Medicare News and Web Updates for JL Part A (2022)

Prior Years:

- Archived Part A News - 2021
- Archived Part A News - 2020
- Archived Part A News - 2019
- Archived Part A News - 2018
- Archived Part A News - 2017

December 30, 2022

The Novitas Solutions' Medical Policy team has evaluated all active Local Coverage Articles for any impact in response to the 2023 Annual HCPCS/CPT Code Update. The following is a list of the impacted Articles. The revised Articles will be published to the Medicare Coverage Database and on our Website in January. Please continue to watch our website for updates.

- Billing and Coding: Acute Care: Inpatient, Observation and Treatment Room Services (A52985)
- Billing and Coding: Assays for Vitamins and Metabolic Function (A56416)
- Billing and Coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device) (A55240)
- Billing and Coding: Autonomic Function Tests (A54954)
- Billing and Coding: Bariatric Surgical Management of Morbid Obesity (A56422)
- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing (A56423)
- Billing and Coding: Complex Drug Administration Coding (A59073)
- Billing and Coding: Endovenous Stenting (A56414)
- Billing and Coding: eVox® System and Other Electroencephalograph Testing for Memory Loss (A56440)
- Billing and Coding: Facet Joint Interventions for Pain Management (A56670)
- Billing and Coding: Frequency of Hemodialysis (A55723)
- Billing and Coding: Frequency of Laboratory Tests (A56420)
- Billing and Coding: Hyaluronan Acid Therapies for Osteoarthritis of the Knee (A55036)
- Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM) (A58110)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Billing and Coding: Information Regarding Uses, Including Off-Label Uses, of Anti-Vascular Endothelial Growth Factor (anti-VEGF), for The Treatment of Ophthalmological Diseases (A53121)
- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)
- Billing and Coding: Nerve Conduction Studies and Electromyography (A54095)
- Billing and Coding: Non-Vascular Extremity Ultrasound (A55037)

- Billing and Coding: Outpatient Sleep Studies (A56923)
- Billing and Coding: Pharmacogenomics Testing (A58801)
- Billing and Coding: Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump (A55134)
- Billing and Coding: Psychiatric Codes (A57130)
- Billing and Coding: Respiratory Pathogen Panel Testing (A58575)
- Billing and Coding: Therapy and Rehabilitation Services (PT, OT) (A57703)
- Billing and Coding: Urodynamic Services - Non-invasive (A58541)
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December 29, 2022

COVID-19 vaccine: New product and administration codes for the Pfizer-BioNTech and Moderna COVID-19 vaccine bivalent

On December 8, the FDA amended the Pfizer-BioNTech COVID-19 emergency use authorizations (EUAs) to authorize bivalent formulations of the vaccines for use as a third primary series dose for ages 6 months through 4 years and Moderna COVID-19 EUAs as a booster for ages 6 months through 5 years. CMS issued four new codes effective December 8, the new Pfizer-BioNTech COVID-19 vaccine bivalent product code 91317 and the new Moderna COVID-19 vaccine bivalent product code 91316 and the two new affiliated administration codes 0173A and 0164A, respectively. CMS added the fees for these recently added codes to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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December 22, 2022

MLN Connects Newsletter: Dec 22, 2022

Editor's Note:

Happy holidays from the MLN Connects team. We'll release the next regular edition on Thursday, January 5, 2023.

News

- HHS Proposes to Standardize Electronic Health Care Attachments Transactions and Electronic Signature Processes to Improve the Care Experience for Patients and Providers
- Long-Term Care Hospital Provider Preview Reports: Review by January 17
- Inpatient Rehabilitation Facility Provider Preview Reports: Review by January 17

- Hospital Ownership Data Release
- Clotting Factor: CY 2023 Furnishing Fee
- Medicare Diabetes Prevention Program: CY 2023 Payment Rates
- CMS Burden Reduction News & Insights

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: January Update
- Integrated Outpatient Code Editor: Version 24.0
- DMEPOS: Revised 2023 Fee Schedule Public Use File
- National Correct Coding Initiative: Annual Policy Manual Update & Information on Other Payers

MLN Matters® Articles

- Clinical Laboratory Fee Schedule: CY 2023 Annual Update
- Hospital Outpatient Prospective Payment System: January 2023 Update
- Laboratory Edit Software Changes: April 2023
- New Medicare Part B Immunosuppressant Drug Benefit
- Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program — Revised

Publications

- Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier
- Rural Emergency Hospitals
- Intravenous Immune Globulin Demonstration — Revised
- Medicare Preventive Services — Revised

From Our Federal Partners

- CDC Interim Guidance: Antiviral Treatment of Influenza
- Important Updates from the CDC on COVID-19 Therapeutics for Treatment & Prevention

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Medical Policy Update

The following LCD posted for comment on August 11, 2022, has been posted for notice. The LCD and related billing and coding article will become effective February 5, 2023.

- Immune Globulin (L35093)
  - Billing and Coding: Immune Globulin (A56786)

The following response to comments article contains summaries of all comments received and Novitas' responses:

- Response to Comments: Immune Globulin (A59283)

The following billing and coding article has been revised:

- Billing and Coding: Allergen Immunotherapy (A56538)

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December 20, 2022

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The November 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. A new question / answer has been added to the return to provider category. Please take time to review these and other FAQs for answers to your questions.

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December 19, 2022

Limited systems availability

There will be Common Working File (CWF) 'Dark' days from December 30, 2022, through Sunday, January 1, 2023, due to the January 2023 release updates. The interactive voice response (IVR) will have limited availability. Additionally, the Customer Contact Center will be closed Monday, January 2, 2023.

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Unsolicited Voluntary Refunds Notification 2022

Please review this notice concerning voluntary refunds for 2022.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

MM12804 - New Medicare Part B Immunosuppressant Drug Benefit

- Make sure your billing staff knows that this new benefit is effective January 1, 2023:
  - Extension of Medicare coverage for immunosuppressant drugs beyond 36 months for certain patients with kidney transplants
  - Coverage of premiums and cost sharing for some of these patients

.

December 15, 2022

MLN Connects Newsletter: Dec 15, 2022

News

- Opioid Treatment Programs: New Information for 2023
- Part B Immunosuppressive Drug Benefit: Check Medicare Eligibility
- Home Health Quality Reporting Program: Get Final OASIS-E Instrument

Compliance

- Bill Correctly: Power Mobility Devices

Claims, Pricers, & Codes

- Intravenous Immune Globulin Treatment in the Home: ICD-10 Code Update

MLN Matters® Articles

- DMEPOS Fee Schedule: CY 2023 Update
- HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: April 2023
- Home or Residence Services: Billing Instructions
- National Coverage Determination 200.3: Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Publications

- Post-Acute Care Quality Reporting Program: Patient Health Questionnaire Cue Card

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December 14, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM13026 - Laboratory Edit Software Changes: April 2023

  Make sure your billing staff knows about changes to the laboratory NCD edit module for April 2023.

- MM13031 - Hospital Outpatient Prospective Payment System: January 2023 Update

  Make sure your billing staff knows about payment system updates and new codes for COVID-19, Drugs, biologicals, radiopharmaceuticals, devices, and other items and services.

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December 13, 2022

Billing for hospital Part B inpatient services – Ancillary services

This article includes updates to the allowed and not allowed revenue codes for billing Medicare Part B for inpatient services on a 12x type of bill based on recently updated information in the CMS IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, section 240.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12970 - Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program

  CMS revised this article due to a revised change request (CR) 12970. CMS is giving your MAC 60 days to reprocess claims affected by the CR. The CR release date, transmittal number, and the web address of the CR are also revised. All other information is the same.

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Unsolicited/Voluntary Refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill but may receive some unsolicited/voluntary refunds as checks. Part B

contractors generally receive checks. Substantial funds are returned to the trust fund each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

- The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Chapter 5, Section 410.10

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December 12, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

MM13023 - Clinical Laboratory Fee Schedule: CY 2023 Annual Update

- Make sure your billing staff knows about:
  - Instructions for the CY 2023 Clinical Laboratory Fee Schedule (CLFS)
  - Mapping for new codes for clinical laboratory tests
  - Updates for laboratory costs subject to the reasonable charge payment

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Medical policy

The following LCD, which was posted for notice on October 27, is now effective. The related billing and coding article for this LCD is also now effective:

- Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (L34998)
  - Billing and Coding: Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (A57072)

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December 9, 2022

Medical policy

The following billing and coding articles have been revised:

- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Billing and Coding: Intravenous Immune Globulin (IVIG) (A56786)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12950 - National Coverage Determination 200.3: Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

    - Make sure your billing staff knows about coverage for:
        - FDA-approved monoclonal antibodies
        - CMS-approved studies
- MM13004 - Home or Residence Services: Billing Instructions
    - Make sure your billing staff knows about billing for the new E/M visit family:
        - Codes
        - Care settings

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December 8, 2022

MLN Connects Newsletter: Dec 8, 2022

News

- CMS Proposes Rule to Expand Access to Health Information and Improve the Prior Authorization Process
- Rural Emergency Hospitals: New Institutional Provider Type Starting January 1
- Certificates of Medical Necessity & DME Information Forms Discontinued January 1
- Drugs & Biologics: Reporting Average Sales Price Data
- Provider Enrollment Application Fee: CY 2023
- Skilled Nursing Facility Value-Based Purchasing Program: December Feedback Report
- Bronchodilator Nebulizer Medications: Comparative Billing Report in December
- Short-term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Flu Shots: Help Address Disparities

Compliance

- Bill Correctly: Power Mobility Device Repairs

Claims, Pricers, & Codes

- Medicare National Correct Coding Initiative: Annual Policy Manual Update
- National Correct Coding Initiative: January Update

Events

- FY 2024 New Technology Town Hall Meeting — December 14
- Medicare Ground Ambulance Data Collection System Webinar: Data Certifier Role — December 15

MLN Matters® Articles

- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2023 Changes
- National Coverage Determination 110.24: Chimeric Antigen Receptor T-cell Therapy
- Rural Health Clinic All-Inclusive Rate: CY 2023 Update

From Our Federal Partners

- Biosimilars & Interchangeable Products: Free Continuing Education Courses from FDA

.

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12842 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)—January 2023 Update – 2 of 2
    - CMS revised this article due to a revised CR12842. As a result, CMS deleted the bullet point for NCD 150.3 on page 2. Also, CMS changed the CR release date, transmittal number and the CR web address. All other information remains the same.

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December 7, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM13006 - Calendar Year 2023 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
    - Make sure your billing staff knows about this annual update:
        * Fee schedule amounts for new and existing codes
        * Payment policy changes

.

December 5, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12814 - Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2023 Changes

  Make sure your billing staff knows about FY 2023 IPPS updates, FY 2023 LTCH PPS updates, and update to certain hospitals that CMS excludes from the IPPS.
- MM12928 - National Coverage Determination 110.24: Chimeric Antigen Receptor T-cell Therapy

  Make sure your billing staff knows about these changes for CAR T-cell Therapy (CAR-T) billing Include additional place of service (POS) codes for office and independent clinics, bill in 0.1-unit fractions, and use 3 modifiers, including new modifier -LU.

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December 2, 2022

Open claim issues - Part A

The open claims issues associated with reason code 38204 has been closed.

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December 1, 2022

MLN Connects Newsletter: Dec 1, 2022

News

- CMS Urges Timely Patient Access to COVID-19 Vaccines, Therapeutics
- Quality Payment Program: Preview Your Performance Information by December 20
- Clinical Laboratory Fee Schedule: CY 2023 Final Payment Determinations
- HIV: Screening is Knowledge

Compliance

- LAAC & ICD National Coverage Determinations: Submit Proper Documentation

MLN Matters® Articles

- National Fee Schedule for Medicare Part B Vaccine Administration
- New Waived Tests
- New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers during the COVID-19 PHE — Revised
- Home Health Claims: New Grouper Edits — Revised

Publications

- Checking Medicare Eligibility — Revised

From Our Federal Partners

- Biosimilars: Are They the Same Quality?

Information for Patients

- Options When ESRD Coverage with Medicare Ends

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12999 - Rural Health Clinic All-Inclusive Rate: CY 2023 Update

  Make sure your billing staff knows about RHC per-visit payment limit for CY 2023, specified (grandfathered) provider-based RHC payment limits, and cost report data requirements.

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November 28, 2022

Medical policy

The comment period is now closed for the following Proposed LCDs. Comments received will be reviewed by our contractor medical directors. The response to comments articles and finalized billing and coding articles will be related to the final LCDs when they are posted for notice.

- Ambulatory Electrocardiograph (AECG) Monitoring (DL39490)
- Controlled Substance Monitoring and Drugs of Abuse Testing (DL35006)

November 23, 2022

MLN Connects Newsletter: Nov 23, 2022

News

- Colorectal Cancer Screening Test: Reduced Coinsurance for Related Procedures Begins January 1
- Ambulance Fee Schedule: CY 2023 Inflation Factor & Productivity Adjustment
- Medicare Ground Ambulance Data Collection System: Information to Help You Report
- Health Professional Shortage Area: CY 2023 Bonus Payments
- Rural Health: Help Address Disparities

MLN Matters® Articles

- ESRD & Acute Kidney Injury Dialysis: CY 2023 Updates
- Home Health Prospective Payment System: CY 2023 Update
- Medicare Physician Fee Schedule Final Rule Summary: CY 2023

Publications

- Federally Qualified Health Center — Revised

From Our Federal Partners

- Managing Monkeypox in Patients Receiving Therapeutics: CDC Update

.

November 22, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12943 - National Fee Schedule for Medicare Part B Vaccine Administration
    - Make sure your billing staff knows about:
        * Updated payment amount for preventive vaccine administration
        * HCPCS codes to which these adjustments apply
        * COVID-19 vaccine administration codes

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November 18, 2022

Medical policy

As a reminder, the comment period for the following proposed LCDs is currently open and will close on November 26. Please consider including literature/evidence in support of your request with your comments. We encourage you to submit your comments as soon as possible.

