CALIFORNIA WILDFIRES PUBLIC HEALTH EMERGENCY

Noridian Frequently Asked Questions (FAQ) for Medicare Part A and B

(Answers provided with information available as of January 20, 2025, unless otherwise noted)

CMS Current emergencies

2025 Southern California Wildfire Waivers

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Last Updated 1/20/2025

Accelerated and Advance Payments

1. **Will providers affected by California wildfires be able to request advance payments?**
   a. Providers financially impacted by the California wildfires may request an Accelerated and Advance Payment (AAP).

- To request an AAP, complete the regular AAP form on our Forms page.
- Requests must include reason for the AAP.
  - Example "unable to submit claims due to California wildfires."
- Providers must meet the below requirements:
  - Has billed claims during 180 days prior to the natural disaster.
  - Does not have any outstanding accelerated and advance payments pending for more than 90 days.
  - Not under a fraud investigation.
  - Has not filed for bankruptcy.
- Approved payments will be issued 5-10 days from request date.
- Payment will be based on equation that uses 90-days of previous claims and current pending claims.
  - Providers will receive approximately 50 percent of what would normally be paid in a 90-day period.
- Once payment is received, recoupments will start offsetting immediately from remits at 100 percent.
  - If AAP is not fully paid after 90-days of receiving the AAP, a recoupment letter goes out.
    - Once a Recoupment letter goes out, interest starts to accrue from date the letter was issued and for each 30-day period.

Ambulance Transports

1. **Our ambulance assisted to move patients to a safe location, how should these transports be billed?**
   a. Medicare Administrative Contractors (MACs) may make payment for ambulance transports for evacuating patients from locations affected by an emergency and disaster. Append the appropriate modifiers for origin and destination locations. The regulatory requirements must be met for such ambulance transports to be covered, such as:

- Vehicle must meet certain requirements
- Crew must be certified
- Ambulance services must be medically necessary
- Transport must be from an eligible origin and to an eligible destination
- Certain billing and reporting requirements must be met, and

- Medicare Part A payment is not made directly or indirectly for the services

Appeals

1. **Will time limit extensions be allowed to file an appeal?**
   a. MACs that process appeals for beneficiaries, providers, and suppliers affected by the wildfires in the state of California shall exercise good cause in accordance with the regulations and follow the guidance in CMS Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 29, Section 240.4, Good Cause - Administrative Relief Following a Disaster.

Billing Code Related to Disaster

1. **Will DR condition code be required on institutional based claim (UB-04)?**
   a. Yes. DR condition code (disaster related) will be required to identify claim that are impacted by specific Medicare policies and related to a regional disaster. Use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned on the presence of a formal waiver.
2. **Will modifier CR be required on professional claims billed on CMS-1500?**
   a. Yes. Modifier CR (catastrophe or disaster related) is required on Part B claims. Use of the CR modifier will be mandatory for applicable codes on any claim for which Medicare Part B payment is conditioned on the presence of a formal waiver.
3. A formal waiver is a waiver of a program requirement that otherwise would apply by statute or regulation. Under the California PHE, a temporary waiver or modification of a requirement under the authority described in § 1135 of the Social Security Act.

Change Request 6451

Cost Report Due Dates

1. **How will I report loss on my cost report?**
   a. In accordance with 42 CFR 413.24(f)(2)(ii) no extensions will be granted except when provider's operations are significantly adversely affected due to extraordinary circumstances over which provider has no control. Example: Flood or fire that forces a provider to cease operations and to transfer its patients temporarily to other providers outside of impacted area. Intermediary is still required to obtain CMS approval.

   Providers can complete the Cost Report Extension request form on our website (Noridian Medicare website > Audit and Reimbursement > Audit and Reimbursement Forms > Cost Report Extension Form) and email it to costreportextenstion@noridian.com.

Enrollment – Facility Changes

1. **Can address changes be submitted on letterhead or by telephone?**

a. No. The CMS-855 application will need to be completed in either PECOS or by mail. A change in practice location must be completed within 30 days.

Regular Mail	Certified Mail
Noridian JE Part B Attn: Enrollment PO Box 6775 Fargo, ND 58108-6775	Noridian JE Part B Attn: Enrollment 4510 13th Ave S Fargo, ND 58103

2. **What should providers do that have closed due to loss of the facility from the fire?**
   a. Contact Provider Enrollment as all address changes need to be submitted on the CMS-855 enrollment forms.

Lost Documents

1. **Can services be billed when the documentation has been destroyed?**
   a. Instructions for how to handle situations where documentation to support payment has been lost or destroyed can be found in CMS IOM Publication, 100-08, Program Integrity Manual, Chapter 3, Section 3.8 entitled "Administrative Relief from MR During a Disaster".

   Contractors may consider payment for another drawing fee, specimen transport, or test if the results have not been communicated to the patient's physician when laboratory specimens are destroyed or compromised by a disruptive event.

Medical Reviews

1. **How should responses to record requests be handled when records have been lost?**
   a. Medical Review will release any pending record requests and will not request additional documentation from providers in affected areas for 30 days.

Recoupments or Extended Repayment Schedule (ERS)

1. **Can repayment schedules or recoupments be paused or postponed?**
   a. CMS cannot waive interest on debts arising from a Medicare overpayment or debt under separate authorities, nor is CMS permitted to defer or extend payments due under an extended repayment schedule.

