expenditures.
New: 7/28/20

31. **Question:** For a claim to be used to identify an episode of care for treatment of COVID-19 according to 42 CFR § 425.611, do International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes B97.29 “Other coronavirus as the cause of diseases classified elsewhere” (for discharges occurring on or after January 27, 2020, and on or before March 31, 2020) or U07.1 “COVID-19” (for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 PHE period) need to be the principal diagnosis on the claim?

**Answer:** We will identify claims for treatment of COVID-19, for use in identifying episodes of care, when the diagnosis code B97.29 or U07.1 is present in any diagnosis code field, based on established coding guidelines. For additional information, please refer to guidelines for providers for coding encounters related to COVID-19 (such as [https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf](https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf)), and CMS claims processing instructions (such as [https://www.cms.gov/files/document/mm11764.pdf](https://www.cms.gov/files/document/mm11764.pdf)).

New: 7/28/20

32. **Question:** Are current procedural terminology (CPT) codes for administration of health risk assessment (96160 and 96161), outpatient visit for the evaluation and management for new (99201–99205) and established patients (99211–99215), transitional care management services (99495 and 99496), and advanced care planning (99497 and 99498) included in the definition of primary care services in 42 CFR § 425.400 and used for purposes of Medicare fee-for-service beneficiary assignment in the Medicare Shared Savings Program, when delivered via telehealth services?

**Answer:** Yes. CPT codes for administration of health risk assessment (96160 and 96161), outpatient visit for the evaluation and management for new (99201–99205) and established patients (99211–99215), transitional care management services (99495 and 99496), and advanced care planning (99497 and 99498) are included in the Medicare Shared Savings Program assignment methodology when delivered via telehealth. These codes were already established as able to be delivered via telehealth prior to the start of the COVID-19 PHE, so regardless of the waivers for place of service during the COVID-19 PHE, they are included in the Shared Savings Program assignment methodology.

When primary care services, as defined in 42 CFR § 425.400(c), are furnished and paid in accordance with Medicare fee-for-service payment policies, allowed charges for these services will be used in assignment in the Shared Savings Program.

New: 7/28/20

**V. Cost Reporting**

1. **Question:** Will CMS delay the filing deadline for cost reports impacted during the COVID-19
PHE?

**Answer:** Yes, 42 CFR 413.24 (f)(2)(ii) allows this flexibility. CMS will delay the filing deadline of Fiscal Year End (FYE) 10/31/2019 and FYE 11/30/2019 cost reports until June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports until August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 2020.

In summary the extension impacts the following cost reporting fiscal year ends for all provider types (hospitals, SNFs, HHAs, hospices, ESRDs, RHCs, FQHCs, CMHCs, OPOs, histocompatibility labs and home office cost statements):

<table>
<thead>
<tr>
<th>Cost Reporting Period Ending</th>
<th>Initial Due Date</th>
<th>Extended Due Date</th>
<th>Revised Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/31/2019</td>
<td>03/31/2020</td>
<td>06/30/2020</td>
<td></td>
</tr>
<tr>
<td>11/30/2019</td>
<td>04/30/2020</td>
<td>06/30/2020</td>
<td></td>
</tr>
<tr>
<td>12/31/2019</td>
<td>05/31/2020</td>
<td>07/31/2020</td>
<td>08/31/2020</td>
</tr>
<tr>
<td>01/31/2020</td>
<td>06/30/2020</td>
<td>08/31/2020</td>
<td></td>
</tr>
<tr>
<td>02/29/2020</td>
<td>07/31/2020</td>
<td>09/30/2020</td>
<td></td>
</tr>
</tbody>
</table>

2. **Question:** How will the Provider Relief Fund (PRF) payments be reported on the Medicare Cost Report in terms of revenue?

**Answer:** All providers must report the PRF payments on the cost report’s statement of revenues for informational purposes. The revenue amount must be identified as COVID-19 PHE PRF. PRF payment amounts must be reported in aggregate on the following forms:

- hospital, form CMS-2552-10, Worksheet G-3, line 24.50;
- Skilled Nursing Facility, form CMS-2540-10, Worksheet G-3, line 24.50;
- HHA, form CMS-1728-94, Worksheet F-1, line 31.50;
- hospice, form CMS-1984-14, Worksheet F-2, column 3, line 16.50;
- ESRD, form CMS-265-11, Worksheet F-1, line 31.50;
- FQHC, form CMS-224-14, Worksheet F-1, line 28.50; and
- CMHC, form CMS-2088-17, Worksheet F, line 20.50

New: 8/26/20

3. **Question:** How will the Small Business Administration (SBA) Loan Forgiveness amounts be reported on the Medicare Cost Report in terms of revenue?

**Answer:** If a provider receives forgiveness for the SBA loan, or any portion thereof, the
provider must report the forgiven amount on the cost report’s statement of revenues for informational purposes. The loan forgiveness amount must be reported in aggregate, on the same cost report forms, worksheets, and lines as noted above for the PRF payments in Question 1. If the provider does not receive forgiveness for the SBA loan, or any portion thereof, the provider reports no forgiven amounts on the Medicare cost report. If the provider pays interest on any portion of the SBA loan, the provider may report the interest expense, similar to other interest expenses, on the cost report.