- Ambulatory Electrocardiograph (AECG) Monitoring (DL39490)
- Controlled Substance Monitoring and Drugs of Abuse Testing (DL35006)

Submit Comments

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12982 - Summary of Policies in the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

  Make sure your billing staff knows about the following CY 2023 MPFS updates:

  - Telehealth originating site facility fee payment amount.
  - Expansion of coverage for colorectal cancer screening.
  - Coverage of audiology services.
  - Other covered services.

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November 17, 2022

MLN Connects Newsletter: Nov 17, 2022

News

- Hospital Price Transparency: Download Machine-Readable File Sample Formats & Data Dictionaries
- Medical Review After the COVID-19 Public Health Emergency: New FAQ
- Flu Shots & COVID-19 Vaccines: Each Visit is an Opportunity

Claims, Pricers, & Codes

- DMEPOS: Corrected 2022 Fee Schedule Amounts
- Hospital Part B Inpatient Services Billing
- Outpatient Prospective Payment System Payment Rate for HCPCS Code Q5124

Events

- HCPCS Public Meeting: November 29 – December 1

MLN Matters® Articles

- Provider Enrollment Instructions: Seventh General Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations (NCDs): April 2023 Update

Publications

- Home Health & Hospice: Medicare Provider Resources
- Independent Diagnostic Testing Facility (IDTF) — Revised

Multimedia

- Quality in Focus Videos to Increase Quality of Care

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Medical policy

The following billing and coding articles have been revised.

- Billing and Coding: Biomarkers Overview (A56541)
- Billing and Coding: eVox® System and Other Electroencephalograph Testing for Memory Loss (A56440)

The following LCD and related billing and coding article have been retired:

- Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (L34822)
  - Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)

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HCPCS codes no longer requiring an invoice - Avoid rejected claims

To reduce provider burden, certain contractor priced HCPCs codes no longer require a paper invoice. Effective November 12 claims not containing information about the invoice or cost associated with the code(s) will reject as unprocessable.

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November 16, 2022

Assist us in developing LCDs – Volunteer as a CAC member!

The parameters of who may serve as a Medicare Contractor Advisory Committee (CAC) member were expanded by Change Request 10901 and the companion MLN Matters article. We invite you to volunteer as a CAC member or alternate to represent your organization during our CAC meetings as part of our LCD development process.

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November 15, 2022

The following articles which were posted for notice on September 29, became effective November 14.

- Billing and Coding: Esketamine (A59249)
- Self-Administered Drug Exclusion List (A53127)

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Medicare secondary payer (MSP): Benefits Coordination & Recovery Center (BCRC) renamed MSP Contractor

Effective with the implementation of MLN MM12765 Significant updates to internet only manual (IOM) publication (Pub.) 100-05 Medicare secondary payer (MSP) Manual, Chapter 5 on October 13, CMS now refers to the entity that used to be known as the BCRC as the MSP Contractor. As a result, Novitas articles on the MSP specialty page referencing the BCRC have been updated to reflect the name change. Please take time to review these articles.

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November 11, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12960- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--April 2023 Update

  Make sure your staff knows about these changes newly available codes, separate NCD coding revisions, and coding feedback.

  Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12960. CMS isn't including any policy changes in this ICD-10 quarterly update. CMS cover NCD policy changes using the current, longstanding NCD process.

- MM12978 - Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2023

  Make sure your billing staff knows about these changes CY 2023 rate updates and policies for the ESRD Prospective Payment System (PPS). Updates to payment for renal dialysis services provided to patients with AKI in ESRD facilities.

Revised:

- MM12888 - Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023

  CMS revised this article due to revised CR 12888. The CR revision didn't affect the substance of the article. CMS did revise the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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November 10, 2022

MLN Connects Newsletter: Nov 10, 2022

News

- Teaching Hospitals: Phase 2 Section 131 Reviews — Submission Deadline November 18
- Medicare Participation for CY 2023
- CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care
- DMEPOS: Appeals & Rebuttals Contractor Clarification
- Lung Cancer: Help Your Patients Reduce Their Risk

Compliance

- What's the Comprehensive Error Rate Testing Program?

Claims, Pricers, & Codes

- Home Health Prospective Payment System Grouper: January Update
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- HCPCS Application Summary for Continuous Glucose Monitoring: Updated

MLN Matters® Articles

- Telehealth Home Health Services: New G-Codes

From Our Federal Partners

- Increased Respiratory Virus Activity, Especially Among Children
- Ebola Virus Disease Outbreak in Central Uganda: Update

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The September 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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MACs will host a multi-jurisdictional CAC meeting regarding RPM/RTM for non-implantable devices on Tuesday, February 28, 2023

This meeting will be held via webinar only.

On February 28, 2023, Medicare administrative contractors (MACs) Novitas Solutions (Jurisdictions H and L) and First Coast Service Options (Jurisdiction N), along with Noridian Healthcare Solutions (Jurisdictions E and F), CGS Administrators (Jurisdiction 15), Palmetto GBA (Jurisdictions J and M), and WPS Government Health Administrators (Jurisdictions 5 and 8) will host a multi-jurisdictional Contractor Advisory Committee (CAC) meeting.

The purpose of the meeting is to obtain advice from a select panel regarding the strength of published evidence on remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) for non-implantable devices and any compelling clinical data to assist in defining meaningful and measurable patient outcomes (e.g., decreases in emergency room visit and hospitalizations) for our Medicare beneficiaries. In addition to discussion, the panelists will opine on pre-distributed questions during the meeting. CAC panels do not make coverage determinations, but MACs benefit from their advice.

All panelists who have completed Conflict of Interest and Consent to Publish Comments Disclosure forms on file will be given the opportunity to submit responses to the questions and/or any written comments within one week of the meeting. The public is invited to attend as observers.

Complete details, including background material, questions, agenda, and registration will be available on our multi-jurisdictional CAC website by February 14, 2023.

.

November 8, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12880 - Provider Enrollment Instructions: Seventh General Update

  Make sure your billing staff knows about updated provider enrollment instructions for:

  - Ownership disclosures
  - Electronic funds transfers (EFTs)
  - Special payment addresses

November 3, 2022

MLN Connects Newsletter: Nov 3, 2022

News

- COVID-19 Vaccine: Novavax Booster Authorized
- Medicare Part B Immunosuppressive Drug: Get Information on New Benefit
- Part B Immunosuppressive Drug Benefit: Check Medicare Eligibility
- Skilled Nursing Facilities: October Care Compare Release
- Clinical Diagnostic Laboratories: Report Private Payor Rate Data Beginning January 1
- Diabetes: Recommend Preventive Services

Claims, Pricers, & Codes

- Home Health Consolidated Billing Enforcement: CY 2023 HCPCS Codes

Publications

- Medicare Provider Compliance Tips — Revised

Multimedia

- Hospice Quality Reporting Program: September Forum Materials

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COVID-19 vaccine: New administration code for the booster dose of Novavax COVID-19 vaccine

On October 19, the FDA amended the Novavax COVID-19 vaccine, Adjuvanted emergency use authorization (EUA) to authorize the use of a first booster dose for patients 18 years and older. CMS issued the CPT code 0044A effective October 19, for the administration of the Novavax COVID-19 vaccine booster dose. CMS added the fee for this code to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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Prior authorization: Hospital outpatient department services frequently asked questions (FAQs)

This article has been updated and new FAQs have been added. Please take time to review the updated information.

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November 2, 2022

Special Edition - Tuesday, November 1, 2022

MLN Connects Newsletter: OPPS/ASC & PFS Final Payment Rules

Final Rules

- HHS Continues Biden-Harris Administration Progress in Promoting Health Equity in Rural Care Access Through Outpatient Hospital and Surgical Center Payment System Final Rule
- HHS Finalizes Physician Payment Rule Strengthening Access to Behavioral Health Services and Whole-Person Care

This newsletter is current as of the issue date. View the complete disclaimer.

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November 1, 2022

Special Edition - Monday, October 31, 2022

MLN Connects Newsletter: Final Rules

Final Rules

- CY 2023 Home Health Prospective Payment System Rate Update and Home Infusion Therapy Services Requirements
- Calendar Year 2023 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)
- Finalized Policies to Simplify Enrollment and Expand Access to Coverage

This newsletter is current as of the issue date. View the complete disclaimer.

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October 28, 2022

Open claim issues - Partial Hospitalization Program (PHP) outpatient claims

Reason code 32804 is editing incorrectly on incoming prior hospitalization interim bills. A correction has been developed and is tentatively scheduled to be installed on November 28. We will post an update confirming when the correction is successfully installed. Providers will be able to resubmit claims after that date.

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October 27, 2022

MLN Connects Newsletter: Oct 27, 2022

News

- COVID-19 Updated Booster Vaccines Covered Without Cost-Sharing for Eligible Children Ages 5–11
- Oversight of Nation’s Poorest-Performing Nursing Homes
- Initial Nursing Facility Evaluation & Management Visits: Comparative Billing Report in October
- Help Promote Efficiency, Reduce Burden, & Advance Equity: Submit Comments by November 4

MLN Matters® Articles

- Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program
- Patient Driven Payment Model: Claim Edit Enhancements

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Medical Policy update

The following LCD posted for comment on June 9, has been posted for notice. The LCD and related billing and coding article will become effective December 11.

- Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (L34998)
  - Billing and Coding: Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (A57072)

The following response to comments article contains summaries of all comments received and Novitas' responses:

- Response To Comments: Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (A59262)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12896 - Enhancements to Patient Driven Payment Model (PDPM) Claim Edits to Improve Claim Processing

  Make sure your billing staff knows about corrections to edits of SNF Type of Bill (TOB) 21X claims and changes to certain hospital overlap edits.

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COVID-19 vaccine: New product and administration codes for the Pfizer-BioNTech and Moderna COVID-19 vaccine bivalent

On October 12, the FDA amended the Pfizer-BioNTech and Moderna COVID-19 emergency use authorizations (EUAs) to authorize bivalent formulations of the vaccines for use as a singer booster does in younger age groups. CMS issued four new codes effective October 12, the new Pfizer-BioNTech COVID-19 vaccine bivalent product code 91315 and the new Moderna COVID-19 vaccine bivalent product code 91314 and the two new affiliated administration codes 0154A and 0144A, respectively. CMS added the fees for these recently added codes to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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October 24, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12970 - Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program

  Make sure you're aware of the extension to the low-volume hospital payment adjustments and MDH program.

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October 21, 2022

Open claim issues - update for 340B-acquired drug claims

On September 28, the United States District Court for the District of Columbia vacated the differential payment rates for 340B-acquired drugs in the calendar year (CY) 2022 outpatient prospective payment system (OPPS) final rule.

The Court vacated the average sales price (ASP) minus 22.5% drug payment rate in the Medicare OPPS system for 340B-acquired drugs with respect to its prospective application and explained that the reimbursement rate will revert to the default payment rate (generally ASP plus 6%) under the Medicare statute.

Update 10/21/2022: Providers may submit adjustments on any claim submitted for date of service in 2022 paid before September 28.

We will not perform mass adjustments on impacted claims with a 2022 date of service paid before September 28. Claims paid on or after September 28, will be automatically adjusted.

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October 20, 2022

MLN Connects Newsletter: Oct 20, 2022

News

- Skilled Nursing Facility Provider Preview Reports: Review by November 14
- Help Your Patients Make Informed Health Care Decisions
- Ambulance Fee Schedule: CY 2023 Ambulance Inflation Factor & Productivity Adjustment

Compliance

- Implanted Spinal Neurostimulators: Document Medical Records

Claims, Pricers, & Codes

- DMEPOS: Corrected 2022 E2102 Fee Schedule Amounts

MLN Matters® Articles

- Medicare Deductible, Coinsurance, & Premium Rates: CY 2023 Update

Information for Patients

- Medicare Open Enrollment: October 15 – December 7

Medical Policy update

The following billing and coding articles have been revised to reflect the annual ICD-10 code updates effective for dates of service on and after October 1:

- Billing and Coding: Ambulance Services (Ground Ambulance) (A54574)
- Billing and Coding: Assays for Vitamins and Metabolic Function (A56416)
- Billing and Coding: Cardiac Event Detection Monitoring (A56600)
- Billing and Coding: Cardiac Rhythm Device Evaluation (A56602)
- Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing (A56423)
- Billing and Coding: Controlled Substance Monitoring and Drugs of Abuse Testing (A56645)
- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Billing and Coding: Flow Cytometry (A56676)
- Billing and Coding: Frequency of Hemodialysis (A55723)
- Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) (A56725)
- Billing and Coding: Intraoperative Neurophysiological Testing (A56722)
- Billing and Coding: Intravenous Immune Globulin (IVIG) (A56786)
- Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Billing and Coding: Magnetic Resonance Angiography (MRA) (A56805)
- Billing and Coding: Monitored Anesthesia Care (A57361)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions (A53134)
- Billing and Coding: Nerve Conduction Studies and Electromyography (A54095)
- Billing and Coding: Oximetry Services (A57205)
- Billing and Coding: Pharmacogenomics Testing (A58801)
- Billing and Coding: Psychiatric Codes (A57130)
- Billing and Coding: Pulmonary Function Testing (A57320)
- Billing and Coding: Real-Time, Outpatient Cardiac Telemetry (A52995)
- Billing and Coding: Speech Language Pathology (SLP) Services: Communication Disorders (A54111)
- Billing and Coding: Thoracic Aortography and Carotid, Vertebral, and Subclavian Angiography (A56631)
- Billing and Coding: Transesophageal Echocardiography (TEE) (A56505)

The following billing and coding article has been revised effective for dates of service on and after October 1:

- Billing and Coding: Hemophilia Factor Products (A56433)

The following LCD has been retired effective October 1:

- Hemophilia Factor Products (L35111)

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October 19, 2022

HCPCS codes no longer requiring an invoice - Avoid rejected claims

To reduce provider burden, certain contractor priced HCPCs codes no longer require a paper invoice. Effective November 12 claims not containing information about the invoice or cost associated with the code(s) will reject as unprocessable. Please review this article for additional information. HCPCS code listing.

