

Medicare Skilled Coverage Eligibility During COVID-19 At-a-Glance & FAQs – *DRAFT April 5, 2020*

Medicare Part A Skilled Coverage Eligibility Summary – NEW ADMISSIONS			
Column A	Column B	Column C	Column D
COVID-19 Test Positive With Symptoms	COVID-91 Test Positive Without Symptoms	COVID-19 Test Results Pending or Untested With Symptoms	COVID -19 Test Negative, Results Pending, or Untested Without Symptoms (a.k.a. traditional admission)
<p>Likely Part A covered under longstanding BPM Chapter 8 skilled care requirements.</p> <p>Will also be subject to CDC/CMS Isolation Guidance for New Admissions and AHCA Guidance for New Admissions that includes skilled nursing observation and assessment requirements which could also qualify for coverage.</p> <p>Further coverage beyond symptom resolution and isolation period dependent on longstanding BPM Chapter 8 skilled care requirements.</p> <p><i>* Documentation requirements for skilled care must be met.</i></p>	<p>Likely Part A covered at a minimum under BPM Chapter 8 skilled care requirements as patient will be subject to CDC/CMS Isolation Guidance for New Admissions and AHCA Guidance for New Admissions that includes skilled nursing observation and assessment requirements at least until the end of the 14-day period identified.</p> <p>Potentially Part A covered under longstanding BPM Chapter 8 skilled care requirements.</p> <p>Further coverage beyond isolation period dependent on longstanding BPM Chapter 8 skilled nursing requirements</p> <p><i>* Documentation requirements for skilled care must be met.</i></p>	<p>Potentially Part A covered under longstanding BPM Chapter 8 skilled care requirements.</p> <p>Likely Part A covered at a minimum under BPM Chapter 8 skilled care requirements as patient is subject to CDC/CMS Isolation Guidance for New Admissions and AHCA Guidance for New Admissions skilled nursing observation and assessment requirements at least until the end of the 14-day period identified, or if symptoms appear or test is positive.</p> <p>Further coverage beyond symptom resolution and isolation period dependent on longstanding BPM Chapter 8 skilled nursing requirements</p> <p><i>* Documentation requirements for skilled care must be met.</i></p>	<p>Likely Part A covered if meeting longstanding BPM Chapter 8 skilled care requirements.</p> <p>Potentially Part A covered at a minimum under BPM Chapter 8 as patient is subject to CDC/CMS Isolation Guidance for New Admissions and AHCA Guidance for New Admissions skilled nursing observation and assessment requirements at least until the end of the 14-day period identified, or if symptoms appear or test is positive.</p> <p><i>* Documentation requirements for skilled care must be met.</i></p>
<p>CDC/CMS Isolation Guidance for New Admissions <i>“Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room).”</i></p>			

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AHCA Guidance for New Admissions

“Based on this [CDC] data, unless a person is tested for COVID-19 and negative before admitting them to your building, you should assume the person has COVID-19 regardless of their having or not having symptoms.”

Medicare Benefit Policy Manual (BPM) Chapter 8, Section 30 – SNF Skilled Level of Care

- The patient requires skilled nursing services or skilled rehabilitation services (§30.2-30.4)
- The patient requires these skilled services on a daily basis (nursing 7d/w, and/or therapy 5-7d/w) (§30.6)
- As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF (§30.7)
- The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury
- At a minimum, the following skilled nursing services furnished during CDC/CMS 14-day isolation guidance can likely be justified due to a “reasonable probability” of COVID-19 symptom appearance or exacerbation based on *CDC Morbidity and Mortality Weekly Reports*:
 - Management and Evaluation of a Patient Care Plan (§30.2.3.1)
 - Observation and Assessment of Patient’s Condition (§30.2.3.2)
 - Teaching and Training Activities (§30.2.3.3)
 - Detailed CDC guidance on steps to *Evaluate and Manage Residents with Symptoms of Respiratory Infection* in SNF under COVID-19 which could be included in supporting documentation can be found [here](#).

