MEDICARE PART A FFS WAIVERS

1. Goal of the Section 1812(f) Waiver is to **free up as many hospital beds as possible, nationwide**.

2. Therefore, the waiver is nationwide and applies to all hospitals and all SNFs regardless of whether there is COVID present in the hospital or not. So, this is blanket and broad-based.

3. Parameters that remain in place are:

   a. Patients ***must*** continue to meet the criteria for skilled care located in the Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf . It is criteria this continues to be documented.

   b. Long-Stay patients may be converted to Part A stays as long-stays as long as there is clinical evidence to support conversion to Part A. This is critical: **if the patient MUST MEET the skilled care criteria noted above. Otherwise you'll have significant audit risk when this is over.**

4. In regard to payment:
   a. Timeframe: The waiver is retroactive to March 1, 2020 and is in place for 60 days with the option for renewal as needed; and

   b. Billing: In terms of claims, to ensure payment and so CMS may track these stays, the "DR" condition code should be used by institutional providers (but not by non-institutional providers such as physicians and other suppliers) in all billing situations related to a declared emergency/disaster. The "DR" condition code is intended for use by providers (but not by physicians and other suppliers) in billing situations related to a declared emergency/disaster.