COVIDー19 R1®

The COVID-19 Uninsured Program

The COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program ("COVID-19 Uninsured Program") provides reimbursements on a rolling basis to eligible providers for claims that are attributed to the testing and treatment of COVID-19 for uninsured patients. The program is authorized via (1) the Families First Coronavirus Response Act, which provides $1 billion to reimburse providers for conducting COVID-19 testing for the uninsured, and (2) the CARES Act, which provides $100 billion in relief funds, including to hospitals and other health care providers. The Secretary of Health and Human Services ("HHS") has delegated administration of the COVID-19 Uninsured Program to the Health Resources & Services Administration ("HRSA"). HRSA has contracted with UnitedHealth Group to process claims for payment.

COVID-19 Uninsured Program Detail		
	Eligible	**Ineligible**
Dates	Enrollment begins April 27, 2020 and claims submission begins May 6, 2020. The earliest a provider will receive payment is May 18, 2020.	Items and services provided prior to February 4, 2020. For inpatient claims, if the admission date is prior to February 4, 2020.
Services	The following items and services are covered if provided on or after February 4, 2020: ▪ Specimen collection, diagnostic and antibody testing. ▪ Testing-related visits including in the following settings: office, urgent care or emergency room or via telehealth. ▪ Treatment, including office visit (including via telehealth), emergency room, inpatient, outpatient/observation, skilled nursing facility, long-term acute care (LTAC), acute inpatient rehab, home health, DME (e.g., oxygen, ventilator), emergency ground ambulance transportation, non-emergent patient transfers via ground ambulance, and FDA-approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay. ▪ FDA-approved vaccine, when available.	Items and services provided prior to February 4, 2020. For inpatient claims, if the admission date is prior to February 4, 2020. Services not covered by traditional Medicare will also not be covered under this program. In addition, the following services are excluded: ▪ Any treatment without a COVID-19 primary diagnosis, except for pregnancy when the COVID-19 code may be listed as secondary. ▪ Hospice services. ▪ Outpatient prescription drugs.
Providers	Health care providers who have conducted COVID-19 testing or provided treatment for uninsured individuals with COVID-19 on or after February 4, 2020.	Individuals/Entities excluded by the HHS Office of Inspector General. Any provider who had their Medicare enrollment revoked.
Patients	Uninsured (pure self-pay) patients in the United States.	Patients with any type of health care coverage including individual, employer-sponsored, Medicare or Medicaid or if any other payer will provide reimbursement for COVID-19 testing and/or care for that patient (e.g., Worker's Compensation)

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To the best of our knowledge, this information was correct at the time of publication.

Operational Guidance

Process	Requirement	Actions/Information
Registration	Obtain Patient Information	Must collect the following: 1. First and last name 2. Date of birth 3. Gender 4. SSN and state of residence; if not available, enter state identification / driver's license 5. Date of service for physician, lab or facility outpatient services* 6. Date of admission and date of discharge for facility inpatient services 7. Address (optional) 8. Middle initial (optional) 9. 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. Claims submitted without an SSN and state of residence, or state identification / driver's license may take longer to verify for patient eligibility.
Financial Counseling	Check Eligibility	Initiate screening. Associates must capture the following information from patients: 1. Age 2. Citizenship status (US Citizen, No SSN, Refugee, Green Card, Visa) 3. Whether the patient has insurance coverage 4. For newborns, whether the newborn will be added to the mother's active Medicaid, commercial plan or if the newborn is in DCFS custody 5. Whether the patient is a parent or caretaker of a child or dependent under 18 years of age; formerly in foster care when the patient turned 18; legally blind in both eyes or disabled 6. Whether the patient is pregnant (within the last 3 months) or the visit is pregnancy-related 7. Whether the patient is being treated as a result of an auto accident, work injury, liability-related injury or a crime Identify uninsured patients needing to be screened based on patient type and date of service. After identifying an uninsured patient, associates must verify: 1. Whether the patient or anyone in his or her household lost insurance coverage (other than Medicaid) in the last 90 days 2. Whether the patient is a veteran/enrolled in the VA Health Care system 3. Whether the patient has any health issues (physical or mental) that limits his or her ability to work 4. Whether the patient was brought from a prison/correctional facility 5. The patient's state of residency Associates must identify and pursue secondary funding solutions that the patient may qualify for, in addition to the primary funding solution.
	Submit Patient Information to the Portal	Submit patient information in one of the following ways: ▪ One patient at a time ▪ Batch file upload with provided .csv template