   Providers and suppliers experiencing financial hardship are encouraged to contact their MAC if they're experiencing a temporary disruption in claims payments or billing.

   ERS schedules may be requested, or reviewed to restructure payments, so long as the payment schedule does not extend past the maximum of 60 months of payments. Providers may email requests to JE-ERS@noridian.com and include:

- Request pertains to the California Wildfire PHE
- If applicable, provider's current ERS approval, or loan number
  - If approval or loan number is unavailable, include NPI, PTAN, and TIN instead

Skilled Nursing Facility (SNF)

1. **How should locations bill claims that are serving as an evacuation center for SNF and nursing home patients impacted by the fires? Will swing bed apply?**

   a. Temporary emergency coverage of SNF services level of care criteria as set forth in 42 CFR 409.31. Under section 1135(b)(1) of the Act, CMS is waiving the eligibility requirements at 42 CFR 482.58(a)(1)-(4), "Special Requirements for hospital providers of long-term care services ('swing-beds')" to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF. Hospitals may need to update their enrollment to include SNF or swing bed services.

   To qualify for this waiver, hospitals must:

   - Not use SNF swing beds for acute-level care.
   - Comply with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
   - Be consistent with the state's emergency preparedness or pandemic plan.

   These temporary emergency policies will apply to the timeframes specified in the waiver issued under §1135 of the SSA.

   Use Occurrence Span Code (OSC) 75 to indicate the From and Through dates for a period of SNF level of care during an inpatient hospital stay only when SNF bed is not available.

2. **Will the three-day prior hospitalization be waived for beneficiaries in affected areas?**

   a. Using the statutory flexibility under Section 1812(f) of the Social Security Act, CMS temporarily waived the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay. This waiver provides temporary emergency coverage of SNF care without a three-day inpatient hospital stay for beneficiaries who experience dislocations or are otherwise affected by the emergency, such as those who are:

      1. Evacuated from a nursing home in the emergency area,
      2. Discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients, or
      3. Need SNF care as a result of the emergency, regardless of whether that individual was in a hospital or nursing home prior to the emergency.

   b. In addition, we will recognize special circumstances for certain beneficiaries who have either begun or are ready to begin the process of ending their spell of illness after utilizing all their available SNF benefit days. A one-time renewal of coverage for extended care services which will not first require starting a new spell of illness for such beneficiaries, who can

then receive up to an additional 100 days of SNF Part A coverage as a result of the waiver. Consistent with the above finding, this waiver does not apply to those cases where coverage restrictions would have had the effect of prolonging the current benefit period and precluding benefit renewal even under normal circumstances (such as a SNF resident's ongoing receipt of skilled care that is unrelated to the emergency); rather, it will include only those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have otherwise occurred.

3. **Will the rural designation used for Home Health (HH) acute wage index also apply to SNF wage index? Lately, we are trying to get an 1135 waiver for at least 12 months because some SNF facilities have burned down, and we don't expect them to rebuild sooner.**
    a. We have not received guidance from CMS on wage index changes.
4. **Do hospitals need to complete the SNF Minimum Data Set (MDS) assessments?**
    a. CMS is not waiving the requirements for facilities to conduct the assessment and collect MDS data at 42 CFR 483.20(b)(1). CMS is modifying the requirements at 42 CFR §483.20(b)(2) to provide relief to SNFs on the timeframes in which they must conduct a comprehensive assessment and collect MDS data.
5. **Do swing bed patients require an assessment?**
    a. Yes, swing beds do require an assessment. Medicare pays for swing bed services in hospitals using the Patient Driven Payment Model (PDMP) under the SNF Prospective Payment System (PPS).

Special Loans or Payments Available

There are no special loans or payments available. See Accelerated and Advance Payments section.

Telehealth – Extended Through March 31, 2025

All telehealth flexibilities applicable in 2024 have been extended through March 2025.

1. **Will telehealth be allowed from providers in other states to treat patients in California?**
    a. The Health and Human Services (HHS) Secretary has authorized 1135 waivers, CMS may waive, on an individual basis, the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which they are practicing. However, the 1135 waiver is not available unless all the following four conditions are met for the physician or non-physician practitioner:
        1. Must be enrolled as such in the Medicare program; and
        2. Must possess a valid license to practice in the State which relates to their Medicare enrollment; and
        3. Has traveled to the State in which the emergency is occurring to contribute to relief efforts in his or her professional capacity; and

4. Is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area. In particular circumstances, CMS may require that additional conditions apply. (Note, provider must be enrolled and bill based on where they render the service)

Timely Filing

1. **Will timely filing for claims to be submitted be extended?**
   a. CMS believes providers or suppliers affected by an emergency or disaster would be able to meet the timely filing requirement window to submit claims within one calendar year after the date of service. If an emergency were to cause difficulties in filing claims electronically, providers may request an exception due to unusual circumstances as defined in in CMS IOM Publication, 100-04, Medicare Claims Processing Manual, Chapter 24, Section 90.3.

Additional Resources

- Emergency-Related Policies and Procedures That May Be Implemented Without § 1135 Waivers
- Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only With a § 1135 Waiver