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HEALTHCARE HURRICANE INFORMATION

As a result of what has been a formidable hurricane season, healthcare providers are once again burdened with balancing preparatory responsibilities with post-hurricane remediation. Hurricane Gustav left Louisiana in a state of recovery and the potential impact of Hurricane Ike on the region remains an unknown. In response to these uncertain times, the following is a compilation of best practices and useful information to assist providers in preparation for future events as well as to aid in current recovery efforts in the wake of Hurricane Gustav.

Reimbursement Issues

For a summary of Federal Payments which may be available for Evacuee Care, go to www.hhs.gov/Katrina/payfederal.html

? Medicare

Question: Do the modifications and flexibilities described in Q&As in response to the existing emergency apply only to providers in the States in which the Secretary of Health and Human Services (HHS) has declared a public health emergency and FEMA or the president has made a declaration under the Stafford Act or National Emergencies Act?

Answer: The waivers apply only to providers in the areas in which the Secretary has declared a public health emergency and the president has made a declaration of an emergency under the Stafford Act, and then only to the extent that the provider in question has been affected by the emergency. Note, however, that Medicare does allow for certain limited flexibilities outside the scope of the Secretary's § 1135 waiver authority as discussed in other Q&As.

Question: What is the duration of the waivers granted by the HHS Secretary under § 1135?

Answer: In general, the length of the waiver is the duration of the emergency period, unless sooner terminated, as described in § 1135(e). However, requirements are waived only to the extent necessary to achieve the purposes of the statute. For example, if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, then the waiver of that requirement would no longer apply to that hospital. Note that if a waiver of EMTALA or HIPAA sanctions is granted, such a waiver is subject to special limits on duration.

Question: In addition to those services provided in the emergency area, can the § 1135 waiver authority be used to include waivers regarding benefits and services provided for evacuees from emergency areas who are receiving those services in non-emergency areas?

Answer: The § 1135 waiver authority does not extend beyond the "emergency area," which is defined as the area in which there has been both a Stafford Act or National Emergencies Act declaration and a public health emergency declaration under Section 319 of the Public Health Service Act. Medicare does allow for certain limited flexibilities outside the scope of the § 1135 waiver authority as discussed in other Q&As. Some of these flexibilities may be extended to areas beyond the declared "emergency area".

Question: At what point will individuals no longer be treated as "emergency victims"? Is there a set period of time or does it vary by individual?

Answer: Emergency policies, including those policies made possible by the § 1135 waiver authority generally do not vary by individual beneficiary. These policies apply to the geographic area(s) in which the emergencies have been declared and may apply to individual health care providers or groups or types of providers. In addition, the § 1135 waiver authority, if invoked, is geared toward requirements upon providers, not individual beneficiaries. However, the effect of a waiver may vary somewhat from individual to individual depending, not upon the waiver authority itself, but rather upon particular circumstances, e.g., whether the person was evacuated to a facility for which requirements were waived (as opposed to a facility to which the waiver did not apply).

Question: Are accelerated or advance payments available for providers whose practices and/or businesses were severely affected by the existing emergency related to the emergency?

Answer: For providers who are still rendering some services or who are taking steps to be able to render services again, accelerated or advance payments may be available. Providers in this position should contact their fiscal intermediary, carrier, or MAC for details.

Question: On October 14, 2005, in response to Hurricane Katrina, CMS issued Change Request 4106, “National Modifier and Condition Code To Be Used To Identify Disaster Related Claims.” May these modifiers and condition codes be used for this emergency’s-related claims?

Answer: Yes.

? Medicaid

Question: If a provider has treated Medicaid patients but is not enrolled in the Louisiana Medicaid program, could it still be eligible to be paid?

Answer: Louisiana Medicaid does provide an emergency enrollment process. For more information and downloadable applications, go to: http://www.lamedicaid.com/provweb1/Gustav/Disaster_Entities.pdf

? FEMA

Question: Can providers be eligible for reimbursement from FEMA for "emergency medical care and medical evacuation expenses"?

Answer: Yes, it is possible for providers to receive this type of reimbursement. for more information, go to http://www.fema.gov/government/grant/pa/9525_4.shtm

Re-Opening Requirements

Question: What are the requirements for re-occupying or re-opening of Healthcare Facilities?

