

Payments for COVID-19 Related Services Furnished to Uninsured Patients Under the Provider Relief Fund May 11, 2020

The following provides an overview of the Department of Health and Human Services (HHS) Claims Reimbursement for Testing and Treatment to Health Care Providers and Facilities Serving the Uninsured Program (the Program) and summarizes our analysis and interpretation of some key terms and conditions associated with the Program. The terms and conditions for the COVID-19 testing portion of the Program can be found [here](#), and the terms and conditions related to the COVID-19 treatment portion, [here](#). (We will collectively refer to these as the “Program terms”).¹

In general, while some of the terms appear ambiguous, we do not believe any of the Program terms are sufficiently concerning that health centers should be counseled not to enroll and ultimately participate in the Program especially given the current financial circumstances most health centers find themselves in.

I. Overview of Program

Program funds to cover COVID-19 treatment for the uninsured are one of various “targeted allocations” that HHS intends to make under the Provider Relief Fund, an appropriation of \$100 billion authorized in the Coronavirus Aid, Relief, and Economic Security (“CARES”) Act.² Program funds to reimburse COVID-19 testing for the uninsured are drawn in part from a \$1 billion appropriated to HHS for this purpose in the Families First Coronavirus Response Act.³

The Program is being administered by the HHS Health Resources and Services Administration (HRSA), which contractually delegated some responsibilities to UnitedHealth Group. On April 27, HRSA released informational guidance on the Program, a fact sheet entitled *COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured*, as well as an accompanying document, *Frequently Asked Questions for Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund*.

¹ The terms relating to treatment and those relating to testing are substantially similar. The reason there are two separate sets of terms and conditions appears to be that the appropriation for the testing portion is from the Families First legislation, and the appropriation for the treatment portion is from the CARES Act. The chief difference between the two sets of terms relates to the definition of “uninsured.” The Families First Coronavirus Response Act, Pub. L. 116-127 (Mar. 18, 2020), Title V (governing the testing portion of the funds) included a specific definition of the term “uninsured,” whereas the CARES Act provision creating the \$100 billion Provider Relief Fund (Pub. L. 116-136 (Mar. 27, 2020), Div. B, Title VIII) did not.

² CARES Act, Div. B, Title VIII. In the law, the fund is termed the Public Health and Social Services Emergency Fund.

³ Families First Coronavirus Response Act, Pub. L. 116-127 (Mar. 18, 2020), Title V.

Following are some basic features of the Program.

- a. Eligibility:** Providers are eligible to sign up for payment for COVID-related services to the uninsured under the Program if they “hav[e] conducted COVID-19 testing or provided treatment for uninsured individuals with COVID-19 on or after February 4, 2020.” Providers who are on the HHS list of excluded individuals/entities or have had their Medicare enrollment revoked by CMS are ineligible to receive funding. We do not see any indication that providers need to be already enrolled in Medicare in order to be eligible to receive the funding.
- b. Services:** The Program will pay for “qualifying testing for COVID-19.” This includes testing-related visits taking place in an office, urgent care or emergency room setting, or via telehealth, as well as specimen collection, diagnostic and antibody testing. As for COVID-19 related treatment, the Program will pay for the following, where COVID-19 is the primary diagnosis: office visits (including via telehealth); care and encounters in other settings (emergency room, inpatient, outpatient/observation, skilled nursing facility, longterm acute care (LTAC) facilities, home health, durable medical equipment (including ventilators and oxygen); emergency and non-emergency ground ambulance transportation; and, once they become available, FDA-approved drugs for COVID-19. The Program will not cover any services not typically covered by Medicare or any service (except certain services for pregnant women) where COVID-19 is not the primary diagnosis.
- c. Amount of Payment:** HHS states that providers will be “reimbursed generally at Medicare rates, subject to available funding.” HHS additionally states: “Reimbursement will be based on current year Medicare fee schedule rates except where otherwise noted.” As noted below, neither the informational materials nor the terms and conditions specify the type or amount of payment for federally qualified health centers (FQHCs) under the Program.
- d. Registering as a Program Provider:** As described by HRSA (COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured), steps required in order to receive payment will involve “enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit.” As to “checking patient eligibility,” providers must attest that they have confirmed that the patient is uninsured (i.e., the patient does not have individual or employer-sponsored insurance and “no other payer will reimburse [the provider] for COVID-19 testing and/or care for that patient”); and that they agree to accept Program reimbursement as payment in full and not to balance bill the patient.