Based on the CMS written guidance and verbal feedback to AHCA from CMS, the [§1135 waivers](#) appear to serve the following purposes:

1. That hospital beds were freed up as easily as possible to open available beds for the surge of active COVID-19 cases if the patient was medically stable and required a SNF level of care but had not reached the 3-day stay requirement,
2. That hospital emergency rooms and beds were not filled with emergent conditions from the community (increasing COVID-19 transmission risk) that could be otherwise managed with a SNF level of care if there were no 3-day stay requirement, and
3. That SNF residents with emergent conditions that require a new or change in skilled level of care needs and that could be otherwise managed in the SNF could receive that care under Part A in the SNF without enduring the risk COVID-19 exposure during an emergency room visit or hospital stay.

CMS has not limited the waiver to types of admissions. Therefore, SNFs may be admitted from if they meet purposes 1-3 above:

- a. Hospitals with less than three days;
- b. Hospitals with only observation stay days;
- c. Emergency Rooms;
- d. Other SNFs
- e. Direct from Community;
- f. Direct from Community where they were receiving home health or outpatient services; and
- g. Long-Stay patients current in residence with a change in status that now requires a skilled level of care may be “skilled-in-place” without a hospital admission (see *Medicare Part A Skilled Coverage Eligibility Summary – CURRENT NURSING FACILITY LONG STAY RESIDENTS table on next page*).

See AHCA 3-Day Waiver and Spell of Illness [FAQs](#) for additional information.

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Medicare Part A Skilled Coverage Eligibility Summary – CURRENT NURSING FACILITY LONG STAY RESIDENTS			
Column E	Column F	Column G	Column H
Develops Need for Skilled Care & Last Skilled Benefit Period > 60 Days Prior	Develops Need for Skilled Care & Last Skilled Benefit Period < = 60 Days Prior	Exhausted 100 Day SNF Benefit, Continues to Receive Ongoing Skilled Care, & Has Change in Status Requiring Different Skilled Services	Exhausted 100 Day SNF Benefit, Continues to Receive Ongoing Skilled Care, or Intermittent Part B PT/OT/SLP & is Otherwise Stable
<p>Likely Part A covered under longstanding BPM Chapter 8 skilled nursing requirements and applying §1135 3-day inpatient stay waiver <u>if the new skilled services would likely prevent the need for emergency room or hospital inpatient care.</u></p> <p><i>* Documentation requirements for skilled care must be met.</i></p> <p>**This includes long stay residents that become COVID-19 positive with symptoms (see column A), without symptoms (see column B), or are symptomatic and are presumed positive (see column C), all who will require at least skilled nursing observation and assessment for 14 days per CDC/CMS Isolation Guidance for New Admissions</p> <p>Rationale: Skilling in place addresses emerging skilled care need without tying up hospital resources or exposing patient unnecessarily to COVID-19 virus)</p>	<p>Likely Part A covered under longstanding BPM Chapter 8 skilled nursing requirements and applying §1135 3-day inpatient stay and benefit period waiver <u>if the new skilled services would likely prevent the need for emergency room or hospital inpatient care.</u></p> <p><i>* Documentation requirements for skilled care must be met.</i></p> <p>**This includes long stay residents that become COVID-19 positive with symptoms (see column A), without symptoms (see column B), or are symptomatic and are presumed positive (see column C), all who will require at least skilled nursing observation and assessment for 14 days per CDC/CMS Isolation Guidance for New Admissions</p> <p>Rationale: Skilling in place addresses emerging skilled care need without tying up hospital resources or exposing patient unnecessarily to COVID-19 virus)</p>	<p>Potentially Part A covered under longstanding BPM Chapter 8 skilled nursing requirements and applying §1135 3-day inpatient stay waiver and benefit period waiver <u>if the new skilled services would likely prevent the need for emergency room or hospital inpatient care.</u></p> <p><i>* Documentation requirements for skilled care must be met.</i></p> <p>**This includes long stay residents that become COVID-19 positive with symptoms (see column A), without symptoms (see column B), or are symptomatic and are presumed positive (see column C), all who will require at least skilled nursing observation and assessment for 14 days per CDC/CMS Isolation Guidance for New Admissions</p> <p>Rationale: Skilling in place addresses emerging skilled care need without tying up hospital resources or exposing patient unnecessarily to COVID-19 virus)</p>	<p>Likely not Part A covered.</p> <p>Rationale: A stable condition would not likely result in a need for any emergency room or hospital inpatient care.</p> <p>Examples: Resident A is a long stay resident on persistent ventilator since exhausting Part A benefits and is medically stable otherwise. Resident B is a long stay resident receiving daily skilled nursing wound care since exhausting Part A benefits and is medically stable otherwise. Resident C is a long stay resident receiving periodic Part B therapy services since exhausting Part A benefits and is medically stable otherwise. In this case, the services are not being furnished on a daily basis. If a new need for daily skilled therapy arises, see if Column or G applies.</p>