Answer: The following applies to any healthcare facility that evacuates, temporarily relocates or temporarily ceases operation at its licensed location in an emergency event.

1. If the healthcare facility has not sustained any damage to the licensed location as a result of the emergency event, AND there was no power outage of more than 48 hours at the licensed location as a result of the emergency event, the healthcare facility may re-open/re-occupy at its

licensed location and shall notify DHH Health Standards Section (HSS) within 24 hours of reopening. (can be done by facsimile to HSS)

2. For all other evacuations, temporary relocations or temporary cessation of operations at its licensed location the healthcare facility shall notify DHH Health Standards Sections with a request to re-occupy the licensed facility. The request shall include:
   a. report of damage to the facility,
   b. the extent and duration of any power outages,
   c. the number of patient/clients that the facility plans to re-enter the facility,
   d. staffing availability,
   e. ability to access emergency or hospital services that are operational in the area (if applicable), and,
   f. Availability to access and obtain food, potable water, medications and all other necessary supplies for care of the patients/clients.
3. End Stage Renal Disease facilities (ESRD) shall follow the technical considerations for bringing an ESRD facility back on line posted on Network 13 website: http://www.network13.org regarding flushing and disinfecting of systems, flushing and water testing. Verification that the process was followed shall be submitted with the request to re-open.

After review of the submitted documentation, the HSS shall make a determination for one of the following actions:

a. an approval to re-open/re-occupy without survey; or
b. what surveys will be required before an approval to reopen will be granted. Such surveys may include OPH, Fire Marshall and Health Standards; or,
c. denial of re-opening.

The purpose of these surveys is to assure that the facility is in compliance with the licensing standards including, but not limited to, the structural soundness of the building, the sanitation code, staffing requirements and the execution of emergency plans.

The Health Standards Section, in coordination with state and parish OHSEP, will determine the facility's access to the community service infrastructure, such as hospitals, transportation, physicians, professional services and necessary supplies.

The Health Standards Section will give priority to reopening surveys. Requests to re-open/re-occupy healthcare facility should be sent to:

Health Standards Section
500 Laurel St. Suite 100
Baton Rouge, HSS Fax #'s: 225-342-5292 or 225-342-0157

Hospital Issues

? Hospital Services - Acute Care

Question: Will a hospital be eligible for additional payment for rendering services to patients that remain in the hospital due to the fact that they continue to need medical care but at less than an acute level and those services are unavailable at any SNFs in the area because of the emergency?

Answer: A physician may certify or recertify the need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF, but no bed is available in a participating SNF. Medicare will pay the DRG rate and any cost outliers for the entire stay until the Medicare patient can be moved to an appropriate facility.

Question: Are prospective payment providers going to be paid using a special payment method? If not, is there a special DRG that IPPS providers will be reimbursed for this situation?

Answer: Normal prospective payment procedures apply to those hospitals reimbursed under the inpatient prospective payment system.

Question: Due to the unexpected emergent nature of the PPS hospital evacuation, there was not time to work out a financial arrangement with the receiving health care institution. Are PPS hospitals responsible to reimburse the receiving hospital for full charges or how can assistance be provided if problems arise with post evacuation payment negotiations?

Answer: Financial agreements between providers are a private matter between those two parties.
CMS cannot dictate the terms of these agreements or interfere in providers' negotiations. If the facilities are unable to work out a financial arrangement, CMS may consider allowing each facility to bill for the services it provided. CMS will make these considerations on a case-by-case basis.

Question: Can a bed in a psychiatric unit be used for acute care patients admitted during the emergency period?

Answer: Yes, beds in a psychiatric unit can be used for acute care; however, it should be fully documented in hospital records and for cost reporting purposes. In addition, the acute portion of the hospital should bill for all Medicare-covered services; the psychiatric unit should record the services/charges as non-Medicare.

? EMTALA Issues

Question: Are hospitals required to comply with all of the requirements of EMTALA during the emergency period in the emergency area?