- e. **Post-Claim Review and Audit:** Providers must agree to Program terms and conditions (see below for discussion of some key terms) and acknowledge that they may be subject to post-reimbursement audit review. Notably, HHS states that all claims submitted are final and “no interim bills or corrected claims will be accepted”; this is different from standard Medicare policies, where claims may be corrected after filing. All claims must be submitted electronically.
- f. **Effective date:** While the HHS documents do not clearly specify the effective date of the Program with respect to coverage for outpatient services, it appears to us that HHS intends to cover services rendered on or after February 4, 2020.
- g. **Timeline:** HHS allowed providers to begin enrolling in the program on Monday, April 27. HRSA and UnitedHealth Group began providing technical assistance on Wednesday, April 29. HHS states: “Providers can begin submitting claims on May 6 and can expect to begin receiving reimbursements by mid-May.”

II. Analysis of Key Terms and Conditions

Providers must accept numerous terms and conditions in order to participate in the Program. Some terms are required by the law, and others have been added independently by HHS.⁴ Prior to the submission of claims (which begins on May 6, 2020), health centers should carefully review the Program requirements, as well as all terms and conditions document, in evaluating potential participation in the Program. In particular, it is important for health centers to review the following terms as they may have implications operationally:

a. Relationship to Other Funding Sources

The fourth bullet point in each of the Program terms requires recipients of Program payments to certify (1) that they will not use the payments to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse; (2) that they will reimburse the Provider Relief fund if they subsequently receive payment that duplicates payments under the Fund; and (3) that they “will not include costs for which Payment [under the Program] was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which Payment was received.”

Under the fourth term, recipients must certify that they will forgo “uncompensated care reimbursement through federal or state programs for items or services for which Payment was received.” A subsequent term requires recipients to consider payment from the Program “to be payment in full for such care or treatment.”

⁴ CARES Act, Div. B, Title VIII.

Unlike some other providers, many health centers have received multiple sources of funding under the various COVID-19 legislative enactments, including the CARES Act, to support the provision of COVID-related services. As such, it is important for health centers to account separately for all funding spent to cover the direct and indirect costs of furnishing COVID-related services to ensure that the same costs are not claimed on more than one source of funding. Rather, the different funding and revenue streams should be spent so that they supplement one another. This is particularly important when considering that the costs associated with the provision of COVID-19 testing and treatment for uninsured individuals often go beyond the scope of clinical services and may include facility and technology costs (e.g., telehealth equipment; costs associated with temporary testing sites).

As noted above, the fourth bullet-point term also requires recipients of Program payments to attest that they “will not include costs for which Payment was received in cost reports.” Health centers typically report on Medicare/Medicaid cost reports all allowable costs (regardless of the patient’s coverage type) relating to types of services/activities that the relevant program covers. All activities relating to COVID-19 testing and treatment would be included on Medicare and (as applicable) Medicaid FQHC cost reports; however, only costs attributable to the relevant program are charged to that program, through an allocation mechanism such as visits. Notably, since the implementation of the Medicare FQHC prospective payment system (PPS), the Medicare cost report is the basis for payment for only for a limited number of clinical activities. We believe the reference to omission of costs on cost reports was probably simply inartful drafting, and not meant to impact health centers’ Medicare and Medicaid (if applicable) FQHC cost reporting obligations.

b. Method and Amount of FQHC Provider Payment Under Program

The eleventh Program term states: “The Secretary will reimburse the Recipient generally at 100 percent of Medicare rates (including any amounts that would have been due to the provider as patient cost sharing) for the items and services that Respondent provided to Uninsured Individuals for which the Recipient submits claims to the Relief Fund.”

Information disseminated by HRSA and United Health Care (to which HRSA has contractually delegated some Program functions) provides details on payment for certain specific provider types, but does not list FQHCs. Thus, at this time it is not clear whether FQHCs may enroll in the program as Facilities and may bill for covered services at the FQHC PPS rate (so long as the services/encounters have qualifying codes); or whether instead, FQHCs would be paid on a fee schedule for professional and laboratory services (similarly to physician groups enrolled under Medicare Part B).