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October 17, 2022

Medical Policy update

The following LCD, which was posted for notice on September 1, became effective on October 16. The related billing and coding article for this LCD is also effective:

- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Amplification Techniques (NAATs) (L38229)
  - Billing and Coding: Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (A56642)

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October 14, 2022

2023 Medicare rates available

CMS has released the 2023 Medicare rates, Part A and B deductible and coinsurance rates, and Part A and B premium amounts. Please review our article Deductibles/co-insurances/therapy thresholds for the updated amounts. This information can also be found directly via the link on the home page of our website.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12903 - Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2023

  Make sure your billing staff knows about these CY 2023 rate changes. Medicare Part A and Medicare Part B deductible and coinsurance rates. Part A and Part B premium amounts.

.

October 13, 2022

MLN Connects Newsletter: Oct 13, 2022

News

- Protect Your Patients in October: Give Them a Flu Shot & COVID-19 Vaccine

- Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period
- Clinical Laboratory Fee Schedule: Final Gap-fill Recommendations

Claims, Pricers, & Codes

- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update Fiscal Year (FY) 2023

MLN Matters® Articles

- Home Health Claims: New Grouper Edits
- New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI

Publications

- Medicare Preventive Services — Revised
- National Expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model — Revised

From Our Federal Partners

- Outbreak of Ebola Virus Disease in Central Uganda

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Medical Policy update

The following proposed LCDs have been posted for comment. The comment period will end on November 26; however, you are encouraged to submit your comments as soon as possible. When submitting your comments, we encourage you to submit literature/evidence supporting your recommendations for our contractor medical directors to consider.

- Ambulatory Electrocardiograph (AECG) Monitoring (DL39490)
- Controlled Substance Monitoring and Drugs of Abuse Testing (DL35006)

Submit comments

The following draft billing and coding articles are related to the above proposed LCDs.

- Billing and coding: Ambulatory Electrocardiograph (AECG) Monitoring (DA59268)
- Billing and coding: Controlled Substance Monitoring and Drugs of Abuse Testing (DA56645)

The following billing and coding article has been revised.

- Billing and coding: Independent Diagnostic Testing Facility (IDTF) (A53252)

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Online registration available for October 28 open meeting and proposed LCDs now posted

Online registration for the October 28 open meeting is now available and will close at noon ET on Wednesday, October 26. **Important: During this unprecedented time, our open meeting will be held via webinar only.** The Novitas Solutions proposed LCDs are now posted.

Open meetings are to allow interested parties the opportunity to make presentations of information and offer comments related to new proposed LCDs and/or the revised portion of a proposed LCD that are in the 45-day open comment period. Interested parties may also request to attend as an observer.

If you are interested in attending as a presenter or observer, please view our Proposed Local Coverage Determination Open Meetings page for specific guidelines and other helpful information.

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HCPCS codes no longer requiring an invoice

To reduce provider burden, certain contractor priced HCPCS codes no longer require a paper invoice. The invoice amount should still be reported in item 19 of the CMS-1500 paper claim form or the electronic equivalent

Please review this article for additional information.

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October 11, 2022

Changes to amount in controversy for appeals in 2023

The Centers for Medicare & Medicaid Services has announced the dollar amount that must remain in controversy to sustain appeal rights beginning January 1, 2023. Please read this article for details.

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Update to the Part A open claim issues log

Update 10/11/22: The correction was successfully installed. The services listed in CR12711 can be submitted.

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October 7, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12889 - New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician National Provider Identifier (NPI)

  Make sure your billing staff knows a new consistency edit that validates the attending provider NPI. Organizational NPIs can't be used in place of individual NPIs, unless exception conditions are met.

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October 6, 2022

MLN Connects Newsletter: Oct 6, 2022

News

- Resources & Flexibilities to Assist with Public Health Emergency in South Carolina
- Implementation of Inflation Reduction Act Provision Addressing Medicare Payments for Biosimilars

- CMS Asks for Public Input on Establishing First, National Directory of Health Care Providers and Services
- Inflation Reduction Act Lowers Health Care Costs for Millions of Americans
- Help Promote Efficiency, Reduce Burden, & Advance Equity: Submit Comments by November 4
- Inpatient Rehabilitation Facilities: IRF-PAI & September Care Compare Release
- Long-Term Care Hospitals: September Care Compare Release
- Help Detect Breast Cancer Early

Claims, Pricers, & Codes

- October 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.3

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: October 2022 Update
- DMEPOS Fee Schedule: October 2022 Quarterly Update
- Inpatient Prospective Payment System Hospitals in the 9th Circuit: Updated Fiscal Years 2019 and 2020 Supplemental Security Income Medicare Beneficiary Data

Information for Patients

- 2023 Medicare & You Handbook

.

Anesthesia services for epidural steroid injections and facet joint injections for pain management

The use of moderate or deep sedation, general anesthesia or monitored anesthesia care is usually unnecessary or rarely indicated for epidural steroid injections. General anesthesia is considered not medically reasonable and necessary for facet joint interventions. Please review this article for additional information.

.

The following billing and coding articles have been revised:

- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)

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October 3, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12656 - Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter As Certain Colorectal Cancer Screening Tests

  CMS revised this article to reflect a revised change request (CR) 12656 that added new business requirements to add the other amount indicator “B2” for co-insurance reduction amount to the claim, modify edits that affect the co-insurance reduction amount, and report the applied coinsurance amount in the co-insurance field. The changes did not affect the contents

of this article. CMS changed the CR release date, transmittal number and the CR web address. All other information remains the same.

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September 30, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12906 - The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Years (FYs) 2019 and 2020 for Inpatient Prospective Payment System (IPPS) Hospitals with Updated Data for Hospitals in the 9th Circuit

  Make sure your billing staff knows that the data for: IPPS hospitals in the Ninth Circuit's jurisdiction is updated based on Supreme Court decision in Azar v. Empire Health Foundation and all other hospitals is unchanged.

- MM12918 - October Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  Make sure your billing staff knows about The October 2022 quarterly update for the DMEPOS fee schedule and fee schedule amounts for new and existing codes.

.

September 29, 2022

MLN Connects Newsletter: Sept 29, 2022

News

- Resources & Flexibilities to Assist with Public Health Emergency in Puerto Rico
- Resources & Flexibilities to Assist with Public Health Emergency in Florida
- 2023 Medicare Parts A & B Premiums and Deductibles
- Clinical Laboratory Fee Schedule Payment Determinations & Voting Results: Submit Comments by October 24
- DMEPOS: Change to Enrollment Contractor After November 6
- Hispanic or Latino Patients: Help Address Disparities

Claims, Pricers, & Codes

- ICD-10 Coordination & Maintenance Committee: Meeting Materials & Deadlines
- HCPCS Application Summary for Non-Drug & Non-Biological Items and Services

.

The following Billing and Coding Article has been added to become effective November 14:

- Billing and Coding: Esketamine (A59249)

The following Article has been revised and will become effective November 14:

- Self-Administered Drug Exclusion List (A53127)

The following Billing and Coding Article has been revised:

- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)

.

September 27, 2022

Medical Policy update

Our Medical Policy team has evaluated all active local coverage articles for any impact in response to the 2023 Annual ICD-10 Code Update. The following is a list of the impacted articles. The revised articles will be published to the Medicare Coverage Database and on our website in the middle of October. Please continue to watch our website for updates.

- Billing and Coding: Ambulance Services (Ground Ambulance) (A54574)
- Billing and Coding: Assays for Vitamins and Metabolic Function (A56416)
- Billing and Coding: Cardiac Event Detection Monitoring (A56600)
- Billing and Coding: Cardiac Rhythm Device Evaluation (A56602)
- Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing (A56423)
- Billing and Coding: Controlled Substance Monitoring and Drugs of Abuse Testing (A56645)
- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Billing and Coding: Flow Cytometry (A56676)
- Billing and Coding: Frequency of Hemodialysis (A55723)
- Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) (A56725)
- Billing and Coding: Intraoperative Neurophysiological Testing (A56722)
- Billing and Coding: Intravenous Immune Globulin (IVIG) (A56786)
- Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Billing and Coding: Magnetic Resonance Angiography (MRA) (A56805)
- Billing and Coding: Monitored Anesthesia Care (A57361)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions (A53134)
- Billing and Coding: Nerve Conduction Studies and Electromyography (A54095)
- Billing and Coding: Oximetry Services (A57205)
- Billing and Coding: Pharmacogenomics Testing (A58801)
- Billing and Coding: Psychiatric Codes (A57130)
- Billing and Coding: Pulmonary Function Testing (A57320)
- Billing and Coding: Real-Time, Outpatient Cardiac Telemetry (A52995)
- Billing and Coding: Speech Language Pathology (SLP) Services: Communication Disorders (A54111)
- Billing and Coding: Thoracic Aortography and Carotid, Vertebral, and Subclavian Angiography (A56631)
- Billing and Coding: Transesophageal Echocardiography (TEE) (A56505)

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Open claim issue with cancel claims for dates of service in 2022

All claims that were incorrectly posted to CWF have been reviewed and any corrections that were needed have been completed. If you have claims that were impacted by a claim that was incorrectly posted to CWF, please adjust or resubmit your claim as appropriate.

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September 26, 2022

Limited systems availability

There will be Common Working File (CWF) "Dark" days from Friday, September 30, through Monday, October 2, due to the October 2022 release upgrades. The interactive voice response will have limited availability.

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The comment period is now closed for the following Proposed LCDs. Comments received will be reviewed by our Contractor Medical Directors. The Response to Comments Articles and finalized Billing and Coding Articles will be related to the final LCDs when they are posted for notice.

- Immune Globulin (DL35093)
- Nerve Stimulators for Chronic Intractable Pain (DL39404)
- Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DL35041)

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Appropriate use criteria (AUC) program for advanced diagnostic imaging services

The payment penalty phase will not begin January 1, 2023, even if the public health emergency (PHE) for COVID-19 ends in 2022. Until further notice, the educational and operations testing period will continue. CMS is unable to forecast when the payment penalty phase will begin. Please review this article for the guidelines.

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September 22, 2022

Encourage Preferred Flu Vaccines for Patients 65+

MLN Connects newsletter for Thursday, September 22, 2022

News

- Flu Shot: Encourage Preferred Vaccines for Patients 65+
- Cataract Surgery: Comparative Billing Report
- Do You Only Order or Certify Services? Use Revised Enrollment Form CMS-855O by January 1

- Cardiovascular Disease: Talk with Your Patients about Screening

Claims, Pricers, & Codes

- October 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Articles

- October 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Publications

- Hospice Quality Reporting Program: New Resources

.

Online registration now available for the October 6 Contractor Advisory Committee (CAC) meeting

Due to the public health crisis this **meeting will be held via webinar only**.

Online registration for the Thursday, October 6, CAC Meeting is now available and will close at 3:30 p.m. ET on Wednesday, October 5. The purpose of the meeting is to obtain advice from CAC members regarding the strength of published evidence for Molecular Testing in Infectious Disease.

The CAC provides a formal mechanism for healthcare professionals to be informed of the evidence used in developing the LCD and promotes communications between the MAC and the healthcare community. CAC members will serve in an advisory capacity as representatives of their constituency to review the quality of the evidence used in the development of the LCD. The final decision on all issues rests with the contractor medical directors (CMDs). More information regarding CAC meetings is available on our website.

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September 20, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12870 - Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

  CMS revised this article due to a revised Change request (CR)12870. The CR revision corrected an acronym. CMS also changed the CR release date, the transmittal number, and the web address of the CR. All other information is the same.

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September 19, 2022

Medical Policy update

The following local coverage article, which was posted for notice on August 4, is now effective:

- Self-Administered Drug Exclusion List (A53127)

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The August 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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September 16, 2022

Medical Policy update

As a reminder, the comment period for the following proposed LCDs is currently open and will close on September 24. Please consider including literature/evidence in support of your request with your comments. We encourage you to submit your comments as soon as possible.

- Immune Globulin (DL35093)
- Nerve Stimulators for Chronic Intractable Pain (DL39404)
- Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DL35041)

Submit Comments

.

September 15, 2022

Make Your Voice Heard

MLN Connects newsletter for Thursday, September 15, 2022

News

- Make Your Voice Heard Request for Information Seeks Public Comment to Promote Efficiency, Reduce Burden, & Advance Equity within CMS Programs
- Enhancing Oncology Model to Improve Cancer Care: Apply by September 30
- Revision to National Coverage Determination (NCD) 240.2 (Home Use of Oxygen) to Align to 1834(a)(5)(E) of the Social Security Act

Claims, Pricers, & Codes

- Billing for Hospital Part B Inpatient Services
- National Correct Coding Initiative: October Quarterly Update

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment — Revised

.

September 13, 2022

COVID-19 vaccine: New product and administration codes for the Pfizer-BioNTech and Moderna COVID-19 vaccine bivalent

On August 31, the FDA amended the Pfizer-BioNTech emergency use authorization (EUA) to authorize bivalent booster doses (updated COVID-19 vaccines) for patients 12 years and older and amended the Moderna EUA to authorize bivalent booster doses (updated COVID-19 vaccines) for patients 18 years and older. CMS issued four new codes effective August 31, the new Pfizer-BioNTech COVID-19 vaccine, bivalent product code 91312 and the new Moderna COVID-19 vaccine, bivalent product code 91313 and the two new affiliated administration codes 0124A and 0134A, respectively. CMS added the fees for recently added codes to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12885 - October 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  Make sure your billing staff knows about New COVID-19 CPT vaccine and administration codes, Redosing update for EVUSHELD, New procedure to assess coronary disease severity using computed tomography angiography.

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September 12, 2022

Monday, September 12, 2022

News

Updated COVID-19 Vaccines Providing Protection Against Omicron Variant Available at No Cost

.

September 8, 2022

Prostate Cancer: Talk to Your Patients about Screening

MLN Connects newsletter for Thursday, September 8, 2022

News

- Short-Term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Prostate Cancer: Talk to Your Patients about Screening

MLN Matters® Articles

- Exceptions to Average Sales Price (ASP) Payment Methodology – Claims Processing Manual Changes

.

September 6, 2022

Medical policy

The comment period is now closed for the following Proposed LCD. Comments received will be reviewed by our contractor medical directors. The Response to Comments article and finalized Billing and Coding article will be related to the final LCD when it is posted for notice.