Answer: Generally, yes. However, the Secretary has the authority not to impose sanctions on a hospital located in the emergency area during the emergency period if the hospital redirects or relocates an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfers an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. These waivers shall be limited to a 72-hour period beginning upon implementation of a hospital emergency or disaster protocol and are not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.

Question: If a hospital remains open during the emergency period and is operating at or in excess of its normal operating capacity and cannot get sufficient staff, may the hospital shut down its emergency department (ED) without violating EMTALA?

Answer: Under these circumstances, EMTALA would not prohibit the hospital from closing its ED to new patients if it no longer had the capacity to screen and treat individuals (in effect, going on diversion). The hospital should follow any applicable State and local notice requirements and its own previously established plan for public notification when it goes on diversionary status. The hospital would continue to have an EMTALA obligation to individuals undergoing examination or treatment in its ED at the time it stops accepting new emergency patients. In addition, in spite of the “closure” if an individual comes to such a hospital and requests examination or treatment for an emergency medical condition, the hospital would be obligated by EMTALA to act within its capabilities to provide screening and, if necessary, stabilization.

? Chemotherapy Issues

Question: Patients are taken to a second facility for chemotherapy services because of inadequate staff at the original facility due to the emergency. How should this be billed?

Answer: For inpatients, the originating medical facility must bill for these services as part of the original inpatient stay and reimburse the second facility for the use of their chemotherapy services. It is important that this occur so that claims are not submitted with overlapping dates of service. If the originating facility is not able to operate, the receiving facility may bill Medicare, beginning with the date they assumed responsibility for the inpatient. If the services were rendered in an outpatient setting at both facilities, both facilities may bill for their own services as long as the dates of services do not overlap. Specifically, each facility may bill for the particular dates on which they serviced the beneficiary by providing chemotherapy. All facilities need to use the specific line item dates of service for each beneficiary encounter.

? Critical Access Hospitals (CAH)

Question: Critical access hospitals (CAHs), which are normally limited to 25 beds and to a length of stay of not more than 96 hours, may need to press additional beds into service or extend lengths of stay to respond to the emergency. Will CMS enforce these limits?

Answer: CMS will not count any bed use that exceeds the 25-bed or 96-hour average length of stay limits if this result is clearly identified as relating to the emergency. CAHs must clearly indicate in the medical record where an admission is made or length of stay extended to meet the demands of the emergency.

? Long Term Care Hospitals (LTCH)

Question: Generally, a hospital must have an average Medicare inpatient length of stay of greater than 25 days in order to be classified as a long-term care hospital (LTCH). If a long-term care hospital (LTCH) admits a patient solely to meet the demands of the emergency, will the patient's stay be counted towards the greater than 25-day average Medicare inpatient length of stay calculation in 42 CFR 412.23(e)(3)(i)?

Answer: If a LTCH admits a patient solely in order to meet the demands of the emergency, the patient's stay will not be included for purposes of the average length of stay calculation in 412.23(e)(3)(i). LTCHs must clearly indicate in the medical record where an admission is made to meet the demands of the emergency.

? Inpatient Rehabilitation Hospitals (IRF)

Question: If an inpatient rehabilitation facility (IRF) provider cannot file the Patient Assessment Instrument (PAI) within the specified time frame, they will be imposed a 25% penalty. The Fiscal Intermediary Shared System (FISS) auto applies the penalty, and currently there is not an override/bypass in FISS. Does CMS have a workaround for this, as the only way we see getting around the penalty is for the provider to bill with an "artificial" PAI date that is within 28 days of the patient's discharge date?

Answer: IRF payment policy allows for a waiver of the penalty in 412.614(e). Do not put an inaccurate date on the claim for the transmission of the IRF PAI. Medicare contractors have the authority to override the penalty in certain circumstances.

Question: The disruption to the hospital system caused by the emergency and its aftermath may require some hospitals to use any available bed to care for patients that have been transferred from the affected areas, or to treat the large number of people requiring hospital care. If an inpatient rehabilitation facility (IRF) admits a patient solely in order to meet the demands of this emergency, will the patient be included in the hospital's or unit's inpatient population for purposes

of calculating the applicable compliance thresholds in 42 Code of Federal Regulations (CFR) § 412.23(b)(2) (“the 60 percent rule”)?