Note that it is possible that in some cases, the FQHC PPS may not be the most beneficial method of Program payment. If the majority of the clinical activity that the Program would likely cover for a given health center (for example, testing not typically administered in the context of a core provider visit) is not encounter-eligible, then a fee schedule methodology may in fact yield greater payment. Thus it is possible that in the case of some health centers, the Part B Physician

Fee Schedule payment might in fact be more advantageous than PPS payment under this Program.

c. Financial Management and Record Retention Requirements

The ninth Program term requires recipients of Program payments to comply with various provisions of 45 C.F.R. Part 75, including financial management and record retention and access. These accountability provisions are similar to those included under the health centers' grant award. As noted above, given the multiple sources of funding provided to health centers under the various COVID-19 related legislative enactments, it is important for health centers to account for each funding source in accordance with its particular terms and conditions. Further, health center records regarding the Program should be clear about the distinction for purposes of health centers' annual audits under the Uniform Guidance, etc.

d. Undocumented Noncitizens

Some health centers have asked whether undocumented noncitizens can qualify as "uninsured individuals" whose COVID-19 testing and treatment can be paid for by the Program (see first bullet-point term). We do not see any express prohibition on submitting claims for undocumented noncitizens. However, as a practical matter, billing the Program for testing and treatment provided to this population could place those patients in vulnerable position given the information that must be reported for each claim. HRSA's operational guidance requires Program participants to check each patient's eligibility (i.e., their uninsured status) and to provide information on each patient to HHS, including date of birth and identification number (such as social security number, driver's license number, other state ID number). While health centers have the option of indicating no such number is available, it is unclear whether doing so could raise an unwelcome "red flag."

e. Prohibition on Billing Uninsured Individuals

The twelfth bullet-point term states: "The Recipient certifies that it will not engage in 'balance billing' or charge any type of cost sharing for any items or services provided to Uninsured Individuals receiving care or treatment for a positive diagnosis of COVID-19 for which the Recipient receives a Payment from the Relief Fund." This provision implies that health centers should not apply their schedule of charges and sliding fee discount schedule ("SFDS"), if applicable, to determine out-of-pocket payments due from uninsured individuals whose treatment and care are paid for under the Program. Rather, the Program should effectively be considered a third-party payor for purposes of the application of SFDS.

The Program terms, however, do not resolve the question of whether, for purposes of HRSA program requirements, a health center should consider the individuals whose treatment is paid under the Program to be, on the one hand, "insured" by the Program with no associated cost-sharing; or, on the other hand, uninsured, self-pay patients for whom the health center would have to waive fees for the health center to be eligible for the Program funding. If the former, the health center would submit claims, as it would to other payors, and not charge patients directly.

If the latter, the health center would be required to waive fees consistent with the current health center program requirements in the Health Center Program Compliance Manual (the “Manual”).

On May 6, 2020, HRSA published a Frequently Asked Question (“FAQ”) addressing the latter – the adjustment of the health center’s sliding fee discount program and/or billing and collection policies and procedures to ensure access to COVID-19 related services. HRSA indicates that, while health centers must continue to comply with the requirements of both the sliding fee discount program and billing and collection policies / procedures, the program requirements also provide discretion to:

“[A]mend policies (with board approval) and/or modify operating procedures in response to the COVID-19 public health emergency, as long as such changes are consistent with applicable statutory, regulatory, and policy requirements. This includes the flexibility to adjust policies and operating procedures for billing and collections and/or sliding fee discounts based on the unique circumstances of the health center and patient population served.”

The FAQ provides several examples of flexibilities afforded health centers, including: (1) eliminating or “sliding” charges to \$0 for patients earning annual incomes at or below 100% of the Federal Poverty Guidelines (“FPG”), consistent with Chapter 9 of the Manual; and (2) expanding the specific circumstances under which the health center can waive or reduce fees due to a patient’s inability to pay, which could be applied to any patients, including those patients earning annual incomes above 100% of the FPG, consistent with Chapter 16 of the Manual. A health center that plans to submit uninsured claims to the Program should review the full FAQ on the HRSA website (<https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions.html>) and revise its policies and procedures to reflect its specific approach for not charging/collecting out-of-pocket payments from uninsured, self-pay individuals whose testing/treatment services will be charged to the Program, consistent with the Health Center Program statutory, regulatory and programmatic requirements that address waiver of fees.

Relatedly, providers are also required to certify that they will timely return to uninsured individuals any fees collected from the individual for COVID-19 testing or treatment, if that care is billed to the Program. It is especially important for health centers to take this into account if they intend to submit claims to the Program for retroactive dates of service. If health centers did charge uninsured patients fees for services ultimately billed to the Program, then the fees must be refunded (or, if the fees were charged but not collected, the charge should be reversed in the system).