- Genetic Testing for Oncology (DL39365)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12888 - Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023

  Make sure your billing staff knows about changes to the Laboratory NCD Edit Module for January 2023 and how to access the NCD spreadsheet that lists relevant changes.

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September 1, 2022

Payment Allowances for Influenza Vaccine

MLN Connects newsletter for Thursday, September 1, 2022

News

- CORRECTION: Monkeypox & Smallpox Vaccines: Include Product Code on Claims
- COVID-19: Novavax Vaccine Authorized for Patients 12–17 Years Old
- Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 & Continues to Deliver High-quality Care
- Increased Use of Telehealth for Opioid Use Disorder Services During COVID-19 Pandemic Associated with Reduced Risk of Overdose
- Sickle Cell Disease: What You Need to Know Video
- Healthy Aging: Recommend Services for Your Patients

Compliance

- DMEPOS Standard Written Order Requirements

Claims, Pricers, & Codes

- Influenza Vaccine Payment Allowances - Annual Update for 2022–2023 Season
- Quarterly Update to Home Health (HH) Grouper

Multimedia

- Introduction to Language Access Plans Web-Based Training
- Combating Medicare Parts C and D Fraud, Waste, & Abuse Web-Based Training — Revised

Information for Patients

- How to Report a Medicare Complaint

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12854 - Exceptions to Average Sales Price (ASP) Payment Methodology – Claims Processing Manual Changes

  Make sure your billing staff knows about the updates to chapter 17 of the Medicare Claims Processing Manual, and the exceptions to ASP payment methods.

Revised:

- MM12822 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--January 2023 Update

  CMS revised this Article due to a revised CR 12822. The CR revision didn't affect the substance of the article. CMS revised the CR release date, transmittal number, and the CR web address. All other information is the same.

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Medical Policy Updates

The following LCD posted for comment on April 14has been posted for notice. The LCD and related Billing and Coding Article will become effective October 16.

- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (L38229)
- Billing and Coding: Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (A56642)

The following Response to Comments Article contains summaries of all comments received and Novitas' responses:

- Response to Comments: Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (A59197)

The following LCD has been revised:

- Trigger Point Injections (L35010)

The following LCD posted for comment on April 14 was reposted for comment on August 11, 2022. The comment period will end on September 24.

- Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DL35041)

The following Draft Billing and Coding Article is related to the above Proposed LCD.

- Billing and Coding: Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DA54117)

Submit Comments

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August 29, 2022

Prior authorization for hospital outpatient department services: Don't wait too long to submit your prior authorization requests

When submitting prior authorization requests, be aware of response timeframes and documentation guidelines. Please take time to review this article for details.

.

August 26, 2022

Medical Policy Updates

As a reminder, the comment period for the following proposed LCD is currently open and will close on September 6. Please consider including literature/evidence in support of your request with your comments. We encourage you to submit your comments as soon as possible.

- Genetic Testing for Oncology (DL39365)

Submit Comments

.

August 25, 2022

Medicare Secondary Payer: Manual Updates

MLN Connects newsletter for Thursday, August 25, 2022

News

- Interns and Residents Information System XML Format: Updated Vendor List

Claims, Pricers, & Codes

- Integrated Outpatient Code Editor: Java Beta File Release

MLN Matters® Articles

- Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 5

Information for Patients

- Coverage to Care: Updated Resources

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August 24, 2022

Update to the Part A open claim issues log

A correction was performed by the shared systems involving cancel claims for dates of service in 2022. This correction removed the incorrectly posted cancel claim information from CWF.

We are in the process of reviewing the results of the correction and adjusting or re-entering impacted claims as needed. We will post notification when the corrections are complete.

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August 19, 2022

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The July 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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CERT deadlines approaching

The Comprehensive Error Rate Testing (CERT) report year is quickly coming to an end. Please review this article for details on upcoming deadlines.

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August 18, 2022

Special Edition – Thursday, August 18, 2022

Creating a Roadmap for the End of the COVID-19 Public Health Emergency

News

- Creating a Roadmap for the End of the COVID-19 Public Health Emergency
- Health Care System Resiliency
  Preparing the Health Care System for Operation After the Public Health Emergency: Secretary of Health and Human Services (HHS) Xavier Becerra extended the existing COVID-19 public health emergency (PHE) through October 15, 2022 – and has committed to providing states, health care providers, and other stakeholders a 60-day notice before ending the PHE.

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Discontinuing Use of Certificates of Medical Necessity & Durable Medical Equipment Information Forms

MLN Connects newsletter for Thursday, August 18, 2022

News

- CMS Discontinuing the Use of Certificates of Medical Necessity and Durable Medical Equipment Information Forms to Increase Efficiency and Reduce Burden for Clinicians, DME Suppliers, and Beneficiaries
- Quality Payment Program: Comment on Proposed Changes by September 6
- Skilled Nursing Facilities: Participate in Interoperability Survey
- Home Health: Revised Guide to Help Desks

Claims, Pricers, & Codes

- Claim Status Category and Claim Status Codes Update

Events

- Home Health OASIS-E Virtual Workshops — September 13 & 14

MLN Matters® Articles

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) — January 2023 Update
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) — January 2023 Update – 2 of 2
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2023
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update — Revised

.

Monkeypox vaccine and laboratory codes

On July 26, new codes were established for smallpox and monkeypox vaccines. When the government provides vaccines at no cost, only bill for the vaccine administration.

.

August 16, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12765 - Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 5

  Make sure your billing staff knows about Updates to Chapter 5 of the Medicare secondary payer manual, and sending claims to primary payers before billing Medicare.
- MM12780 - Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

  Make sure your billing staff knows about these changes -updates to advanced diagnostic laboratory tests, next CLFS data reporting period, and new codes added to the National HCPCS file.

.

August 15, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12822 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--January 2023 Update

Make sure your staff knows about newly available codes, separate NCD coding revisions, and coding feedback.

Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12822. CMS isn't including any policy changes in this ICD-10 quarterly update. We cover NCD policy changes using the current, longstanding NCD process.

- MM12842 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--January 2023 Update--2 of 2

  Make sure your staff knows about newly available codes, separate NCD coding revisions, and coding feedback.

  Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12842. CMS isn't including any policy changes in this ICD-10 quarterly update. We cover NCD policy changes using the current, longstanding NCD process.

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Payment allowance update for COVID-19 mAb Bebtelovimab (Q0222)

Information has been added to the COVID-19 vaccine and monoclonal antibodies billing for Part A article relating to commercially purchased payment allowance for the COVID-19 monoclonal antibody therapy Bebtelovimab (Q0222). Please review the article.

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August 12, 2022

CAAP Debt Dispute form

This new form is available on our Forms Catalog and is required by CMS when submitting a CAAP dispute.

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August 11, 2022

Monkeypox & Smallpox Vaccines: New Product Codes

MLN Connects newsletter for Thursday, August 11, 2022

News

- Monkeypox & Smallpox Vaccines: New Product Codes
- Payment Allowance Update for COVID-19 Monoclonal Antibody Therapy Q0222 Injection, Bebtelovimab, 175 mg
- CMS Announces Resources & Flexibilities to Assist Kentucky Due to Recent Storms
- Hospice Quality Reporting Program: Measure Change

Compliance

- What's the Comprehensive Error Rate Testing Program?

Claims, Pricers, & Codes

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2022
- Integrated Outpatient Code Editor: Java Beta File Release

MLN Matters® Articles

- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2023
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2023
- New Waived Tests
- Implementation of the Capital Related Assets (CRA) Adjustment for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End-Stage Renal Disease Prospective Payment System (ESRD PPS) — Revised

Publications

- Skilled Nursing Facility Billing Reference — Revised

Multimedia

- Hospice Quality Reporting Program Videos

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The following proposed LCDs have been posted for comment. The comment period will end on September 24; however, you are encouraged to submit your comments as soon as possible. When submitting your comments, we encourage you to submit literature/evidence supporting your recommendations for our medical directors to consider.

- Immune Globulin (DL35093)
- Nerve Stimulators for Chronic Intractable Pain (DL39404)
- Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DL35041)

Submit comments

The following draft billing and coding articles are related to the above proposed LCDs.

- Billing and coding: Immune Globulin (DA56786)
- Billing and coding: Nerve Stimulators for Chronic Intractable Pain (DA59188)
- Billing and coding: Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DA54117)

The following billing and coding articles have been revised:

- Billing and coding: Complex Drug Administration Coding (A59073)
- Billing and coding: Monitored Anesthesia Care (A57361)

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Online registration available for August 26 open meeting and proposed LCDs now posted

Online registration for the August 26 open meeting is now available and will close at noon ET on Wednesday, August 24. **Important: During this unprecedented time, our open meeting will be held via webinar only.** Our proposed LCDs are now posted.

Open meetings are to allow interested parties the opportunity to make presentations of information and offer comments related to new proposed LCDs and/or the revised portion of a proposed LCD that are in the 45-day open comment period. Interested parties may also request to attend as an observer. If you are interested in attending as a presenter or observer, please view our Proposed local coverage determination open meetings page for specific guidelines and other helpful information.

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August 5, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12859 - Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2023

  Make sure your billing staff knows about updates to:

  - FY 2023 Wage Index
  - FY 2023 Pricer
  - IPF Quality Reporting Program
- MM12807 - Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2023

  Make sure your billing staff knows about these changes:

  - Fiscal year (FY) 2023 payment rates
  - Wage index cap

Revised:

- MM12347 - Implementation of the Capital Related Assets Adjustment (CRA) for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End Stage Renal Disease Prospective Payment System (ESRD PPS)

  CMS revised the article due to an updated CR that clarified language to present the policy as described in the regulation and to update the sequence of events in the example calculation. This correction clarifies that the offset adjustment is subtracted from the per treatment amount before the application of the 65% adjustment. The changes are in dark red font on pages 1 and 2. CMS also changed the CR transmittal date, transmittal number and the link to the transmittal. All other information is the same.

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August 4, 2022

ICD-10-CM Code Files: Fiscal Year 2023

MLN Connects newsletter for Thursday, August 4, 2022

News

- Hospices: Volunteer to Test Hospice Outcomes & Patient Evaluation Instrument
- Immunization: Protect Your Patients

Claims, Pricers, & Codes

- ICD-10-CM Code Files: Fiscal Year 2023
- ICD-10 Medicare Severity Diagnosis-Related Group Version 40

Events

- ICD-10 Coordination & Maintenance Committee Meeting — September 13–14

Publications

- Items & Services Not Covered Under Medicare — Revised

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The following Billing and Coding articles have been revised to reflect the July 2022 CPT/HCPCS Code Quarterly updates and/or in response to inquiries:

- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM) (A58110)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Billing and Coding: Information Regarding Uses, Including Off-Label Uses, of Anti-Vascular Endothelial Growth Factor (anti-VEGF), for The Treatment of Ophthalmological Diseases (A53121)
- Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions (A53134)
- Billing and Coding: Pharmacogenomics Testing (A58801)
- Billing and Coding: Respiratory Pathogen Panel Testing (A58575)

The following Article has been revised effective for dates of service on and after September 19.

- Self-Administered Drug Exclusion List: (A53127)

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August 1, 2022

Special Edition – Monday, August 1, 2022

New CMS Rule Increases Payments for Acute Care Hospitals & Advances Health Equity, Maternal Health

On August 1, CMS issued a final rule for inpatient and long-term care hospitals that builds on the Biden-Harris Administration's key priorities to advance health equity and improve maternal health outcomes. As required by statute, the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule updates Medicare payments and policies for hospitals, drives high-quality, person-centered care, and promotes fiscal stewardship of the Medicare program. In addition, the rule finalizes new measures to encourage hospitals to build health equity into their core functions. These actions will improve care for people and communities who are disadvantaged or underserved by the health care system.

The rule includes three health equity-focused measures in hospital quality programs and establishes a “Birthing-Friendly” hospital designation. CMS will award this new designation to hospitals that participate in a statewide or national perinatal quality improvement collaborative program and have implemented the recommended quality interventions.

For acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record users, the final rule will result in an increase in operating payment rates of 4.3%. This reflects a FY 2023 projected hospital market basket update of 4.1%, reduced by a statutorily required productivity adjustment of a 0.3 percentage point and plus a 0.5 percentage point adjustment required by statute. This is the highest market basket update in the last 25 years and is primarily due to higher expected growth in compensation prices for hospital workers. Under the LTCH PPS, CMS expects payments in FY 2023 to increase by approximately 2.4% or $71 million.

“CMS is taking action to support hospitals, including updating payments to hospitals by a significantly higher rate than in the proposed IPPS rule. This final rule aligns hospital payments with CMS’ vision of ensuring access to health care for all people with Medicare and maintaining incentives for our hospital partners to operate efficiently,” said CMS Administrator Chiquita Brooks-LaSure. “It also takes important steps to advance health equity by encouraging hospitals to implement practices that reduce maternal morbidity and mortality.”

Advancing Health Equity:

Consistent with the agency’s definition of health equity, CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

To address health care disparities in hospital inpatient care and beyond, CMS is adopting three health equity-focused measures in the IQR Program. The first measure assesses a hospital’s commitment to establishing a culture of equity and delivering more equitable health care by capturing concrete activities across five key domains, including strategic planning, data collection, data analysis, quality improvement, and leadership engagement. The second and third measures capture screening and identification of patient-level, health-related social needs — such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.

In the near future, CMS is also interested in using measures focused on connecting patients with identified social needs to community resources or services. CMS sought comment on the proposed rule. In the final rule, CMS acknowledges the robust comments received on key considerations that inform our approach to improving data collection, to better measure and analyze disparities across programs and policies, and approaches for updating the Hospital Readmissions Reduction Program (HRRP) that encourage providers to improve performance for socially at-risk populations.

CMS is also discontinuing the use of proxy data for uncompensated care costs in determining uncompensated care payments for Indian Health Service and Tribal hospitals, and hospitals in Puerto Rico, and we are establishing a new supplemental payment to prevent undue long-term financial disruption for these hospitals and to promote long-term payment stability. CMS is also finalizing new flexibilities for graduate medical education for rural hospitals participating in rural track programs, which will help promote workforce development in rural areas.