Answer: In order to meet the demands of the emergency, CMS will modify enforcement of the requirements specified in 42 CFR § 412.23(b)(2), which is the regulation commonly referred to as the “60 percent rule.” If an IRF admits a patient solely to respond to the emergency and the patient’s medical record properly identifies the patient as such, the patient will not be included in the hospital’s or unit’s inpatient population for purposes of calculating the applicable compliance thresholds outlined in § 412.23(b)(2). In the case of an admission that is made solely to meet the demands of the emergency, a facility should clearly identify in the inpatient’s medical record by describing why the patient is being admitted solely to meet the demands of the emergency. In addition, during the applicable waiver time period, the exception described in this answer would also apply to facilities not yet classified as IRFs, but that are attempting to attain classification as an IRF. An institutional provider would use the “CR” (catastrophic/disaster related) modifier to designate any service line item on the claim that is disaster related. If all of the services on the claim is disaster related, the institutional provider should use the “DR” (disaster related) condition code to indicate that the entire claim is disaster related.

Question: In addition to suspending the “60 percent rule” during the emergency, will the Medicare admission criteria for inpatient rehabilitation found (IRF) in Section 110 of the Medicare Benefits Policy Manual, such as the 3-hour rule, also be temporarily suspended?

Answer: CMS recognizes that it may become necessary for patients who are not rehabilitation candidates to be admitted to IRFs due to the emergency. In these instances, CMS would not apply the IRF specific criteria (e.g., the 3-hour rule) to any review of claims. IRFs should clearly document in the patient’s medical record that the patient was admitted solely to meet the demands of the emergency.

Skilled Nursing Facility (SNF)

Question: Is CMS waiving the skilled nursing facility (SNF) benefit’s 3- day qualifying hospital stay requirement for those beneficiaries affected by the emergency situation?

Answer: Yes. Section 1812(f) of the Social Security Act (the Act) confers the administrative authority to grant SNF coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program costs and does not alter the SNF benefit’s “acute care nature” (that is, its orientation toward relatively short-term and intensive care). Under this authority, CMS has issued a temporary waiver of the SNF benefit’s qualifying hospital stay
requirement for those beneficiaries who are evacuated or transferred as a result of the emergency
situation. In this way, beneficiaries who may have been discharged from a hospital early to make room for more seriously ill patients will be eligible for Medicare Part A SNF benefits. In addition, beneficiaries who had not been in a hospital or SNF prior to being evacuated, but who now need skilled nursing care, will be eligible for Medicare Part A SNF coverage.
CMS’s waiver of the requirement for a 3-day hospital stay is limited to the time period during which the Secretary’s Waiver or Modification of Requirements under Section 1135 of the Social Security Act remains in effect.

Question: When a SNF evacuates patients to another SNF or hospital as part of an emergency plan, who should bill for the services?

Answer: If the evacuation is for less than 30 days, the initial SNF can transfer the patients to another facility “under arrangements.” The transferring SNF is still considered the provider and should bill Medicare for each day of care. The SNF is then responsible for reimbursing the provider that accepted the patients during the emergency period. For specific instructions on the procedures to be followed, please review the detailed survey and certification instructions at

http://www.cms.hhs.gov/SurveyCertEmergPrep/04_Resources.asp#TopOfPage.

Question: Is CMS temporarily relaxing the requirements for establishing a new spell of illness for beneficiaries who have a renewed need for skilled nursing facility (SNF) services as a direct result of the dislocations and trauma related to the emergency situation?

Answer: Yes. A new SNF Part A benefit period will be available to any beneficiary recently discharged from a nursing home who has not had the time to establish a new benefit period. The Part A SNF coverage is available to any beneficiary who has experienced trauma through dislocation or evacuation in connection with this emergency, regardless of the location of the SNF that provides the care. Therefore, in this situation, the admitting SNF does not need to be located in the emergency area. Part A coverage will be available as long as the beneficiary requires skilled care, up to 100 days. Full coverage will be available for the first 20 days. The daily Medicare coinsurance will be applied from days 21-100. CMS's policy to provide a new benefit period will apply only during the time period in which the Secretary's Waiver or Modification of Requirements under Section 1135 of the Social Security Act remains in effect.