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Based on the CMS written guidance and verbal feedback to AHCA from CMS, the [§1135 waivers](#) appear to serve the following purposes:

1. That hospital beds were freed up as easily as possible to open available beds for the surge of active COVID-19 cases if the patient was medically stable and required a SNF level of care but had not reached the 3-day stay requirement,
2. That hospital emergency rooms and beds were not filled with emergent conditions from the community (increasing COVID-19 transmission risk) that could be otherwise managed with a SNF level of care if there were no 3-day stay requirement, and
3. That SNF residents with emergent conditions that require a new or change in skilled level of care needs and that could be otherwise managed in the SNF could receive that care under Part A in the SNF without enduring the risk COVID-19 exposure during an emergency room visit or hospital stay.

See AHCA 3-Day Waiver and Spell of Illness [FAQs](#) for additional information.

[COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#)

3-Day Prior Hospitalization. Using the authority under Section 1812(f) of the Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for 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 occurred under normal circumstances)

[Medicare Benefit Policy Manual \(BPM\) Chapter 8, Section 30 – SNF Skilled Level of Care](#)

- The patient requires skilled nursing services or skilled rehabilitation services (§30.2-30.4)
- The patient requires these skilled services on a daily basis (nursing 7d/w, and/or therapy 5-7d/w) (§30.6)
- As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF (§30.7)
- The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury
- At a minimum, the following skilled nursing services furnished during CDC/CMS 14-day isolation guidance can likely be justified due to a “*reasonable probability*” of COVID-19 symptom appearance or exacerbation based on *CDC Morbidity and Mortality Weekly Reports*”:
 - Management and Evaluation of a Patient Care Plan (§30.2.3.1)
 - Observation and Assessment of Patient’s Condition (§30.2.3.2)
 - Teaching and Training Activities (§30.2.3.3)
 - Detailed CDC guidance on steps to *Evaluate and Manage Residents with Symptoms of Respiratory Infection* in SNF under COVID-19 which could be included in supporting documentation can be found [here](#).

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Frequently Asked Questions (FAQs)

Coverage Eligibility – Admissions from Outside of SNF

Q1. Can a SNF provider skill a COVID-19 positive resident under Medicare Part A on admission?

A1. Likely Yes. As reflected in the At-a-Glance chart above,

- **Symptomatic patients** (see column A of the At-a-Glance chart above) will likely already qualify for coverage under longstanding SNF coverage policy due to the complexity of the medically necessary nursing care (i.e. isolation, pulmonary treatments, etc.).
- **Asymptomatic patients** (see column B of the At-a-Glance chart above) will likely be covered at a minimum under BPM Chapter 8 Skilled Nursing observation and assessment requirements, at least until the end of the CDC/CMS isolation guidance period.

As long as the resident being admitted 1) requires skilled nursing services or skilled rehabilitation services, 2) requires these skilled services on a daily basis, 3) as a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF, and 4) the services delivered are reasonable and necessary for the treatment of a patient's illness or injury. See the Medicare Benefit Policy Manual, [Chapter 8](#), Section 30 for coverage details.

Q2. Can a SNF provider skill a patient who has symptoms of COVID-19, and that we have tested, even though we don't have test results back yet?

A2. Likely Yes. As reflected in Column C of the At-a-Glance chart above, symptomatic patients may possibly already qualify for coverage under longstanding SNF coverage policy due to the complexity of the medically necessary nursing care (i.e. isolation, pulmonary treatments, etc.).