For additional information on the “Claims Reimbursement for Testing and Treatment to Health Care Providers and Facilities Serving the Uninsured Program” please see the attached HRSA COVID-19 Uninsured Program Q & A, based on questions that arose during the provider webcasts held on April 29, 2020 and April 30, 2020.

HRSA COVID-19 Uninsured Program

Questions and Answers from the April 29th and 30th Provider Webcasts

Eligible Providers

Which type of health care providers are eligible for reimbursement under this program? Are non-profits or Federally Qualified Health Centers (FQHCs) eligible?

Eligibility for reimbursement under this program is not based on profit/nonprofit status. Health care providers who have conducted COVID-19 testing of uninsured individuals or provided treatment to uninsured individuals with a COVID-19 diagnosis for dates of service or admittance on or after February 4, 2020 may be eligible for claims reimbursement through the program as long as the service(s) provided meet the coverage and billing requirements established as part of the program.

Are pharmacies/pharmacists that administer COVID-19 tests eligible providers for reimbursement under the program?

Pharmacies/pharmacists that are permitted under state law to bill for other testing services are eligible to request reimbursement for testing under this program.

Patient Eligibility

Do health care providers need to determine if an otherwise uninsured individual is Medicaid eligible?

Providers must verify and attest that to the best of the provider's knowledge, the patient does not have individual, employer-sponsored, Medicare or Medicaid coverage, and no other payer will reimburse them for COVID-19 testing and/or treatment for that patient. Providers may submit a claim for uninsured individuals before Medicaid eligibility determination is complete. However, if the individual is retroactively enrolled in Medicaid as of the date of service, the provider must return the payment to HRSA.

What type of unique identifiable identification information is required when submitting patient information?

Providers should submit the following patient information as part of the HRSA COVID-19 Uninsured Program:

- First and last name
- Date of birth
- Gender
- *SSN and state of residence; if not available, enter state identification / driver's license
- Date of service for professional, institutional outpatient services.
- Date of admission and date of discharge for institutional inpatient services.
- Address (optional)
- Middle initial (optional)
- Patient account number (optional)

* A SSN and state of residence, or state identification / driver's license is needed to verify patient eligibility. If a SSN and state of residence, or state identification / driver's license is not submitted, you will need to attest that you attempted to capture this information

before submitting a claim and the patient did not have this information at the time of service, or that you did not have direct contact with the patient and thus did not have an opportunity to attempt to capture this information. Claims submitted without a SSN and state of residence, or state identification/driver's license may take longer to verify for patient eligibility.

Who is considered to be an “uninsured individual” for purposes of providers requesting reimbursement for testing or treatment?

For claims for COVID-19 Testing and Testing-Related Items and Services, a patient is considered uninsured if the patient does not have coverage through an individual, or employer-sponsored plan, a federal healthcare program, or the Federal Employees Health Benefits Program at the time the services were rendered. For claims for treatment for positive cases of COVID-19, a patient is considered uninsured if the patient did not have any health care coverage at the time the services were rendered.

Eligible Claims and Coding

Are diagnostic testing and testing-related visits eligible for reimbursement if the result of the COVID-19 test is negative?

For the HRSA COVID-19 Uninsured Program, claims for diagnostic testing will be eligible for reimbursement if one of the following diagnoses codes is included in any position on the claim:

- Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)
- Z11.59 - Encounter for screening for other viral diseases (asymptomatic)
- Z20.828 - Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19)

Claims for diagnostic testing-related visits will be eligible for reimbursement if the place of service is an office visit, telehealth visit, urgent care or emergency room AND one of the following diagnoses codes is included in any position on the claim:

- Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)
- Z11.59 - Encounter for screening for other viral diseases (asymptomatic)
- Z20.828 - Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19)

While U0001, U0002, U0003, U0004, G2023, G2024 and 87635 are COVID-19 specific procedure codes, one of the Z codes above will need to be included on the claim to be eligible for reimbursement for testing as part of the HRSA COVID-19 Uninsured Program.

If a provider tests for COVID-19 as part of pre-operative or other medical treatment unrelated to COVID-19, is the test eligible for reimbursement?

For the HRSA COVID-19 Uninsured Program, the COVID-19 testing will be eligible for reimbursement if one of the following diagnoses codes is included in any position on the claim:

- Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)
- Z11.59 - Encounter for screening for other viral diseases (asymptomatic)
- Z20.828 - Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19)

Related treatment visits and services would not be eligible for reimbursement since the primary reason for treatment is not COVID-19.