Question: Our SNF was affected by the emergency and, as a consequence, some of our patients were transferred to other providers. I have not submitted my claims for the month of the transfer. What is the correct patient status code that should be used?

Answer: Those affected providers that are aware of the location of their former resident's transfer should include the correct patient status code for the transfer (i.e., patient status code "03" = transfer to SNF). If not aware of the exact transfer, providers should use patient status code "01" (discharged to home or self care) in order to bypass any potential overlapping claim situations. Providers should include "Hurricane Emergency" on their remarks page prior to submitting the claim to Medicare.

Question: Our SNF has received beneficiaries transferred from another SNF provider affected by this emergency. I have submitted my claims to Medicare for the month after the transfer but I am receiving an overlap with the prior month's claim previously sent by the affected SNF. How can I get my claim paid?

Answer: Receiving providers should make sure they include remarks indicating "Hurricane Emergency" on any claims affected by this emergency. The receiving provider should contact their FI or MAC for assistance with these overlap situations. FIs and MACs shall identify the overlap and develop the claim accordingly, including working with other FIs that might service the affected SNF. If the transferring provider submitted its "transfer-month" claim with a patient status of "30" (still patient) but the patient was actually transferred in that month, the FI/MAC shall adjust the claim or work with the transferring provider's servicing FI/MAC to have the claim adjusted and use an appropriate patient status code to indicate a transfer.

Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to the emergency and who wishes to return to a nursing facility closer to family members or home after the emergency is over?

Answer: Part B of the Medicare program covers only local ambulance transportation to and from the nearest appropriate SNF facility, as long as the beneficiary is not a SNF resident in a covered Part A stay whose transport would be subject to consolidated billing rules. If there are exceptional circumstances that require transport outside the locality, Medicare can pay for this transport, but only if the destination is still the nearest SNF with appropriate facilities. In any case, the ambulance transport must be medically necessary.

Question: How should a facility bill for a beneficiary who was classified into rehabilitation Resource Utilization Group, Version III (RUG-III) group prior to the emergency when the facility is

no longer able to provide therapy services as a result of the dislocations associated with the emergency?

Answer: As explained in the Long-Term Care Facility Resident Assessment Instrument User's Manual, the RUG-III category stays in place for the Minimum Data Set (MDS) coverage period (e.g., the 5-day assessment can be used to bill from Day 1 up through Day 14, etc.) as long as the MDS was coded accurately. Payment will continue to be made at the assigned rehabilitation RUG level until the end of the covered time frame or until an Other Medicare-required assessment (OMRA) is completed. The OMRA must be completed 8 – 10 days after all therapies have been discontinued.

Home Health Services

Question: How will payments be processed for home health agencies (HHAs)?

Answer: CMS will advise the FI or MAC to facilitate payment for home health services for beneficiaries who have been displaced due to the emergency. The FI or MAC will work with the HHAs that have transferred or received patients to ensure that claims are processed timely and issues are addressed quickly.

Question: What adjustments or flexibility is allowed related to Medicare requirements for completion of the OASIS assessment process?

Answer: As indicated in Survey and Certification Memo 05-43, and in the time period indicated in the statutory waiver invoked by the HHS Secretary under § 1135 of the Social Security Act, CMS may modify certain timeframe and completion requirements for OASIS. In this emergency situation, an abbreviated assessment can be completed to assure the patient is receiving proper treatment and to facilitate appropriate payment. For those Medicare approved HHAs serving qualified home health patients in the public health emergency areas determined by the Secretary, the following modifications to the comprehensive assessment regulation at 42 CFR § 484.55 may be made. These minimal requirements will support reimbursement when billing is resumed and help ensure appropriate care is provided.

• The Start of Care assessment (RFA 1) may be abbreviated to include the Patient Tracking Sheet and the payment items.

• The Resumption of Care assessment (RFA 3) and the Recertification assessment (RFA 4) may be abbreviated to the payment items. HHA should maintain adequate documentation to support provision of care and payment.

• The OASIS transmission requirements at 42 CFR 484.20 are suspended for those Medicare approved HHAs that are serving qualified home health patients in the affected areas.