As long as the resident being admitted 1) requires skilled nursing services or skilled rehabilitation services, 2) requires these skilled services on a daily basis, 3) as a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF, and 4) the services delivered are reasonable and necessary for the treatment of a patient's illness or injury. See the Medicare Benefit Policy Manual, [Chapter 8](#), Section 30 for coverage details.

Q3. Can a SNF provider skill a patient who is asymptomatic and has tested negative for COVID-19, has results pending, or is untested?

A3. Likely Yes. In most cases such a situation Column D of the At-a-Glance chart above would reflect a "traditional SNF Part A admission" in that the resident being admitted 1) requires skilled nursing services or skilled rehabilitation services, 2) requires these skilled services on a daily basis, 3) as a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF, and 4) the services delivered are reasonable and necessary for the treatment of a patient's illness or injury. See the Medicare Benefit Policy Manual, [Chapter 8](#), Section 30 for coverage details.

In addition, such patients may also be subject to CDC/CMS and AHCA isolation guidance for new admissions skilled eligibility and may be receiving skilled observation and assessment services during the 14-day period identified.

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Q4. Can a SNF admit a hospital inpatient for any condition without completing a 3-day qualifying stay?

A4. Likely Yes. During the COVID-19 public health emergency, SNF providers can apply the §1135 3-day stay waiver to admit a beneficiary from a hospital for covered Part A care with only 1-2 inpatient days if he/she requires a SNF level of care. The §1135 spell of illness waiver may also apply if the beneficiary has not completed a 60-day break. This is intended to free up the hospital bed capacity to treat COVID-19 patients.

Q5. Can a SNF admit a patient directly from an emergency room or an observation stay for any condition without completing a 3-day qualifying stay?

A5. Likely Yes. During the COVID-19 public health emergency, SNF providers can apply the §1135 3-day stay waiver to admit a beneficiary directly from an emergency room or observation stay for covered Part A care if he/she requires a SNF level of care. The §1135 spell of illness waiver may also apply if the beneficiary has not completed a 60-day break. This is intended to free up the hospital bed capacity to treat COVID-19 patients.

Q6. Can a SNF admit a patient directly from the community for any condition without completing a 3-day qualifying stay?

A6. Likely Yes. During the COVID-19 public health emergency, SNF providers can apply the §1135 3-day stay waiver to admit a beneficiary directly from community if he/she requires a SNF level of care. The §1135 spell of illness waiver may also apply if the beneficiary has not completed a 60-day break. This is intended to free up the hospital bed capacity to treat COVID-19 patients.

Q7. Can a SNF admit a patient directly from another SNF for any condition if they have exhausted their 100-day benefit, have not completed a 60-day break in spell of illness, but require a skilled level of care?

A7. Likely Yes. During the COVID-19 public health emergency, SNF providers can apply the §1135 3-day stay and spell of illness waivers to admit a beneficiary directly from another SNF for covered Part A care with a new 100-day benefit period if he/she requires a SNF level of care, even if the beneficiary has exhausted their 100 day benefit and has not completed a 60 day break in spell of illness. This is intended for residents dislocated due to COVID-19. For example, if a COVID-19 negative resident with skilled needs is moved in to another SNF due to efforts to cohort COVID-19 positive patients into a dedicated SNF.

Coverage Eligibility – “Skill-In-Place” in SNF

Q8. Can a SNF provider “skill-in-place” a long stay resident without skilled needs that develops a need for skilled care?

- A8. Likely Yes.** As reflected in the At-a-Glance chart above,
- **If the Last Beneficiary Skilled Benefit Period > 60 Days Prior** (see column E of the At-a-Glance chart above) would likely qualify for coverage under longstanding BPM Chapter 8 skilled nursing requirements by applying §1135 3-day inpatient stay waiver if starting skilled services would likely prevent the need for emergency room or hospital inpatient care.
 - **If the Last Beneficiary Skilled Benefit Period ≤ 60 Days Prior** (see column F of the At-a-Glance chart above) would likely qualify for coverage under longstanding BPM Chapter 8 skilled nursing requirements

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by applying §1135 3-day inpatient stay waiver and benefit period waiver if starting skilled service would likely prevent the need for emergency room or hospital inpatient care.