Improving Maternal Health Outcomes:

CMS is creating a new hospital designation to identify “Birthing-Friendly” hospitals and additional quality measure reporting to drive improvements in maternal health outcomes. CMS is finalizing this designation following the release of the comprehensive CMS Maternity Care Action Plan.

The Biden-Harris Administration has championed policies to improve maternal health and equity since taking office. Earlier this year, Vice President Harris convened a first-ever White House meeting with Cabinet Secretaries and agency leaders, including Secretary Becerra and CMS Administrator Chiquita Brooks-LaSure, to discuss the Administration’s whole-of-government approach to reducing maternal mortality and morbidity. In December 2021, Vice President Harris announced a historic call to action to improve health outcomes for parents and their young children in the United States. Implementing this new hospital designation is part of the Biden-Harris Administration’s continued response to that call to action, as noted in the CMS Maternity Care Action Plan.

The “Birthing-Friendly” hospital designation will provide important information to consumers about hospitals with a demonstrated commitment to reducing maternal morbidity and mortality by implementing best practices that advance health care quality and safety for pregnant and postpartum patients.

Conditions of Participation Pandemic Reporting for Hospital and Critical Access Hospitals (CAH):

CMS proposed to continue the current COVID-19 reporting requirements for hospitals and CAHs as well as establish new reporting requirements for future public health emergencies (PHE). Based on public feedback, CMS is finalizing the proposed requirements for continued COVID-19-related reporting for hospitals and CAHs with a reduced number of data categories as an off ramp to the current PHE. CMS is not finalizing the proposed reporting requirements for future PHEs.

Continued Public Reporting of Patient Safety Metrics:

CMS uses quality measures to ensure safety and quality within the health care system and to pay providers through value-based programs. For the FY 2023 Hospital-Acquired Condition (HAC) Reduction Program, CMS proposed to pause — meaning not calculate and subsequently not publicly report — the data for the PSI-90 measure, which is a composite measure that covers multiple patient safety indicators, such as pressure sores, falls, and sepsis. CMS’ proposal reflected concerns about the impact COVID-19 would have on the ability to interpret data and was also sensitive to the risks of financially penalizing hospitals for factors potentially out of their control. CMS recognizes the importance of this measure for patients and providers and is finalizing the calculation and public reporting of the CMS PSI-90 measure results. CMS will include the measure in Star Ratings in alignment with the feedback we received. Although this measure will be publicly reported, it will not be used in payment calculations in the HAC to avoid unintentional penalties related to the uneven impacts of COVID-19 across the country.

More Information:

- Final Rule fact sheet
- Maternal Health fact sheet
- Final Rule

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July 29, 2022

Special Edition - Friday, July 29, 2022

Skilled Nursing Facilities: Final FY 2023 Payment Rule

- Skilled Nursing Facilities: Learn What’s New for Fiscal Year 2023

- CMS Seeks Public Feedback to Improve Medicare Advantage

Skilled Nursing Facilities: Learn What's New for Fiscal Year 2023

CMS issued the Fiscal Year (FY) 2023 Skilled Nursing Facility (SNF) Prospective Payment System final rule to update payment policies and rates. See a summary of key provisions effective October 1, 2022:

- 2.7% net payment rate increase for skilled nursing facilities
- Patient Driven Payment Model parity adjustment recalibration (use the FY 2023 proposed rule calculator to learn more) and changes in ICD-10 code mappings
- Permanent 5% cap on annual wage index decreases
- SNF Quality Reporting Program: compliance date revisions for certain requirements, new influenza vaccination coverage for health care personnel measure, and regulation text revisions
- SNF Value Based Purchasing: not apply the SNF 30-Day All Cause Readmission Measure for the FY 2023 program year and add 3 new measures for FY 2026 & 2027 program expansion years

CMS Seeks Public Feedback to Improve Medicare Advantage

The Centers for Medicare & Medicaid Services (CMS) released a Request for Information seeking public comment on the Medicare Advantage program. CMS is asking for input on ways to achieve the agency's vision so that all parts of Medicare are working towards a future where people with Medicare receive more equitable, high quality, and person-centered care that is affordable and sustainable.

CMS encourages the public to submit comments to the Request for Information. Feedback from plans, providers, beneficiary advocates, states, employers and unions, and other partners to this Request for Information will help inform the Medicare Advantage policy development and implementation process.

More Information:

- Press release
- Request for Information

July 28, 2022

Enhanced Nursing Home Rating System

MLN Connects newsletter for Thursday, July 28, 2022

News

- CMS Enhances Nursing Home Rating System with Staffing & Turnover Data
- Clinical Laboratory Improvement Amendments Proposed Rule: Submit Comments by August 25
- Hospices: Submit Technical Expert Panel Nominations by August 12

- Viral Hepatitis: Talk to Your Patients about Screening

Claims, Pricers, & Codes

- Integrated Outpatient Code Editor: Java Beta File Release

Events

- Medicare Ground Ambulance Data Collection System Webinar: Using Facilities & Vehicles Templates — August 4

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As indicated on July 25, the comment period for Genetic Testing for Oncology has been extended until September 6, due to changes that are being made to the final billing and coding article. Detailed information regarding the changes to the article is now visible on the document notes at the top of the proposed LCD and draft article.

Please refer to the related local coverage documents section at the bottom of the Proposed LCD for changes made to the draft article (DA59125, Billing and Coding: Genetic Testing for Oncology).

- Genetic Testing for Oncology (DL39365)
- Billing and Coding: Genetic Testing for Oncology (DA59125)

Submit comments

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July 27, 2022

Special Edition – Wednesday, July 27, 2022

3 Final FY 2023 Payment Rules: Hospices, Inpatient Psychiatric Facilities, & Inpatient Rehabilitation Facilities

- Hospices: Learn What's New for Fiscal Year 2023
- Inpatient Psychiatric Facilities: Learn What's New for Fiscal Year 2023
- Inpatient Rehabilitation Facilities: Learn What's New for Fiscal Year 2023

Hospices: Learn What's New for Fiscal Year 2023

CMS issued a Fiscal Year (FY) 2023 Hospice Payment Rate Update final rule to update Medicare hospice payments, wage index, quality reporting programs, and policies. See a summary of key provisions effective October 1, 2022:

- Routine annual rate setting changes resulting in a 3.8% increase in payments for FY 2023
- Permanent 5% cap on negative wage index changes
- Hospice Quality Reporting Program (HQRP) updates, including the new Hospice Outcomes and Patient Evaluation Tool, the Consumer Assessment of Healthcare Providers and Systems hospice survey, quality measures for FY 2023, and a summary of public comments from the request for information to inform future efforts related to HQRP health equity

Inpatient Psychiatric Facilities: Learn What's New for Fiscal Year 2023

CMS issued the Fiscal Year 2023 Inpatient Psychiatric Facilities (IPF) Prospective Payment System final rule to update IPF payments, wage index, and policies. See a summary of key provisions effective October 1, 2022:

- Updated payment rates by 3.8% with estimated payments to increase by 2.5% after productivity adjustment
- Applied a permanent 5% cap on wage index decreases

Inpatient Rehabilitation Facilities: Learn What's New for Fiscal Year 2023

CMS issued the Fiscal Year 2023 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) final rule to update Medicare payment policies and rates. See a summary of key provisions effective October 1, 2022:

- Updated IRF PPS payment rates by 3.9% with estimated overall payments to increase by 3.2% after productivity and outlier adjustments
- Applied a permanent 5% cap on annual wage index decreases
- Expanded quality data reporting on all IRF patients, regardless of payer

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July 25, 2022

The comment period for the following proposed LCD has been extended until September 6, due to changes that will be made to the final related billing and coding article. The change in the comment end date along with detailed information regarding the changes to the article will be visible on the Medicare Coverage Database (MCD) and our website on July 28. The information will be located on the document note at the top of the proposed LCD and on the document note at the top of the draft article. Please check our website on July 28, for this information.

Please do not resubmit comments already submitted, but we welcome additional comments related to the changes.

- Genetic Testing for Oncology (DL39365)

The comment period is now closed for the following proposed LCD. Comments received will be reviewed by our contractor medical directors. The response to comments article and finalized billing and coding article will be related to the final LCD when it is posted for notice.

- Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (DL34998)

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July 21, 2022

988 Suicide & Crisis Lifeline Available Nationwide

MLN Connects newsletter for Thursday, July 21, 2022

News

- 988 Suicide & Crisis Lifeline Available Nationwide

- COVID-19: Novavax Vaccine, Adjuvanted — New Codes
- Allergy & Immunology: Comparative Billing Report in July
- Inpatient Rehabilitation Facilities: Care Compare July Refresh
- Long-Term Care Hospitals: Care Compare July Refresh
- Hospices & Home Health Agencies: Submit Technical Expert Panel Nominations by August 12
- Skilled Nursing Facility Provider Preview Reports: Review by August 15
- Opioid Treatment Programs: Comment by September 6

Compliance

- Implanted Spinal Neurostimulators: Document Medical Records

Information for Patients

- Medicare Savings Programs Help Pay Premiums

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COVID-19 vaccine: New product and administration codes for the Novavax vaccine

On July 13, the FDA amended the Novavax COVID-19 vaccine emergency use authorization. CMS issued new codes effective July 13, for the vaccine (91304) and administration codes (0041A and 0042A). CMS added the fees for recently added codes to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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July 20, 2022

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The June 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. A new question / answer has been added to the general information category. Please take time to review these and other FAQs for answers to your questions.

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July 15, 2022

Special Edition – Friday, July 15, 2022

CMS Proposes Rule to Advance Health Equity, Improve Access to Care, & Promote Competition and Transparency

CMS is proposing actions to advance health equity and improve access to care in rural communities by establishing policies for Rural Emergency Hospitals (REH) and providing for payment for certain

behavioral health services furnished via communications technology. Additionally, in line with President Biden's Executive Order on Promoting Competition in the American Economy, the calendar year 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System proposed rule includes proposed enhanced payments under the OPPS and the Inpatient Prospective Payment System for the additional costs of purchasing domestically made NIOSH-approved surgical N95 respirators and a comment solicitation on competition and transparency in our nation's health care system.

More Information:

- Press release
- Proposed rule fact sheet
- REH fact sheet
- Proposed rule

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Medicare secondary payer (MSP) status location RB75XX or PB75XX

Please review our new article regarding claims in MSP status/location RB75XX or PB75XX.

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July 14, 2022

COVID-19: FDA Authorizes Pharmacists to Prescribe PAXLOVID with Certain Limits

MLN Connects newsletter for Thursday, July 14, 2022

News

- COVID-19: FDA Authorizes Pharmacists to Prescribe PAXLOVID with Certain Limits
- COVID-19: Moderna Vaccines for Children as Young as 6 Months — New Codes
- Establishing the Framework for Health Equity at CMS
- Post-Acute Care Report to Congress: Prototype Unified Payment for Medicare
- Long Term Care Facilities: Nursing Home Five Star Rating Changes
- Program for Evaluating Payment Patterns Electronic Reports for Home Health Agencies & Partial Hospitalization Programs
- Home Health Quality Reporting Program: Final OASIS Data Specifications

Compliance

- Collaborative Patient Care is a Provider Partnership

Claims, Pricers, & Codes

- Claims Processing Instructions for the New Hepatitis B Vaccine Code 90759
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- New Edit for Prospective Payment System (PPS) Outpatient and Inpatient Bill Types Receiving an Outlier Payment When a Device Credit is Reported

Events

- Medicare Ground Ambulance Data Collection System Webinar: Allocating Expenses & Revenue — July 21

Information for Patients

- Affordable Connectivity Program Lowers Cost of Broadband Services for Eligible Households

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COVID-19 vaccine: New product and administration codes for Moderna COVID-19 pediatric vaccine and redosing update for EVUSHELD for COVID-19

On June 17, the FDA amended the Moderna emergency use authorization to authorize the use for all patients 6 months - 5 years old and patients aged 6 years – 11 years. The vaccine is supplied in multiple dose vials. CMS issued an effective date of June 17, for the new vaccine product code (91311) and the new administration codes (0111A, 0112A, 0113A) for the first, second, and third dose with a blue cap with a magenta border and (0091A, 0092A and 0093A) for the first, second, and third dose with a blue cap with a purple border respectively. CMS added the fees for these recently added codes to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

On June 29, the FDA authorized revisions to EVUSHELD (tixagevimab co-packaged with cilgavimab) dosing to recommend repeat dosing six months with a dose of 300 mg of tixagevimab and 300 mg cilgavimab if patients need ongoing protection. For more information about dosage, dosing interval, and administration, review the Fact Sheet for Health Care Providers: EUA for EVUSHELD (tixagevimab co-packaged with cilgavimab) (ZIP).

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Reason code W7120 update

Reason code W7120 was incorrectly returning claims to providers when the PT modifier was reported with surgical ranges 10000-69999 or 0000T-9999T. The Integrated Outpatient Code Editor was updated successfully.

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As a reminder, the comment period for the following proposed LCDs is currently open and will close on July 23, 2022. Please consider including literature/evidence in support of your request with your comments. We encourage you to submit your comments as soon as possible.

- Genetic Testing for Oncology (DL39365)
- Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (DL34998)

Submit comments

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July 8, 2022

Frequently Asked Questions (FAQs)

Have questions and not sure where to turn? Check out our FAQs for answers to your questions.

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July 7, 2022

Special Edition – Thursday, July 7, 2022

CMS Proposes Physician Payment Rule to Expand Access to High-Quality Care

On July 7, CMS issued the Calendar Year 2023 Physician Fee Schedule (PFS) proposed rule, which would significantly expand access to behavioral health services, Accountable Care Organizations (ACOs), cancer screening, and dental care — particularly in rural and underserved areas. These proposed changes play a key role in the Biden-Harris Administration's Unity Agenda — especially its priorities to tackle our nation's mental health crisis, beat the overdose and opioid epidemic, and end cancer as we know it through the Cancer Moonshot — and ensure CMS continues to deliver on its goals of advancing health equity, driving high-quality, whole-person care, and ensuring the sustainability of the Medicare program for future generations.