• The Discharge assessment (RFA 8 or RFA 9) and the Transfer assessment (RFA 6, RFA 7) are suspended during the waiver period.

HHAs should maintain adequate documentation to support provision of care and payment.

Question: Can the "residence" component of the homebound requirements be suspended by allowing the delivery of home health services at any site of temporary residence during the crisis? Can this include a residence that is a nursing facility or hospital provided the patient is otherwise not at such level of care when the patient is using the facility as a medical shelter?

Answer: The Social Security Act stipulates that beneficiaries must be confined to the home in order to be eligible to receive home health services. A beneficiary's home is any place in which a beneficiary resides that is not a hospital, skilled nursing facility (SNF), or nursing facility as defined in § 1861(e)(2), § 1819(a)(1), or § 1919(a)(1) of the Social Security Act, respectively.

Under these temporary extraordinary circumstances, place of residence can include services provided at temporary locations like a family member's home, a shelter, a community facility, a church, or a hotel. A hospital, SNF, or nursing facility as defined above would not be considered a temporary residence.

Question: Can the application of Partial Episode Payment (PEP) be suspended for patients displaced to other home health agencies (HHAs) due to the emergency?

Answer: Normal prospective payment procedures will apply. We believe it crucial that home health agencies remain responsible for home health beneficiaries, up until a PEP situation is determined. The PEP appropriately truncates the previous episode, and allows for a subsequent episode to be established with each home health agency being reimbursed for the services provided.

Question: If a home health agency (HHA) affected by the emergency is unable to submit within 60 days the final claims for home health episodes that are already begun, Medicare will automatically cancel the request for anticipated payment (RAP) for those episodes. The recovery of the RAP payments will decrease already strained cash flow for this agency. Will CMS waive the requirement to submit final home health claims within 60 days of the end of the episode?

Answer: CMS is instructing the Regional Home Health Intermediaries (RHHIs) and MACs to temporarily cease to automatically cancel the RAPs of HHAs in the region affected by the emergency. The RHHIs/MACs will identify all HHAs located within the areas affected by the emergency. RAPs for these agencies will be assigned a new cancellation date to be specified. This will allow an additional 60-90 days for the HHAs to resume submission of final claims.

Question: How should home health agencies (HHAs) that have received patients that were displaced by the emergency, code their claims for these new admissions.

Answer: HHAs should use source-of-admission code "B" (indicating transfer from another HHA) on their requests for anticipated payment (RAPs) for these patients. The use of this code will ensure that Medicare systems do no reject the RAP due to the overlapping home health episode at the prior HHA. This is standard coding procedure for all transfers under the home health prospective payment system, so no other special indicators are needed on these RAPs.

Hospice

Question: What is a hospice agency's responsibility in the event of a disaster?

Answer: A hospice agency, as indicated in 42 CFR § 418.100(b), "Disaster Preparedness," must have a written plan to be followed in the event of a internal or external disaster, including care of casualties arising from such a disaster. We note that this provision does not necessarily address all public health emergencies.

Question: If a hospice provider cannot provide care for its patients, can these patients transfer to another hospice provider?

Answer: Under CMS regulations at 42 C.F.R. § 418.30(a), a Medicare beneficiary may transfer from one hospice agency to another hospice for any reason once per election period. If a Medicare beneficiary has already utilized this one-time right to transfer but needs to move again because of the public health emergency, § 1861(dd)(5)(D) of the Act provides for a hospice agency to arrange with another hospice for the delivery of services in extraordinary circumstances. We would not deem a change in hospice under these circumstances to be a voluntary transfer under 42 C.F.R. § 418.30 (i.e., a beneficiary would still be entitled to transfer voluntarily after a transfer for "extraordinary circumstances").

Question: In the event that the originating hospice is able to resume provision of services to their patients, may patients be transferred back to the originating hospice?

Answer: CMS believes that patients should be provided with the choice of resuming care from the originating hospice or continuing with the existing hospice provider. If the beneficiary remains with the "host"/replacement hospice at the end of the emergency period, we would consider this a transfer under our regulations at 42 CFR § 418.30. If a beneficiary uses the services of an alternate hospice agency for a short period of time due to extraordinary circumstances such as a natural disaster, neither the departure from nor return to the original hospice agency would be considered a "transfer" within the meaning of 42 CFR § 418.30.