New: 8/26/20

4. **Question:** Should PRF payments offset expenses on the Medicare cost report?  
**Answer:** No, providers should not adjust the expenses on the Medicare cost report based on PRF payments received. However, providers must adhere to HRSA’s guidance regarding appropriate uses of PRF payments, in order to ensure that the money is used for permissible purposes (namely, to prevent, prepare for, or respond to coronavirus, and for health care related expenses or lost revenues that are attributable to coronavirus) and that the uses of the PRF payments do not violate the prohibition on using PRF money to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Recipients may find additional information on the terms and conditions of the PRF at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html. Questions regarding use of the funds, pursuant to the Fund Terms and Conditions and any questions about overpayments should be directed to HRSA.

New: 8/26/20

5. **Question:** Should SBA loan forgiveness amounts offset expenses on the Medicare cost report?  
**Answer:** No. Do not offset SBA Loan Forgiveness amounts against expenses unless those amounts are attributable to specific claims such as payments for the uninsured. The Paycheck Protection Program loan administered by the SBA is a loan designed to provide a direct incentive for small businesses to keep their workers on the payroll. The terms and conditions of the SBA loan forgiveness, overseen by the SBA, include employee retention criteria, and the funds must be used for eligible expenses.


New: 8/26/20

6. **Question:** Should hospitals report charges reimbursed through the PRF Uninsured Program on Worksheet S-10?
Answer: Subsection (d) hospitals that receive PRF payments from the Uninsured Program must not report charges reimbursed through that program for uninsured COVID-19 patients on Worksheet S-10 of the Medicare cost report. New: 8/26/20

7. Question: Should PRF payment amounts for lost revenue not directly attributable to patient-specific claims be used to offset expenses on the Medicare cost report? 
Answer: PRF payment amounts that are not attributable to patient-specific claims and are not PRF payment amounts from the Uninsured Program, should not be used to offset expenses on the Medicare cost report. Providers must adhere to HRSA’s guidance regarding appropriate uses of PRF payments, in order to ensure that the money is used for permissible purposes (namely, to prevent, prepare for, or respond to coronavirus, and for health care related expenses or lost revenues that are attributable to coronavirus) and that the uses of the PRF payments do not violate the prohibition on using PRF money to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. New: 8/26/20

8. Question: Can I claim my “employer’s share of Social Security tax” that I elected to defer in accordance with section 2302 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, as an accrued liability in the year the costs were incurred? 
Answer: Yes, in limited circumstances only. Section 2302 of the CARES Act provides that employers may defer the deposit and payment of the employer's portion of Social Security taxes and certain railroad retirement taxes (collectively referred to as the “employer’s share of Social Security tax”). The deferral applies to deposits and payments of the employer’s share of Social Security tax that would otherwise be required to be made during payroll tax deferral period that begins on March 27, 2020, and ends December 31, 2020. Providers that elect to take advantage of this payment deferral may expense this liability on the Medicare cost report in the year the costs were incurred in accordance with 42 CFR 413.100(c)(2)(i)(B), which states that “if, within the 1-year time limit, the provider furnishes to the contractor sufficient written justification (based upon documented evidence) for nonpayment of the liability, the contractor may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting period in which the liability was incurred.” Contractors may grant extensions for good cause for COVID-19-related deferrals of the employer’s share of Social Security taxes that were permitted under section 2302 of the CARES Act. Section 2302 of the CARES Act requires employers to deposit 50 percent of the deferred taxes on or before December 31, 2021, and the remaining 50 percent by December 31, 2022. However, if employers received loans under the Small Business Act and such loans were forgiven under section 1106 of the CARES Act, then such employers are not eligible for this deferral relief.
W. Opioid Treatment Programs (OTPs)

1. **Question:** How are the add-on codes for take-home supplies of medication provided by opioid treatment programs billed?
   **Answer:** There are two codes that describe take-home dosages of medication:
   - HCPCS code G2078 — take-home supplies of methadone — describes up to 7 additional days of medication and is billed along with the respective weekly bundled payment in units of up to 3 (for a total of up to a one-month supply). This add-on code is only used with the methadone weekly episode of care code (HCPCS code G2067).
   - HCPCS code G2079 — take-home supplies of oral buprenorphine — describes up to 7 additional days of medication and is billed along with the base bundle in units of up to 3 (for a total of up to a 1-month supply). This add-on code is only used with the oral buprenorphine weekly episode of care code (HCPCS code G2068).

2. **Question:** What is the threshold for billing the weekly bundled payment codes for opioid treatment programs?
   **Answer:** The threshold to bill a full episode is that at least one service is furnished (from either the drug or non-drug component) to the patient during the week that corresponds to the episode of care. If no drug was provided to the patient during that episode, the OTP must bill the G-code describing a weekly bundle not including the drug (HCPCS code G2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

3. **Question:** Will there be any changes to the rules for Opioid Treatment Programs (OTPs) billing the periodic assessment add-on code (HCPCS code G2077) during the COVID-19 public health emergency (PHE)?
   **Answer:** Yes, in light of the PHE for the COVID-19 pandemic, in CMS-5531-IFC, CMS revised § 410.67(b)(7) on an interim final basis to allow periodic assessments (described by HCPCS code G2077) to be conducted via two-way interactive audio-video communication technology. In cases where the beneficiary does not have access to two-way interactive audio-video communication technology, the periodic assessment may be furnished using audio-only telephone calls.