Both scenarios above include long stay residents that become COVID-19 positive with symptoms (see column A), without symptoms (see column B), or are symptomatic and are presumed positive (see column C). In these cases, all will likely require at least skilled nursing observation and assessment for 14 days per CDC/CMS Isolation Guidance for New Admissions

Q9. Can a SNF provider “skill-in-place” a long stay resident Exhausted 100 Day SNF Benefit and Continues to Receive Ongoing Skilled Care

A9. Potentially Yes. As reflected in the At-a-Glance chart above,

- **If the Beneficiary Exhausted the 100 Day SNF Benefit, Continues to Receive Ongoing Skilled Care, & Has Change in Status Requiring Different Skilled Services** he/she would potentially qualify for coverage under longstanding BPM Chapter 8 skilled nursing requirements and applying §1135 3-day inpatient stay waiver and benefit period waiver if the new skilled services would likely prevent the need for emergency room or hospital inpatient care.
- **If the Beneficiary Exhausted the 100 Day SNF Benefit, Continues to Receive Ongoing Skilled Care or Intermittent PT/OT/SLP under Part B & is Otherwise Stable** he/she would unlikely be covered for Part A under the §1135 3-day inpatient stay waiver and benefit period waiver because a stable condition would not likely result in a need for any emergency room or hospital inpatient care.

Q10. Can a beneficiary who has 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 occurred under normal circumstances have their benefit period renewed to complete the care?

A10. It appears that this is possible in limited circumstances. Here are two potentially feasible examples:

- Example 1 - A SNF resident was at day 90 of the Medicare stay and was placed on COVID-19 isolation for a 14-day period before being cleared to be discharged home on day 105 of the SNF stay. It appears that the §1135 waiver may possibly cover days 101-104.
- Example 2 - A beneficiary was admitted to a SNF for skilled rehabilitation and on day 70 was placed on COVID-19 isolation for a 14-day period before being cleared to resume skilled rehabilitation services. Due to the interruption, the skilled rehabilitation was not completed until day 110 of the stay and the beneficiary was discharged to home on day 111. It appears that the §1135 waiver may possibly cover days 101-110.

It appears unlikely that the §1135 spell of illness waiver would apply to residents needing skilled care beyond 100 days (i.e. ventilator or wound care) that did not have their benefit period skilled services needs disrupted by COVID-19.

Claims Processing

Q11. How does a SNF indicate on a claim that it is related to a COVID-19 §1135 waiver?

A11. Providers use the “DR” (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450

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Q12. Which ICD-10-CM diagnosis code should providers use related to COVID-19?

A12. The CDC Interim ICD-10-CMS Coding Guidance relate to the COVID-19 outbreak

- For dates 2/20/2020-3/31/2020 can be found [here](#).
- For dates 4/1/2020-9/30/2020 can be found [here](#).

MDS Assessments

Q13. Which MDS assessment type do I use to start a SNF PPS Part A stay when applying a §1135 COVID-19 waiver?

Q13. It appears that the SNF PPS 5-day assessment would be the only assessment type available to use for the 3-day stay waiver and the break in spell of illness waiver that would restart the 100-day benefit period.

Q14. Is there a COVID-19 ICD-10-CM code that can be used on the MDS in item I0020B (primary reason for SNF stay) that will map to a PDPM condition group?

A14. The SNF PPS PDPM payment model policy requires that providers should use the most appropriate ICD-10-CM code to describe the reason for the SNF stay in MDS item field I0020B. *See Q12 above for detailed CDC coding guidance related to COVID-19.*

Providers have reported concern that if the primary reason for SNF stay is due to the COVID-19 virus, the initial ICD-10-CM diagnosis codes identified by the CDC as appropriate to code for COVID-19 were not compatible with the Medicare Part A SNF PPS PDPM payment model. Specifically, none of the initial 2/20/2020-3/31/2020 CDC identified codes could be used to represent the Primary Reason for SNF Stay on the MDS assessment Item I0020B.