Question: Will the hospice inpatient and aggregate payment caps be waived for FY 2008?

Answer: No. Because these caps are not conditions of participation or program participation provisions within the meaning of Section 1135 of the Act, we do not believe that sufficient statutory authority exists to permit CMS to waive these payment caps.

Stark

Question: What is the process for requesting and receiving a Stark waiver (waiver of sanctions under section 1877(g) of the Act)?

Answer: Stark waivers under authority of section 1135 of the Act are granted only upon request and only on a case-by-case basis. A specific request, detailing the proposed financial relationship between the referring physician(s) and the entity should be mailed to CMS at the following address, CMS, Division of Technical Payment Policy, ATTN: Request for Section 1135 Stark Waiver, Rm C4-25-02, Woodlawn, MD 21244-1850, or by e-mailing the request to donald.romano@cms.hhs.gov, or lisa.ohrin@cms.hhs.gov. A determination will then be made by CMS to approve or deny the request. Unless and until a determination is made approving a request, parties must comply with all physician self-referral (Stark) rules

Individual Provider Issues

Question: What is the status of the Louisiana State Board of Medical Examiners?

Answer: The LSBME offices in New Orleans reopened on Monday September 8, 2008 at 8 AM. The licenses and permits of all persons in renewal will be extended to October 1, 2008 due to the storm and office closure.

Question: Is there any resource available to reconnect physicians and patients?

Answer: The website www.findladocs.com is a point of connection for physicians and patients who have been displaced. Physicians should register with findladocs to keep in touch with patients who may be dislocated.

Question: How can health care providers volunteer to assist during this emergency?

Answer: Volunteers are needed to meet health/medical surge needs during emergencies. To register to become an emergency volunteer, go to: https://www.lava.dhh.louisiana.gov/
Question: What is the status of the Louisiana State Board of Nursing?

Answer: The LSBN advises that its office will remain closed to general operations until power is restored., check back the lsbn website, http://www.lsbn.state.la.us/ for notice of re-opening. For other inquiries email us at lsbn@lsbn.state.la.us. The Board meetings have been postponed. The new dates for the board meetings are still to be determined.

Question: What should an out-of-state nurse do who wants volunteer?

Answer: The Louisiana State Board of Nursing website offers a link to download a disaster permit affidavit. To download the appropriate form, go to: http://www.lsbn.state.la.us/. The form should be faxed to (225) 755-7581, or (225) 612-7005 if primary number is down, with copy of valid Driver's License and proof of current licensure in another state. Upon receipt of fax transmission, practice is authorized unless otherwise notified. Verfication of processed affidavit is available on LSBN website: www.lsbn.state.la.us

Pharmacy

Question: How can the Drug Enforcement Agency be reached for hurricane related problems?

Answer: The DEA has established the email address, STORM.GUSTAV@USDOJ.GOV as a point of contact for DEA registered manufacturers, distributors, pharmacies and narcotic treatment programs for storm-related emergency matters.

Question: Has Louisiana's Pharmacy Board released any guidelines in light of the State of Emergency?

Answer: The State of Emergency relating to Hurricane Gustav began on August 26, 2008 and will expire on September 26, 2008. In light of that, the Pharmacy Board has issued the following guidance:

- Pharmacists and Technicians

A. For the duration of the State of Emergency, pharmacists not licensed in Louisiana, but currently licensed in another state, may engage in a legitimate relief effort within the state of Louisiana provided the pharmacist has some type of identification to verify current licensure in another state. The pharmacist does not need any credential from this office, but must notify the board of their presence and approximate location prior to engaging in pharmacy practice. Notifications can be faxed to: 225-922-0316. The pharmacist-in-charge is responsible for verifying the credentials of every pharmacist practicing in that location.

B. For the duration of the State of Emergency, technicians not credentialed by the Louisiana Board of Pharmacy may assist in the practice of pharmacy in Louisiana provided the technician can demonstrate registration/certification/licensure in another state OR can demonstrate a current credential from the

Pharmacy Technician Certification Board (PTCB). However, the technician must notify the board of their presence and approximate location prior to engaging in pharmacy practice. Notifications can be faxed to: 225-922-0316. The pharmacist-in-charge is responsible for verifying the credentials of every technician practicing in that location.