If a patient is admitted to the hospital and a COVID-19 test is performed, the results of which are negative, is the test or any part of the inpatient claim eligible for reimbursement?

The testing-related visit (the admission) would not be eligible for reimbursement because the care setting is not an office visit, telehealth visit, urgent care or emergency room and is not separately billable with applicable CPT/HCPCS codes on the inpatient claim. Unless COVID-19 is the primary diagnosis for the admission, no portion of this claim would be eligible for reimbursement under the program since the primary reason for treatment is not COVID-19.

If a patient presents to the emergency department with cough and fever and then tested negative for COVID-19, would the test and the emergency room visit be eligible for reimbursement?

The test and visit would be eligible for reimbursement if it meets the criteria defined by the program.

For the HRSA COVID-19 Uninsured Program, claims for diagnostic testing will be eligible for reimbursement if one of the following diagnoses codes is included in any position on the claim:

- Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)
- Z11.59 - Encounter for screening for other viral diseases (asymptomatic)
- Z20.828 - Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19)

Claims for diagnostic testing-related visits will be eligible for reimbursement if the place of service is an office visit, telehealth visit, urgent care or emergency room AND one of the following diagnoses codes is included in any position on the claim:

- Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)
- Z11.59 - Encounter for screening for other viral diseases (asymptomatic)
- Z20.828 - Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19)

While U0001, U0002, U0003, U0004, G2023, G2024 and 87635 are COVID-19 specific procedure codes, one of the Z codes above will need to be included on the claim to be eligible for reimbursement for testing as part of the HRSA COVID-19 Uninsured Program.

If a patient is being treated for cancer and also tests positive for COVID-19, is the cancer treatment eligible for reimbursement?

No. Since the primary reason for treatment was for cancer and not COVID-19, the cancer treatment would not be eligible for reimbursement.

The Terms and Conditions for the Uninsured Treatment pool of funding indicate that providers can request claims for reimbursement for care or treatment related to positive diagnoses of COVID-19. To qualify as a positive diagnosis of COVID-19, does the primary diagnosis on a claim for treatment need to be B97.29 or U07.1?

For the HRSA COVID-19 Uninsured Program, eligible treatment claims are determined as follows:

- Treatment for services or discharges prior to April 1, 2020, will be eligible for reimbursement if the primary diagnosis is B97.29 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is B97.29.
- Treatment for services or discharges on or after April 1, 2020, will be eligible for reimbursement if the primary diagnosis is U07.1 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is U07.1.

If a patient is treated for sepsis and also tests positive for COVID-19, is the sepsis treatment eligible for reimbursement?

The ICD-10-CM Official Coding Guidelines – Supplement for Coding encounters related to COVID-19 Coronavirus Outbreak do not apply to the HRSA Uninsured COVID 19 program. For the HRSA COVID-19 Uninsured Program, eligible treatment claims are determined as follows:

- Treatment for services or discharges prior to April 1, 2020, will be eligible for reimbursement if the primary diagnosis is B97.29 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is B97.29.
- Treatment for services or discharges on or after April 1, 2020, will be eligible for reimbursement if the primary diagnosis is U07.1 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is U07.1.

HRSA is not providing coding guidance to providers. The program guidance is intended to define what services are eligible for reimbursement under the program.

Prior to the April 1, 2020, effective date for U07.1 COVID-19 diagnosis, the program guidelines indicate that treatment would be eligible for reimbursement if B97.29 is the primary diagnosis. Can B97.29 be used for a primary diagnosis?

For the HRSA COVID-19 Uninsured Program, the criteria for treatment to be eligible for reimbursement is as follows:

- Treatment for services or discharges prior to April 1, 2020, will be eligible for reimbursement if the primary diagnosis is B97.29 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is B97.29.
- Treatment for services or discharges on or after April 1, 2020, will be eligible for reimbursement if the primary diagnosis is U07.1 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is U07.1.

To address the usage of B97.29 as a primary diagnosis, we refer providers to recent guidance released by CMS: (see CR 11764 at: [cms.gov/files/document/mm11764.pdf](https://www.cms.gov/files/document/mm11764.pdf)). This guidance explicitly allows for B97.29 to be included in any position on the claim.

The goal of the program is to provide consistent eligibility for reimbursement of COVID-19 treatment before and after April 1, 2020, when the U07.1 diagnosis code became effective. Prior to the effective date of the U07.1 code we are relying on the B97.29 code to identify claims where COVID-19 is the primary reason for treatment.