"At CMS, we are constantly striving to expand access to high quality, comprehensive health care for people served by the Medicare program," said CMS Administrator Chiquita Brooks-LaSure. "Today's proposals expand access to vital medical services like behavioral health care, dental care, and cancer treatment options, all while promoting access, innovation, and cost savings in the Medicare program."

"Integrated coordinated, whole-person care — which addresses physical health, behavioral health, and social determinants of health — is crucial for people with Medicare, especially those with complex needs," said Dr. Meena Seshamani, CMS Deputy Administrator and Director of the Center for Medicare. "If finalized, the proposals in this rule will advance equity, lead to better care, support healthier populations, and drive smarter spending of the Medicare dollar.

The proposed CY 2023 PFS conversion factor is $33.08, a decrease of $1.53 to the CY 2022 PFS conversion factor of $34.61. This conversion factor accounts for the statutorily required update to the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in PFS payments for CY 2022 as required by the Protecting Medicare and American Farmers From Sequester Cuts Act, and the statutorily required budget neutrality adjustment to account for changes in Relative Value Units.

Modernizing Coverage for Behavioral Health Services

In the 2022 CMS Behavioral Health Strategy, CMS set goals to remove barriers to care and improve access to, and the quality of, mental health and substance use care. To help address the acute shortage of behavioral health practitioners, the agency is proposing to allow licensed professional counselors, marriage and family therapists, and other types of behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. Additionally, CMS is proposing to pay for clinical psychologists and licensed clinical social workers to provide integrated behavioral health services as part of a patient's primary care team.

CMS is also proposing to bundle certain chronic pain management and treatment services into new monthly payments, improving patient access to team-based comprehensive chronic pain treatment. Lastly, CMS is proposing to cover opioid treatment and recovery services from mobile units, such as vans, to increase access for people who are homeless or live in rural areas.

Expanding Access to Accountable Care Organizations

ACOs are groups of health care providers who come together to give coordinated, high-quality care to their Medicare patients. The Medicare Shared Savings Program covers more than 11 million people with Medicare and includes more than 500,000 providers.

CMS is proposing changes to the Medicare Shared Savings Program that, if finalized, represent some of the most significant reforms since the final rule that established the program was finalized in November 2011 and ACOs began participating in 2012. Building on the CMS Innovation Center's successful ACO Investment Model, CMS is proposing to incorporate advance shared savings payments to certain new Medicare Shared Savings Program ACOs that could be used to address Medicare beneficiaries' social needs. This is one of the first times Traditional Medicare payments would be permitted for such uses and is expected to be an opportunity for providers in rural and other underserved areas to make the investments needed to become an ACO and succeed in the program. CMS is also proposing that smaller ACOs have more time to transition to downside risk, further helping to grow participation in rural and underserved communities. CMS is also proposing a health equity adjustment to an ACO's quality performance category score to reward excellent care delivered to underserved populations. Finally, CMS is proposing benchmark adjustments to encourage more ACOs to participate and succeed, which would help achieve the goal of having all people with Traditional Medicare in an accountable care relationship with a healthcare provider by 2030.

Improving Access to Colon Cancer Screening

Colon and rectal cancer were the second-leading cause of cancer deaths in the United States in 2020, with higher colorectal cancer death rates for Black Americans, American Indians, and Alaska Natives. To reduce barriers to getting a colonoscopy, CMS is proposing that a follow-up colonoscopy to an at-home test be considered a preventive service, which means that cost sharing would be waived for people with Medicare. Additionally, Medicare is proposing to cover the service for individuals 45 years of age and above, in line with the newly lowered age recommendation (down from 50) from the United States Preventive Services Task Force.

Proposing Payment for Dental Services that are Integral to Covered Medical Services

Medicare Part B currently pays for dental services when that service is integral to medically necessary services required to treat a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following accidental injury or tooth extractions done in preparation for radiation treatment for jaw cancer. CMS is proposing to pay for dental services, such as dental examination and treatment preceding an organ transplant. In addition, CMS is seeking comment on other medical conditions where Medicare should pay for dental services, such as for cancer treatment or joint replacement surgeries, as well as on a process to get public input when additional dental services may be integral to the clinical success of other medical services.

More Information:

- PFS fact sheet
- Quality Payment Program fact sheet
- Medicare Shared Savings Program Proposals fact sheet
- Blog
- Proposed rule

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Expanding Access to Emergency Care Services in Rural Communities

MLN Connects newsletter for Thursday, July 7, 2022

News

- Taking Action to Expand Access to Emergency Care Services in Rural Communities
- People with Disabilities: Help Address Disparities

Compliance

- DMEPOS Standard Written Order Requirements

Claims, Pricers, & Codes

- Long COVID: Use ICD-10 Code U09.9

MLN Matters® Articles

- July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised

Publications

- Teaching Physicians, Interns, & Residents Guidelines — Revised

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July 6, 2022

Claim submission errors (April-June)

The Part A quarterly claim submission errors and resolutions are now available. Please take time to review these errors and avoid them on future claims.

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Prior authorization for hospital outpatient department (OPD) services reminder

Since CMS has mandated prior authorization for certain hospital OPD services as a condition of payment, when a prior authorization request (PAR) is received and it has been determined that the related procedure has already been rendered, the PAR will be non-affirmed.

Visit the prior authorization for certain hospital OPD services webpage and the frequently asked questions for more information.

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June 30, 2022

No Surprises Act: Fact Sheets for Your Patients

MLN Connects newsletter for Thursday, June 30, 2022

News

- CMS Issues Significant Updates to Improve the Safety and Quality Care for Long-Term Care Residents & Calls for Reducing Room Crowding
- COVID-19: Pfizer-BioNTech Vaccines for Children as Young as 6 Months — New Codes
- New Model to Improve Cancer Care for Medicare Patients: Apply by September 30

- Internet-Only Manual Update to Publication 100-04, Chapter 16, Sections 70.5, 70.8, and 70.9 to Remove References to the Clinical Laboratory Improvement Amendments (CLIA) Files
- Provide Ostomy Supplies Promptly

Events

- Cancelled — CMS National Provider Enrollment Conference in Boston
- MLN Matters® Articles
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2022
- Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2 — Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) * July 2021 — Revised

Publications

- Hospital Price Transparency — Updated Resources
- Medicare Provider Enrollment — Revised
- Information for Medicare Patients
- No Surprises Act: Fact Sheets for Your Patients

Information for Medicare Patients

- No Surprises Act: Fact Sheets for Your Patients

Medical Policy Update

As a reminder, the comment period for the following proposed LCDs is currently open and will close on July 23. Please consider including literature/evidence in support of your request with your comments. We encourage you to submit your comments as soon as possible.

- Genetic Testing for Oncology (DL39365)
- Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (DL34998)

Submit comments

Open claim issues

All claims for HCPCS codes G0008, G0009, and G0010 that were reimbursed at an incorrect rate for dates of service in 2021 have been adjusted.

2022 Part A System availability alert

FISS DDE, IVR, and Novitasphere will be unavailable for the following dates from Noon ET on Saturday through 6:00 a.m. ET Monday for quarterly release implementation.

System unavailability begins (Noon ET)	System availability resumes (6:00 a.m. ET)
Saturday, July 2, 2022	Monday, July 4, 2022
Saturday, October 1, 2022	Monday, October 3, 2022

COVID-19 vaccine: New product and administration codes for Pfizer pediatric vaccine

On June 17, the FDA amended the Pfizer-BioNTech COVID-19 vaccine (PDF) emergency use authorization to authorize the use for all patients 6 months - 4 years old. The vaccine is supplied in multiple dose vials with maroon caps. CMS issued an effective date of June 17, for the new vaccine product code (91308) and the new administration codes (0081A, 0082A, 0083A) for the first, second, and third dose respectively. CMS added the fee for this recently added code to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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June 27, 2022

Patients With Questions for Medicare

Please direct patients who have Medicare related questions to 1-800-MEDICARE or Medicare.gov for assistance. Our Customer Contact Center only service calls from providers.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12774 - Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  Make sure your billing staff knows about the latest update of the RARC and CARC code sets, what you must do if you use MREP or PC Print, and where to find the official code lists.

  If you use MREP or PC Print, be sure to get the latest version when available

- MM12803 - Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2022

  Make sure your billing staff knows about the changes to the laboratory NCD edit module for October 2022, and how to access the NCD spreadsheet that lists relevant changes.

June 23, 2022

Medical Records Correspondence Address

MLN Connects newsletter for Thursday, June 23, 2022

News

- Ambulance Prior Authorization Model Expands August 1
- Orthoses Referring Providers: Comparative Billing Report in June
- Medical Records Correspondence Address
- Inpatient Rehabilitation Facility Provider Preview Reports: Review by July 15
- Long-Term Care Hospital Provider Preview Report: Review by July 15
- Cognitive Assessment: What's in the Written Care Plan?

Claims, Pricers, & Codes

- Quarterly Update to the National Correct Coding Initiative [NCCI] Procedure-to-Procedure [PTP] Edits, Version 28.2, Effective July 1, 2022

MLN Matters® Articles

- July Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

Publications

- Medicare Diabetes Self-Management Training — Revised

.

The following billing and coding article has been revised.

- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee) (A56796)

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June 22, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12705 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2022 Update

  CMS revised this article due to a revised change request (CR) 12705. The CR revision didn't affect the substance of the article. CMS did revise the CR release date, transmittal number, and the web address of the CR. All other information is the same.

- MM12124 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--July 2021

  CMS revised this article due to a revised change request (CR) 12124. The CR revision changed business requirements for NCD 90.2, Next Generation Sequencing. This results in a new spreadsheet for that NCD by retaining all ICD-10 Not Otherwise Classified (NOC) diagnosis codes proposed for deletion effective July 1. CMS also changed the CR release date, transmittal number, and the CR web address. All other information is the same.

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June 21, 2022

Special Edition – Tuesday, June 21, 2022

Home Health & ESRD Proposed CY 2023 Payment Rules

- Home Health Agencies: Calendar Year 2023 Proposed Rule — Submit Comments by August 16
- ESRD Facilities: Calendar Year 2023 Proposed Rule—Submit Comments by August 22

Home Health Agencies: Calendar Year 2023 Proposed Rule — Submit Comments by August 16

CMS issued a Calendar Year (CY) 2023 Home Health Prospective Payment System (HH PPS) Rate Update proposed rule to update Medicare payment policies and rates for home health agencies. See a summary of key provisions. Proposals include:

- Routine updates to the Medicare HH PPS and home infusion therapy services payment rates for CY 2023
- Permanent prospective payment adjustment to the home health 30-day period payment rate
- Requests for input on how best to implement a temporary payment adjustment for CYs 2020 and 2021, and collecting telehealth data on home health claims

We encourage you to review the rule, and submit formal comments by August 16, 2022.

ESRD Facilities: Calendar Year 2023 Proposed Rule—Submit Comments by August 22

CMS issued a Calendar Year 2023 ESRD Prospective Payment System (PPS) proposed rule to update Medicare payment policies and rates for renal dialysis services. See a summary of key provisions. Proposals include:

- Rebase and revise ESRD Bundled market basket to a 2020 base year and update the labor-related share
- Change ESRD PPS methodology for calculating the outlier threshold for adult patients
- Apply a permanent 5% cap on decreases in the ESRD PPS wage index and increase the wage index floor
- Change definition of “oral-only drug” beginning January 1, 2025, and clarify ESRD PPS functional category definitions
- Request comments on whether 3 products meet eligibility criteria for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Request input on a potential add-on payment adjustment for new renal dialysis drugs and biological products and health equity issues under the ESRD PPS, with a focus on pediatric dialysis payment
- Update requirements and input requests for the ESRD Quality Incentive Program

We encourage you to review the rule, and submit formal comments by August 22, 2022.

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June 17, 2022

Prior authorization request for hospital outpatient department services revised cover sheets

Effective June 21, both the standard and expedited prior authorization request (PAR) coversheets are updated with new fields to improve the PAR process. The new fields include the facility fax number, the physician fax number, and a field relating to the implanted spinal neurostimulator.

Based on provider feedback, adding the new facility fax number field and a new physician fax number field will enable both parties to receive the prior authorization decision letters. Please include both fax numbers to ensure the decision letters are received by the facility and the physician. If you're submitting for procedure code 63650 (implanted spinal neurostimulator), the new field allows you to indicate if it's for a trial or permanent implant.

For the coversheet, the term 'facility' relates to the hospital outpatient department where the services requiring prior authorization will be performed. The term 'physician' relates to the physician performing the services.

Note: It's important that all fields on the cover sheet are completed to avoid delays in the process.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12761 - July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  CMS revised this article due to a revised change request (CR) 12761. The CR revision added some codes to table 1. CMS also revised the CR release date, transmittal number, and web address. All other information is the same.

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June 16, 2022

ICD-10-CM Diagnosis Codes: Fiscal Year 2023

MLN Connects newsletter for Thursday, June 16, 2022

News

- Comprehensive Error Rate Testing Program Report: Sample Reduced for Reporting Year 2023
- Men's Health: Talk to Your Patients About Preventive Services

Compliance

- Implanted Spinal Neurostimulators: Document Medical Records

Claims, Pricers, & Codes

- ICD-10-CM Diagnosis Codes: Fiscal Year 2023
- July 2022 Quarterly Average Sales Price [ASP] Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Articles

- July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers — Revised

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June 15, 2022

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The May 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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June 10, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12772 - July Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  Make sure your billing staff knows about The July 2022 quarterly update for the DMEPOS fee schedule and fee schedule amounts for new and existing codes.