On March 31, CMS posted an updated [FY 2020 PDPM ICD-10 Mappings file \(.zip\)](#) which adds the ICD-10-CMS code **'U07.1 - 2019-nCoV acute respiratory disease'** as an appropriate code to enter in the MDS I0020B Primary reason for SNF stay item field. **This new code U07.1 is ONLY in effect for assessments with target date April 1, 2020 and later.** Note: Per the CDC 4/1/2020-9/30/2020 coding guidance, this code can only be used for a "confirmed" positive or a "presumptive positive" COVID-19 test result.

For assessments with an assessment reference date March 31, 2019 or earlier, providers will need to enter the most appropriate ICD-10 code available that is not listed as a 'return to provider' code in the MDS I0020B item field.

Additional files related to coding specifications necessary for software companies to implement this change are located on the [MDS 3.0 Technical Information webpage](#). Providers do not need to review these files but should check with their MDS software vendors to confirm when these updated have been applied or you will see a 'return to provider' error in your MDS software.

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Q15. How does the new ‘U07.1 - 2019-nCoV acute respiratory disease’ ICD-10-CM code, if applicable, impact PDPM case-mix classification and payments?

A15. If entered as the primary reason for SNF stay into MDS item I0020B, the ‘U07.1 - 2019-nCoV acute respiratory disease’ ICD-10-CM code will map to the PDPM ‘Pulmonary’ clinical category used in the lowest PT, OT, and SLP component clinical categories. This new code does not impact the PDPM Nursing or NTA component classifications at present.

Q16. Are PDPM payments impacted depending on how a provider isolates a resident following [CDC/CMS Isolation Guidance for New Admissions](#) and [AHCA Guidance for New Admissions](#)?

A16. Yes. The MDS coding guidance associated with item O0100M – *Isolation for active infectious disease (does not include standard precautions)* located in Chapter 3 of the [MDS 3.0 RAI Manual](#) v 1.17.1 October 2019 has not changed to date due to the COVID-19 pandemic. This item can only be marked as present if the resident is on single occupancy room isolation. It cannot be used for multiple residents cohorted into a single room when following CDC/CMS guidance.

Below is an excerpt from the current coding requirements describing the four specific conditions that must be met to check the O0100M item box for the presence of isolation for active infectious disease.

Code for “single room isolation” only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

In a recent email received from CMS the Agency indicates that providers should continue to code residents for the O0100M isolation item per current MDS-RAI manual instructions.

The table below compares the impact on PDPM per-diem nursing component payments if a COVID-19 patient (not on a ventilator or with a tracheostomy) is cohorted into the same isolation room as another similar patient.

PDPM Nursing Component and Number of Sub-Components	Nursing Component Per-Diem Revenue Difference if COVID-19 Isolation Patient Cohorted with a Roommate - Based on FY 2000 PDPM Case-Mix Adjusted Federal Urban Rates
Special Care High (4)	(\$56.14 - \$113.34)
Special Care Low (4)	(\$90.04 - \$158.88)
Clinically Complex (6)	(\$112.28 - \$210.79)
Behavioral Symptoms/Cognitive Performance (2)	(\$200.19 - \$205.49)
Reduced Physical Function (6)	(\$144.06 - \$240.44)

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The impact on PDPM NTA component per-diem payments if a COVID-19 patient (not on a ventilator or with a tracheostomy) is cohorted into the same isolation room as another similar patient (based on FY 2000 PDPM case-mix adjusted federal urban rates) is less significant as the MDS O0100M Isolation item has a value of only 1 NTA point. The potential impact of not being able to code isolation patients cohorted into the same room is **(\$18.33 - \$54.20)** per day.

AHCA recognizes that many providers have applied recent CMS and CDC guidance and 1135 waivers during the COVID-19 emergency and have sometimes cohorted beneficiaries in the same isolation room when the residents have tested positive for COVID-19 or are presumed to be positive. We also recognize that with respect to payment models including PDPM, State case-mix, and Medicare Advantage, the current inability to code for isolation in situations where residents were required to be cohorted into the same room may result in a lower payment rate. CMS is aware of this concern. AHCA will share updates as they become available.