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		You will receive Reference Numbers for completed patient roster submissions that you can print for your records
	Retrieve Temporary Member ID	After submitting patient information, a temporary member ID will be available for each individual in the portal approximately one to three days after information is submitted. Temporary member ID is valid for 30 days from date of service or date of discharge for facility inpatient services.
Coding	DX Codes: Testing & Testing-Related Services	For testing and testing-related services (including telehealth) to be eligible for reimbursement, claims submitted must include one of the following DX codes: ▪ **Z03.818** Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19) ▪ **Z20.828** Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19) ▪ **Z11.59** Encounter for screening for other viral diseases (asymptomatic)
	DX Codes: Treatment	For services related to treatment to be eligible for reimbursement, claims submitted must meet the following criteria: ▪ **Sequencing**. The COVID-19 diagnosis code must be the primary diagnosis code submitted. The only exception is for pregnancy (O98.5-), when the COVID-19 code may be listed as secondary. ▪ On or after April 1, 2020: **U07.1** 2019-nCoV acute respiratory disease ▪ Prior to April 1, 2020: **B97.29** Other coronavirus as the cause of diseases classified elsewhere COVID-19 diagnosis codes for claims Procedural coding for all services should follow normal billing practices using the correct ICD-10 diagnosis to identify testing-related or treatment-related services as described above.
	Antibody Testing	For antibody testing to be eligible for reimbursement, claims submitted must include one of the following procedure codes: 1. **86318** Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (e.g., reagent strip) 2. **86328** Immunoassay for infectious agent antibody(ies), qualitative or semi-quantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) 3. **86769** Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])
Billing & Follow Up	Electronic Claims Submission	Claims may only be submitted electronically using the 837 EDI transaction set. Providers will need the following information to submit a claim: ▪ **Payer ID**: 95964 ▪ **Payer Name**: COVID19 HRSA Uninsured Testing and Treatment Fund ▪ **Temporary Patient ID Number**: Assigned based on the patient roster submitted by the provider ▪ **Items and Services**
	Only Final Billing	▪ All claims submitted must be complete and final. ▪ Interim bills, corrected claims, late charges, voided claim transactions and appeals will not be accepted. ▪ Claims will undergo a version of Smart Edits, with errors routed back to the provider as a 277CA claim rejection for correction. ▪ Rejected claims should be re-submitted using a claim frequency code of "1" (not "7" or "8").

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	Payment in Full	The provider is not allowed to charge or bill the patient any amount for items or services for which the provider receives payment from the COVID-19 Uninsured Program.
	Reimbursement	Payment will be at Medicare rates, generally, including any amounts that would have been due to the provider as patient cost sharing (i.e., 100% of the Medicare allowable). ▪ Reimbursement will be based on current year Medicare fee schedule rates except where otherwise noted. ▪ Publication of new codes and updates to existing codes will be made in accordance with published CMS guidance. ▪ For any new codes where a CMS published rate does not exist, claims will be held until CMS publishes corresponding reimbursement information. **Facility:** ▪ Facility reimbursement based on IPPS will not include the 20% increase to the DRG weight for COVID-19 diagnoses U07.1 or B97.29 as authorized by Section 3710 of the CARES Act. ▪ Reimbursement rates for facilities not paid on IPPS [Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Children's Hospitals, and PPS Exempt Cancer Hospitals] will not be updated after February 4, 2020. **Professional:** ▪ Services will price with current year CMS pricing with geographic adjustments, as applicable. ▪ If no geographic adjustments are applicable, services will price with current year CMS national pricing. ▪ COVID-19 testing and specimen collection procedures will price in accordance with rates published in the CARES Act (PDF) and CMS interim final rules.
	Cash Posting	Optum Pay will send electronic payment to the provider's account in approximately 7-10 business days.
Customer Service & Patient Financial Solutions	Balance Billing	The provider should not charge or collect from the uninsured patient any amounts for items and services for which the provider received a payment from the COVID-19 Uninsured Program.
	Refunds	If a provider already billed or collected amounts from an uninsured patient for COVID-19 testing or treatment for which the provider later receives a payment from the COVID-19 Uninsured Program, the provider will communicate to the patient that they do not owe any money, or return amounts as necessary.