HRSA is not providing coding guidance to providers. The program guidance is intended to define what services are eligible for reimbursement under the program.

Are ambulance providers and other emergency medical service providers eligible for reimbursement for treatment services? Will claims for presumptive diagnoses be eligible for reimbursement under this program?

For the HRSA COVID-19 Uninsured Program, eligible treatment claims are determined as follows:

- Treatment for services or discharges prior to April 1, 2020, will be eligible for reimbursement if the primary diagnosis is B97.29 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is B97.29.
- Treatment for services or discharges on or after April 1, 2020, will be eligible for reimbursement if the primary diagnosis is U07.1 OR if the primary diagnosis is pregnancy O98.5- and the secondary diagnosis is U07.1.

Program Administration

When I tried to enter my TIN in the program portal, I received a message that said the TIN already has a program administrator, and the person listed no longer works at my organization. How do I change the TIN administrator?

Multiple individuals in an organization can have an Optum ID, but only one person per TIN can serve as the administrator. If the portal indicates that the TIN you entered already has an administrator and you cannot identify that individual, please call 866-569-3522. We will work with your organization to identify the correct TIN administrator and reassign this role after appropriate security requirements are met.

What is the payer address for the clearinghouse?

COVID19 HRSA Uninsured Testing and Treatment Fund
UnitedHealth Group
Attention: CARES Act Provider Relief Fund
PO Box 31376, Salt Lake City, UT 84131-0376

See our **837 companion guide** for more details.

Are these claims subject to timely filing limits?

Yes, for the HRSA COVID-19 Uninsured Program, claims must be submitted within 365 calendar days from date of service or admittance, and are subject to available funding.

Reimbursement/Payment

If a provider already received payment from an uninsured individual, are they required to reimburse that individual after receiving payment from the program?

Yes. The program reimburses providers for COVID-19 testing or treatment of uninsured individuals; therefore, any money collected from the individual must be returned to the individual if the provider received funding for that patient through this program. This requirement is included in the Terms and Conditions that the provider signs in order to enroll in the program.

Given the Uninsured program is paid generally at Medicare rates, will reimbursement include the 20% add-on to the Medicare diagnosis related group (DRG) payment for COVID-19 treatment?

No. For the HRSA COVID-19 Uninsured Program, facility reimbursement based on IPPS will not include the 20% increase to the DRG weight for COVID-19 diagnoses U07.1 and B97.29 authorized by Section 3710 of the CARES Act.

If a temporary member ID is valid for 30 days, can providers still submit a claim after the 30-day period is over?

For professional and institutional outpatient – Temporary member ID will be valid for 30 days from date of service. Eligible claims can be submitted using the temporary member ID with date of service within the validity period. For example, if Patient A had a date of service of February 4, 2020, then the temporary ID assigned to her will be valid from February 4, 2020, through March 4, 2020.

For institutional inpatient – Temporary member ID will be valid from date of admission and expire 30 days from date of discharge. Eligible claims can be submitted using the temporary member ID with date of admission and date of discharge within the validity period. For example, if Patient B had a date of admission of February 4, 2020, and date of discharge of February 20, 2020, then the temporary member ID assigned to him will be valid from February 4, 2020, through March 20, 2020.

Note: If an uninsured individual was treated in the ER before being admitted as an inpatient, use the date of admittance to the ER as the inpatient admittance date.

Claims can still be submitted after the date of validity, but the temporary member ID must be eligible for the date of service or admittance.

When I submit a claim as part of the HRSA COVID-19 Uninsured Program, will I receive an 835 file through my clearinghouse to help me review the amount paid on each submitted claim? If not, where should I go to receive the associated claims payment information?

You will be able to download an 835 file, as well as download the Electronic Provider Remittance Advice (PDF version of the 835 file) for the HRSA COVID-19 Uninsured Program, by accessing **Optum Pay™** with your Optum ID. On the Optum Pay website you can access your remittance information on the View Payments tab. You can find that tab by following this path:

- Log in to **Optum Pay**.
- Select the Tax Identification Number (TIN) associated with the claims you are looking to reconcile.
- Select View Payments.

You will need to be able to access the 835 file in order to upload it into your practice management system. This will allow you to reconcile your claims as you would if you had received the 835 file via your clearinghouse. Please allow for appropriate processing time. As part of the HRSA COVID-19 Uninsured Program, the 835 file will not be electronically routed to you from your clearinghouse.

