treatment coverage. More specifically, it notes that contractors should locate and initiate adjustments for claims with diagnosis codes B97.29 and U07.1 (***in any diagnosis field***) (Figure A). However, the language on the HRSA website related to "primary diagnosis" remains, which, in effect, nullifies whatever good intent HRSA may have had in posting the link to the MLN. Accordingly, the HRSA language must be modified to conform to the MLN article.

Figure A

	on or after January 27, 2020.							
11764.2	Medicare contractors shall locate and initiate adjustments of IPPS claims with the following criteria by June 1, 2020. • a diagnosis code B97.29 (in any diagnosis code field) and • a discharge date on or after January 27, 2020, through March 31, 2020.	X						
11764.3	Medicare contractors shall locate and initiate adjustments of IPPS claims with the following criteria by June 1, 2020: • a diagnosis code U07.1 (in any diagnosis code field) and • a discharge date on or after April 1, 2020, through the successful implementation of the Pricer.	X						

The CMS guidance draws upon national coding guidelines and we believe is consistent with Congressional intent. The issue of code position is critical for claims processing and compliance. For example, there are situations where ICD-10-CM code U07.1, COVID-19, would be in a secondary diagnosis code. For example, for a patient admitted with sepsis due to COVID-19, the Coding Guidelines stipulate that code U07.1, COVID-19 would be a secondary diagnosis and not the primary diagnosis. Another example is the COVID-19 diagnosis code of B97.29, which, per coding guidelines, should never be listed as the primary diagnosis. **HRSA's instructions, however, violate these national guidelines.** All claims representing testing or treatment for COVID-19, reported consistent with coding guidelines, should be eligible for coverage and paid accordingly.

We are also concerned with the proper placement of "Z-codes", or COVID-19 related diagnosis codes that correspond to the testing. While information on the HRSA website does not specify that the Z-codes must be in the primary location, UHS has informed providers of this requirement. However, this could make the claims that have the Z-code in a non-primary position for testing claims reject. National coding guidelines clearly permit the Z-code to be primary or in some cases a secondary diagnosis code.

The below example illustrates our concerns with the requirement that the Z-code be primary:

A patient presents to the Emergency Department with a cough and fever, and tests negative for COVID-19. In this example, national coding guidelines state that the codes for the cough and fever be listed first, followed by a code of Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases.* This is clearly a COVID-19 testing claim eligible for payment; however, based on current HRSA and UHS interpretation, the claim would reject.

The FAH supports the following recommendations consistent with CMS and national coding guidelines. Specifically, claims should be coded and paid in accordance with the following:

- For discharges of an individual diagnosed with COVID-19, **patients should be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes in any diagnosis field**:
    - B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or before March 31, 2020, based on the Supplement guidelines.
    - U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period, based on the updated guidelines for the new code.
- **For testing-related visits, including specimen collection, diagnostic and antibody testing, if the results are negative, inconclusive or not available at the time of testing, they would not be assigned a primary diagnosis of U07.1, COVID-19 diagnosis code. Instead, anyone of the following codes would be the correct diagnosis code:**
    - Z01.84, Encounter for antibody response examination
    - Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out
    - Z11.59, Encounter for screening for other viral diseases
    - Z20.828, Contact with and (suspected) exposure to other viral communicable diseases
    - Z86.19, Personal history of other infectious and parasitic diseases

The FAH urges HRSA to move quickly to implement these recommendations, make all claim edits transparent, and, if necessary, to briefly delay claims submission and processing until these issues are corrected. The FAH strongly supports funding for the testing and treatment for uninsured individuals. This program is critically important. We look forward to continued partnership with HHS and HRSA on these important issues. If you have any questions regarding our recommendations, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,