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June 9, 2022

Learn about the CMS National Quality Strategy

MLN Connects newsletter for Thursday, June 9, 2022

News

- CMS National Quality Strategy: A Person-Centered Approach to Improving Quality
- Strategy to Strengthen Behavioral Health Care
- Program for Evaluating Payment Patterns Electronic Reports for Short-Term Acute Care Hospitals
- Interns and Residents Information System (IRIS) XML Format
- LGBTQ+ Community: Help Address Disparities

Compliance

- Collaborative Patient Care is a Provider Partnership

MLN Matters® Articles

- Update to 'J' Drug Code List for Billing Home Infusion Therapy (HIT) Services
- July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Publications

- Medicare Preventive Services — Revised

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The following proposed LCDs have been posted for comment. The comment period will end on July 23, 2022; however, you are encouraged to submit your comments as soon as possible. When submitting your comments, we encourage you to submit literature/evidence supporting your recommendations for the Novitas Solutions Contractor Medical Directors to consider.

- Genetic Testing for Oncology (DL39365)
- Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (DL34998)

Submit Comments

The following Draft Billing and Coding Articles are related to the above Proposed LCDS.

- Billing and Coding: Genetic Testing for Oncology (DA59125)
- Billing and Coding: Transcranial Magnetic Stimulation (TMS) in the Treatment of Adults with Major Depressive Disorder (DA57072)

The following billing and coding article has been revised:

- Billing and Coding: Information Regarding Uses, Including Off-Label Uses, of Anti-Vascular Endothelial Growth Factor (anti-VEGF), for the Treatment of Ophthalmological Diseases (A53121)

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Online registration available for June 24 open meeting and proposed LCDs now posted

Online registration for the June 24 open meeting is now available and will close at noon ET on Wednesday, June 22. **Important: During this unprecedented time, our open meeting will be held via webinar only.** Our proposed LCDs are now posted.

Open meetings are to allow interested parties the opportunity to make presentations of information and offer comments related to new proposed LCDs and/or the revised portion of a proposed LCD that are in the 45-day open comment period. Interested parties may also request to attend as an observer. If you are interested in attending as a presenter or observer, please view our Proposed local coverage determination open meetings page for specific guidelines and other helpful information.

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June 8, 2022

Reason code C7111

Please review our new article regarding claims receiving reason code C7111.

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June 7, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12723 - Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2

  CMS revised this article due to a revised change request (CR) 12723. The revised CR added language that was inadvertently left out of the CR. We added that language in dark red font on page 2. We also revised the CR release date, transmittal number, and the CR web address. All other information is the same.

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Open claim issues

It has come to our attention that claims containing COVID-19 vaccine and another vaccine (flu or PPV) are not processing for payment when billed on the same date of service. These claims are returned with reason code 32287. A correction is expected to be installed on October 3, 2022. You should not submit these claims until the correction has been installed. After the correction is installed any previously returned claims can be resubmitted.

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June 2, 2022

ICD-10-PCS Procedure Codes: Fiscal Year 2023

MLN Connects newsletter for Thursday, June 2, 2022

News

- Medicare Shared Savings Program: Application Deadlines for January 1 Start Date

Claims, Pricers, & Codes

- ICD-10-PCS Procedure Codes: Fiscal Year 2023
- July 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.2

Multimedia

- Inpatient Rehabilitation Facility & Long-Term Care Hospital Virtual Training Program — Part 1

.

The following articles have been revised and will become effective June 6, 2022:

- Billing and Coding: Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents (A53049)
- Billing and Coding: Complex Drug Administration Coding (A59073)
- Billing and Coding: Surgical Treatment of Nails (A52998)
- Self-Administered Drug Exclusion List (A53127)

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Open claim issues

Reason code W7120 was incorrectly returning claims to providers when the PT modifier was reported with surgical ranges 10000-69999 or 0000T-9999T. The reason code will be bypassed until the issue is corrected in the July 2022 Integrated Outpatient Code Editor update.

You may resubmit claims that were returned in error.

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Billing Veklury (remdesivir) antiviral medication in outpatient settings

We have added a reference to the New COVID-19 Treatments Add-On Payment (NCTAP) article for IPPS billing guidance.

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June 1, 2022

The comment period is now closed for the following proposed LCDs. Comments received will be reviewed by our contractor medical directors. The response to comments articles and finalized billing and coding articles will be related to the final LCDs when they are posted for notice.

- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (DL38229)
- Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DL35041)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12761 - July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  Make sure your billing staff knows about these changes:

  - New COVID-19 CPT vaccines and administration codes.
  - CPT proprietary laboratory analyses (PLA) coding changes effective July 1.
  - New CPT Category III codes effective July 1.

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May 31, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12613 - An Omnibus CR Covering: (1) Removal of Two National Coverage Determination (NCDs), (2) Updates to the Medical Nutrition Therapy (MNT) Policy, and (3) Updates to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) Conditions of Coverage

  CMS revised this article due to a revised CR 12613. The CR revision didn't affect the substance of the article. CMS revised the CR release date, transmittal numbers, and the web address of the CR. All other information is the same.

- MM12738 - Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2022

CMS revised this article due to a revised CR 12738. The CR revision didn't affect the substance of the article. CMS revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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May 27, 2022

Fiscal Intermediary Shared System (FISS) Training Manual

The FISS training manual has been converted into a new format. We have broken it up into seven chapters combining all claims-related inquiry menus into one chapter. Please take a moment to review.

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May 26, 2022

Biosimilars: Interchangeable Products May Increase Patient Access

MLN Connects newsletter for Thursday, May 26, 2022

News

- COVID-19: New Administration Code for Pfizer Pediatric Vaccine Booster Dose
- Biosimilars: Interchangeable Products May Increase Patient Access
- Critical Care Evaluation & Management Services: Comparative Billing Report in May

Compliance

- Surgical Dressings: Medicare Requirements

Publications

- Screening Pap Tests & Pelvic Exams — Revised

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COVID-19 vaccine: New administration code for Pfizer pediatric vaccine booster

On May 17, the FDA amended the Pfizer-BioNTech COVID-19 vaccine (PDF) emergency use authorization to authorize the use of a single booster pediatric dose (orange cap) for all patients 5-11 years old. CMS issued the new code 0074A, effective May 17, for the pediatric vaccine booster administration. The fee for 0074A has been added to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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May 24, 2022

End stage renal disease (ESRD) billing requirements

The ESRD billing requirements article has been updated to add instructions for HCPCS paid outside of the ESRD prospective payment system (PPS) with an effective date or fee schedule rate change mid-month.

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May 20, 2022

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The April 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. A new question / answer has been added to the general information category. Please take time to review these and other FAQs for answers to your questions.

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May 19, 2022

Biosimilars: Safe, Effective, & May Reduce Patient Costs

MLN Connects newsletter for Thursday, May 19, 2022

News

- Biosimilars: Safe, Effective, & May Reduce Patient Costs
- PECOS Scroll Functionality
- Clinical Laboratory Improvement Amendments: Unpaid Certificate Fees
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB)
- Mental Health: Help Address Disparities

Compliance

- Collaborative Patient Care is a Provider Partnership

MLN Matters® Articles

- Elimination of Certificates of Medical Necessity & Durable Medical Equipment Information Forms
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)–October 2022 Update
- Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2

Publications

- Chronic Care Management Services — Revised
- Home Health Quality Reporting Program: Draft OASIS-E Guidance Manual

.

The following billing and coding article has been retired:

- Billing and Coding: Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Physician Requirements (A55758)

The following LCDs have been revised:

- Ambulance Services (Ground Ambulance) (L35162)
- Cosmetic and Reconstructive Surgery (L35090)
- Implantable Continuous Glucose Monitors (I-CGM) (L38617)

As a reminder, the comment period for the following proposed LCDs is currently open and will close on May 28. Please consider including literature/evidence in support of your request with your comments. We encourage you to submit your comments as soon as possible.

- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (DL38229)
- Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DL35041)

Submit Comments

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May 12, 2022

Biosimilars Curriculum: Resources for Teaching Your Students

MLN Connects newsletter for Thursday, May 12, 2022

News

- Comprehensive Error Rate Testing Documentation Center Moved on April 13
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Open Payments Review & Dispute Ends May 15
- Ambulance Prior Authorization Model Expands June 1
- Clinical Laboratory Fee Schedule 2023 Preliminary Gap-fill Rates: Submit Comments by July 11
- Medicare Cards Without Full Names
- CMS Releases Chronic Pain Experience Journey Map
- Biosimilars Curriculum: Resources for Teaching Your Students
- Women’s Health: Talk to Your Patients About Preventive Services

Compliance

- Home Health Low Utilization Payment Adjustment Threshold: Bill Correctly

Events

- HCPCS Public Meeting — June 7–10

MLN Matters® Articles

- Calendar Year 2023 Modifications/Improvements to Value-Based Insurance Design (VBID) Model – Implementation

- Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests
- National Coverage Determination (NCD) 210.14 Reconsideration – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers — Revised

Information for Medicare Patients

- Affordable Connectivity Program Lowers Cost of Broadband Services for Eligible Households

.

May 9, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12705 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2022 Update

  Make sure your staff knows about newly available codes, separate NCD coding revisions, and coding feedback.

  Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12705.

  CMS isn't including any policy changes in this ICD-10 quarterly update. We cover NCD policy changes using the current, longstanding NCD process.

- MM12723 - Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2

  Make sure your billing staff knows about these changes to the Benefit Policy Manual:

  - CMS updated the Medicare coverage for pneumococcal vaccinations to align with the Advisory Committee on Immunization Practices (ACIP) recommendations.
  - The ACIP recommendations vary based on patient age and risk factors.

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May 6, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12741 - Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)

  Make sure your billing staff knows about these CMS changes:

  - Revised list of outlier services to include 27 National Drug Codes (NDCs), effective January 1, 2022.

- Updated mean unit cost for renal dialysis drugs that are oral equivalents to injectable drugs, effective July 1, 2022.
- Revised mean dispensing fee for NDCs qualifying for outlier to $0.57 per NDC per month, effective July 1, 2022.

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May 5, 2022

COVID-19: Patients Can Get Free Over-the-Counter Tests from Participating Providers

MLN Connects newsletter for Thursday, May 5, 2022

News

- COVID-19: Patients Can Get Free Over-the-Counter Tests from Participating Providers
- Immunosuppressive Drug Coverage for Kidney Transplant Patients: Proposed Rule
- Diabetic Testing Supplies Ordering Guide
- Inpatient Rehabilitation Facilities: Care Compare March Preview Reports Reissued & April Refresh
- Long-Term Care Hospitals: Care Compare March Preview Reports Reissued & April Refresh
- Skilled Nursing Facilities: Care Compare April Preview Reports & Refresh
- May is National Asian American, Native Hawaiian, & Pacific Islander Heritage Month

Claims, Pricers, & Codes

- Outpatient Claims with Reason Code W7120 Returned in Error
- Eliminating Certificates of Medical Necessity & Durable Medical Equipment Information Forms — January 1, 2023

Events

- CMS National Provider Enrollment Conference in Boston — August 16 & 17

MLN Matters® Articles

- Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance
- Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2022
- Section 127 of the Consolidated Appropriations Act: Graduate Medical Education (GME) Payment for Rural Track Programs (RTPs)
- New Waived Tests — Revised
- Update to Chapter 7, “Home Health Services,” of the Medicare Benefit Policy Manual (Pub 100-02) — Revised

Publications

- Medical Record Maintenance & Access Requirements — Revised
- Medicare Mental Health — Revised

.

The following billing and coding articles have been revised:

- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Billing and Coding: eVox® System and Other Electroencephalograph Testing for Memory Loss (A56440)
- Billing and Coding: Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (A56642)
- Billing and Coding: Information Regarding Uses, Including Off-Label Uses, of Anti-Vascular Endothelial Growth Factor (anti-VEGF), for The Treatment of Ophthalmological Diseases (A53121)
- Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)
- Billing and Coding: Respiratory Pathogen Panel Testing (A58575)

Please refer to the sticky note on the following for revisions:

- Self-Administered Drug Exclusion List (effective 6/6/2022) (A53127)

The following LCD has been revised:

- Therapy and Rehabilitation Services (PT, OT) (L35036)

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12737 - Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

  Make sure your billing staff knows about these changes:

  - Where to find updates pertaining to Advanced Diagnostic Laboratory Tests (ADLTs).
  - Delays in the next CLFS data reporting period for clinical diagnostic laboratory tests.
  - New codes, effective July 1, 2022.

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May 4, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12691 - National Coverage Determination (NCD) 210.14 Reconsideration – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

  Make sure your billing staff knows about these changes to National Coverage Determination (NCD) 210.14:

  - CMS expanded patient eligibility for screening for lung cancer with low dose computed tomography (LDCT), including lowering the minimum age for screening.
  - We removed the restriction that a physician or non-physician practitioner must provide the counseling and shared decision-making (SDM).
  - We removed the requirement that facilities participate in a registry.

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May 3, 2022

Open claim issues

Inpatient claims reporting diagnosis codes Z28.310, Z28.311, or Z28.39, which are exempt from present on admission reporting, incorrectly received reason code 34931. A correction is tentatively scheduled for May 9. When the correction is installed, previously returned claims can be resubmitted for processing.

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May 2, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12688 - Calendar Year 2023 Modifications/Improvements to Value-Based Insurance Design (VBID) Model – Implementation

  Make sure your billing staff knows about:

  - Modifications in the VBID Model's Hospice Benefit Component for Calendar Year (CY) 2023.
  - The applicable requirements in CR 11754 and CR 12349 that still apply.
- MM12656 - Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests

  Make sure your billing staff knows about:

  - Reduced coinsurance for certain screening flexible sigmoidoscopies and screening colonoscopies.

Revised:

- MM12606 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) -- July 2022

  CMS revised this article due to a revised change request (CR) 12606. The CR revision didn't affect the substance of the article. CMS revised the CR release date, transmittal number, and the web address. All other information is the same.

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April 29, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12707 - Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance

  Make sure your billing staff knows about these changes:

  - Billing when the patient dies before the ambulance arrives.
  - Billing when the patient dies after being loaded on the ambulance.

- MM12709 - Section 127 of the Consolidated Appropriations Act: Graduate Medical Education (GME) Payment for Rural Track Programs (RTPs)

  Make sure your billing staff knows about these changes:

  - A new definition for Rural Track Programs.
  - Changes in Section 127 of the Consolidated Appropriations Act (CAA), 2021.
  - Documentation requirements for hospitals requesting indirect and direct GME rate increases.
- MM12738 - Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2022

  Make sure your billing staff knows about these changes:

  - How facilities can transition to become grandfathered tribal FQHCs.
  - CY 2022 payment rates for grandfathered tribal FQHCs.
  - Services for which the grandfathered tribal FQHC Prospective Payment System (PPS) rate isn't applicable.