Question: What is required for the dispensation of an emergency prescription?

Answer: For the duration of the State of Emergency (for Hurricane Gustav, from August 26, 2008 to September 26, 2008), a pharmacist may dispense a one-time emergency prescription of up to a thirty (30) day supply of any prescribed medication if:

1. in the pharmacist's professional opinion the medication is essential to the maintenance of life or to the continuation of therapy; AND

2. the pharmacist prepares a written record marked “Emergency Prescription”, then files and maintains that prescription as required by law.

Question: If a pharmacy has been directly impacted by Hurricane Gustav, what should it do to ensure the integrity of medication stock?

Answer: For those pharmacies that sustain flood and/or fire damage in the prescription department, the entire medication inventory – including any prescriptions that may have been awaiting pickup – is unfit for dispensing. You must prepare a DEA Form 106 to document your losses of controlled substances, and then send copies of that document to the DEA and the Board. To the extent that you may be able to receive product replacement from some manufacturers or perhaps some other type of assistance, you may wish to consider preparing an accurate record of all your prescription medication losses.

For those pharmacies that do not sustain any flood or fire damage in the prescription department, but do sustain a loss of power for a sustained period of time, please remember the USP standards for medication product integrity. In particular, the USP has defined the proper temperature for storage of medications. For those medications labeled for storage at “controlled room temperature”, the acceptable range of temperature is 68° to 77°F. The USP standards permit temporary spikes in the temperature, but the maximum deviation permitted is 104°F for a maximum of 24 hours. If you have questions about these federal standards, please contact USP directly at (800) 227-8772. Pharmacies in that lose power and/or air conditioning for several days should consider the strong probability that their medication inventory no longer meets federal standards and should not be considered safe for dispensing. Again, you must prepare a DEA Form 106 to document your losses of controlled substances, and report those losses in the usual manner. Finally, you may wish to consider preparing an accurate record of all your prescription medication losses to facilitate any claims for product replacement or other assistance.

Lab and Other Diagnostic Providers

Question: In situations where laboratory specimens are destroyed or compromised by a disruptive event, how will laboratories be paid?

Answer: Medicare contractors may consider payment for another drawing fee, specimen transport, or test if the results have not been communicated to the patient’s physician.

Mental Health Providers

Question: Will Medicare help pay for counseling to help the beneficiary deal with the mental health issues associated with the emergency?

Answer: Certain mental health service benefits (including counseling) may be available to Medicare beneficiaries with Part B coverage. In certain situations partial hospitalization may also be covered.

Ambulance Services

Question: Will Medicare pay for ambulance services for emergency evacuation situations?

Answer: Medicare contractors may make payment for ambulance transports for evacuating patients from locations affected by the emergency. The regulatory requirements must be met in order for such ambulance transports to be covered (i.e., the vehicle must meet certain

requirements, the crew must be certified, ambulance services must be medically necessary, the 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).

Question: How will ambulance services be paid when patients are moved from hospital to hospital or other approved locations?

Answer: Charges for ambulance transportation will be paid according to the usual payment guidelines. Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals should be included on the inpatient claims submitted by the originating hospitals. Payment will be included in the diagnostic related group (DRG) payment amounts made to hospitals paid under the prospective payment system. Outpatient claims may be submitted as separately billable claims for ambulance charges incurred by those patients who were transported from the originating hospitals and subsequently discharged by receiving hospitals.

Question: Will Medicare cover ambulance transportation (under Part B) for a beneficiary who has been evacuated from a skilled nursing facility due to the emergency, and who wishes to return to a nursing facility closer to family members or home after the emergency is over?

Answer: Part B of the Medicare program covers only local ambulance transportation to and from the nearest appropriate SNF equipped to treat the beneficiary, as long as the beneficiary is not a SNF resident in a covered Part A stay whose transport would be subject to consolidated billing rules. If there are exceptional circumstances that require transport outside the locality, Medicare can pay for this transport, but only if the destination is still the nearest SNF with appropriate facilities. In any case, the ambulance transport must be medically necessary.

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