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April 28, 2022

Get Patient Eligibility Information for Additional Services

MLN Connects newsletter for Thursday, April 28, 2022

News

- Patient Eligibility Information for Additional Services — Now Available
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Open Payments Review & Dispute Ends May 15
- Are You on the Missing Digital Contact Information Report?

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs and Biologicals
- Corrections to Home Health Billing for Denial Notices and Calculation of 60-Day Gaps in Services
- Updates for Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy Fiscal Years (FYs) 2021-2022
- Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Events

- Inpatient Rehabilitation Facility & Long-Term Care Hospital Virtual Training Program — June 15–16

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April 21, 2022

Medicare Provider Compliance News

MLN Connects newsletter for Thursday, April 21, 2022

News

- Hospice Quality Reporting Program: Key Dates & Measure Change
- Ambulance Ground Transport: Comparative Billing Report in April
- Hospices: Aggregate & Inpatient Caps under the Value-Based Insurance Design Model

Compliance

- Medicare Provider Compliance Newsletter
- DMEPOS Items: Medical Record Documentation

Events

- CMS Health Equity Symposium — April 28

MLN Matters® Articles

- Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding Novel Coronavirus (COVID-19) and its Administration to Current Claims Processing Requirements and Other General Updates

Publications

- Medicare Modernization of Payment Software — Revised

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The following LCD has been revised:

- Implantable Continuous Glucose Monitors (I-CGM) (L38617)

The following billing and coding article has been added and will become effective June 6, 2022:

- Billing and Coding: Complex Drug Administration Coding (A59073)

The following local coverage article has been revised effective for dates of service on and after June 6, 2022:

- Self-Administered Drug Exclusion List (A53127)

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April 20, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12634 - Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding Novel Coronavirus (COVID-19) and its Administration to Current Claims Processing Requirements and Other General Updates

  Make sure your billing staffs know about updates to the Medicare Claims Processing and Benefits Policy Manuals to:

- Add information for COVID-19 claims processing
- Revise the centralized billing enrollment process to streamline provider enrollment

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April 19, 2022

Over-the-counter (OTC) COVID-19 tests

A new article has been added regarding Medicare coverage of OTC COVID-19 tests at no cost to people with Medicare Part B, including those with Medicare Advantage (MA) plans. Please review the article.

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The March 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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April 18, 2022

Special Edition – Monday, April 18, 2022

CMS Proposes Policies to Advance Health Equity & Maternal Health, Support Hospitals

On April 18, CMS issued a proposed rule for inpatient and long-term hospitals that builds on the Biden-Harris Administration's key priorities to advance health equity and improve maternal health outcomes. In addition to annual policies that promote Medicare payment accuracy and hospital stability, the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule includes measures that will encourage hospitals to build health equity into their core functions, thereby improving care for people and communities who are disadvantaged and/or underserved by the health care system. The rule includes 3 health equity-focused measures in hospital quality programs, seeks stakeholder input related to documenting social determinants of health in inpatient claims data, and proposes a "Birthing-Friendly" hospital designation.

For acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users, the proposed increase in operating payment rates is projected to be 3.2%. This reflects a FY 2023 projected hospital market basket update of 3.1% reduced by a projected 0.4 percentage point productivity adjustment and increased by a 0.5 percentage point adjustment required by statute. Under the LTCH PPS, CMS expects payments to increase by approximately 0.8% or $25 million.

Additional items in the proposed rule related to payment stability for hospitals include a policy that smooths out significant year-to-year changes in hospitals' wage indexes and a solicitation for comments on payment adjustments for purchasing domestically made surgical N95 respirators. Specifically, CMS is proposing to apply a 5% cap on any decrease to a hospital's wage index from its wage index in the prior FY; and is considering the appropriateness of payment adjustments accounting for additional costs of purchasing surgical N95 respirators made in the U.S.

More Information:

- Complete press release

- Proposed payment rule fact sheet
- Maternal health & health equity measures fact sheet
- White House statement on Reducing Maternal Mortality and Morbidity
- Proposed rule: Comment by June 17

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April 14, 2022

COVID-19: New Codes for Moderna Vaccine Booster Doses

MLN Connects newsletter for Thursday, April 14, 2022

News

- Launch of the Cross-Cutting Initiatives
- Value-Based Insurance Design Model: Medicare Advantage Organizations Pay for Hospice Care

Compliance

- Collaborative Patient Care is a Provider Partnership

Claims, Pricers, & Codes

- COVID-19: New Codes for Moderna Vaccine Booster Doses

Events

- Medicare Cost Report E-Filing System: Interim Rate & Settlement Documentation Webinar — April 26

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COVID-19 vaccine: New product and administration code for Moderna vaccine booster

On March 29, the FDA amended the Moderna COVID-19 vaccine emergency use authorization (PDF), including new packaging for vaccine boosters (blue cap). CMS issued new codes, effective March 29, for the vaccine booster (91309) and administration (0094A). CMS added the fees for these recently added codes to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following references:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

.

The following proposed LCDs have been posted for comments. The comment period will end on 5/28/2022; however, you are encouraged to submit your comments as soon as possible.

- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (DL38229)
- Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DL35041)

Submit Comments

The following draft billing and coding articles are related to the above proposed LCDS.

- Billing and Coding: Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (DA56642)
- Billing and Coding: Skin Substitutes for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (DA54117)

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PC-ACE and Novitasphere – Together!

We offer two free options you can use together for your electronic Medicare billing needs.

- PC-ACE - software where you can create electronic Medicare claims.
- Novitasphere - offers a feature to send electronic claim files (and many other great features!).

Only one form is needed to receive access to both PC-ACE and Novitasphere! Visit the Novitasphere Enrollment web page for instructions and the form.

Our website offers a detailed "PC-ACE Training Module for use with Novitasphere Portal" as well as a "PC-ACE User Quick Steps" document. You can review these resources at any time.

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Online registration available for April 29, open meeting and proposed LCDs now posted

Online registration for the April 29, open meeting is now available and will close at noon ET on Wednesday, April 27. **Important:** During this unprecedented time, our open meeting will be held via webinar only. Our proposed LCDs are now posted.

Open meetings are to allow interested parties the opportunity to make presentations of information and offer comments related to new proposed LCDs and/or the revised portion of a proposed LCD that are in the 45-day open comment period.

Interested parties may also request to attend as an observer. If you are interested in attending as a presenter or observer, please view our Proposed local coverage determination open meetings page for specific guidelines and other helpful information.

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April 12, 2022

Prior authorization: Botulinum toxin injections

The A/B MAC Prior Authorization Collaboration Workgroup developed a new article on botulinum toxin injections. This new article has been added to our Prior authorization (PA) program for certain hospital outpatient department (OPD) services page. Please review this information.

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Claim submission errors (January-March)

The Part A quarterly claim submission errors and resolutions are now available. Please take time to review these errors and avoid them on future claims.

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April 11, 2022

Special Edition – Monday, April 11, 2022

HHS Takes Actions to Promote Safety & Quality in Nursing Homes

On April 11, CMS issued its fiscal year (FY) 2023 Skilled Nursing Facilities Prospective Payment System (SNF PPS) proposed rule, which includes asking for public feedback on how staffing in nursing homes and health equity improvements could lead to better health outcomes.

The proposed rule builds upon the Biden-Harris Administration's commitment to advance health equity, drive high-quality person-centered care, and promote sustainability of its programs. The rule is an important step in fulfilling its goal to protect Medicare skilled nursing facility (SNF) residents and staff by improving the safety and quality of care of the nation's SNFs (commonly referred to as nursing homes). The SNF PPS provides Medicare payments to over 15,000 nursing homes, serving more than 1.5 million people. Medicare spending to nursing homes is projected to be approximately $35 billion in FY 2022. Through the SNF PPS proposed rule, CMS is continuing its work to transform the SNF payment system to a more patient-centered model by making payments based on the needs of the whole patient, rather than focusing on the volume of certain services the patient receives.

"Everyone deserves to receive safe, dignified, and high-quality care, no matter where they live," said HHS Secretary Xavier Becerra. "Today we are starting the necessary work to ensure our loved ones living in nursing homes receive the best care at the staffing levels they need. We are working hard to deliver on President Biden's commitment to protecting seniors and improving the quality of our nation's nursing homes."

The SNF PPS proposed rule aims to realize the President's vision for the nation's nursing homes as outlined in his State of the Union Address, with a focus on providing safe, dignified, and appropriate care for residents. As part of this vision, the Biden-Harris Administration recently set a goal to improve the quality of nursing homes so that seniors, people with disabilities, and others living in nursing homes get the reliable, high-quality care they deserve. A key part of reaching this goal is addressing staffing levels in nursing homes, which have a substantial impact on the quality of care and outcomes residents experience.

"The COVID-19 pandemic has highlighted serious problems at some of the nation's nursing homes that have persisted for too long. And we have seen the tragic impact that inadequate staff resources can have on residents and staff," said CMS Administrator Chiquita Brooks-LaSure. "The Biden-Harris Administration has promised that we will work with all stakeholders to do better for nursing home residents, and today's proposed rule includes important steps toward our goal to promote safety and quality of care for all residents and staff."

In the SNF PPS proposed rule, CMS is soliciting input to help the agency establish minimum staffing requirements that nursing homes will need to meet to ensure all residents are provided safe, high-quality care, and nursing home workers have the support they need. This input will be used in conjunction with a new research study being conducted by CMS to determine the optimal level and type of nursing home staffing needs. The agency intends to issue proposed rules on a minimum staffing level requirement for nursing homes within one year.

CMS is also requesting stakeholder input on a measure that would examine staff turnover levels in nursing homes for possible inclusion in CMS' SNF Value-Based Purchasing (VBP) Program, which

rewards facilities with incentive payments based on the quality of care they provide to people with Medicare. Looking at the relationship between staff turnover and quality of care, preliminary analysis by CMS has shown that as the average staff turnover decreases, a facility's overall rating on CMS' Nursing Home Five Star Quality Rating System increases, which suggests that lower turnover is associated with higher overall quality. CMS will use the stakeholder feedback to inform a proposal of this measure to include in the SNF VBP Program in the future.

In January, CMS began posting nursing home staff turnover rates (as well as weekend staff levels) on the Medicare.gov Care Compare website, and CMS will be including this information in the star rating system starting in July 2022. This information helps consumers better understand each nursing home facility's staffing environment and also helps providers to improve the quality of care and services they deliver to residents.

The proposed rule also proposes the adoption of 3 new measures into the SNF VBP Program:

- The Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI) is an outcome measure that assesses SNF performance on infection prevention and management.
- The Total Nursing Hours per Resident Day is a structural measure that uses auditable electronic data to calculate total nursing hours per resident each day.
- The Adoption of the Discharge to Community – Post Acute Care Measure for SNFs (DTC) is an outcome measure that assesses the rate of successful discharges to community from a SNF setting.

To advance health equity and address the health disparities that underlie the U.S. health care system, CMS is requesting stakeholder feedback on the role health equity plays in improving health outcomes and the quality of care in nursing homes. Specifically, CMS is seeking comment on how to arrange or classify measures in nursing home quality reporting programs by indicators of social risk to better identify and reduce disparities.

CMS is proposing a 3.9%, or $1.4 billion, update to the payment rates for nursing homes, which is based on a 2.8% SNF market basket update plus a 1.5 percentage point market basket forecast error adjustment and less a 0.4 percentage point productivity adjustment. The proposed rule also contains a proposed adjustment to payment rates as the result of the transition to the SNF payment case-mix classification model * the Patient Driven Payment Model (PDPM) that went into effect on October 1, 2019. When finalizing the PDPM, CMS also stated that the transition to PDPM would not result in an increase or decrease in aggregate SNF spending. Since PDPM implementation, CMS' data analysis has shown an unintended increase in payments. Therefore, CMS is proposing to adjust SNF payment rates downward by 4.6%, or $1.7 billion, in FY 2023 to achieve budget neutrality with the previous payment system. As a result, the estimated aggregate impact of the payment policies in this proposed rule would be a decrease of approximately $320 million in Medicare Part A payments to SNFs in FY 2023 compared to FY 2022.

More Information:

- Proposed rule
- Fact sheet: President Biden's remarks during the State of the Union Address on improving nursing home safety and quality
- Fact sheet: FY 2023 SNF PPS proposed rule

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Frequently Asked Questions (FAQs)

Have questions and not sure where to turn? Check out our FAQs for answers to your questions.

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April 8, 2022

Coding a conditional payment claim

A conditional payment is a payment made by Medicare for services on behalf of a Medicare beneficiary when there is evidence that the primary plan does not pay promptly. In order for the claim to process correctly, you must follow the conditional payment coding guidelines. A claim submitted without the necessary information will return to provider, which may include reason codes 31102 and 31361.

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Reason code resolution help

We have noticed an increase in claim rejections/returns for reason codes U6802 and 38038. Please review the articles below for resolution tips and billing guidance.

- Reason code U6802

  Received when the Medicare secondary payer (MSP) claim has no direct match on the MSP auxiliary record.

- Reason code 38038

  Received when an outpatient prospective payment system (OPPS) claim date of service is overlapping or on the same day as another processed OPPS claim for the same provider number.

For clarification and billing guidance on other common reason codes, please visit our Other claim submission & reason code errors page.

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April 7, 2022

Special Edition – Thursday, April 7, 2022

Returning to Certain Pre-COVID-19 Policies & Coverage of Monoclonal Antibodies for Alzheimer's Disease Stakeholder Call

- CMS Returning to Certain Pre-COVID-19 Policies in Long-term Care and Other Facilities
- Join CMS for a Stakeholder Call on the Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

CMS Returning to Certain Pre-COVID-19 Policies in Long-term Care and Other Facilities

CMS is taking steps to continue to protect nursing home residents' health and safety by announcing guidance that restores certain minimum standards for compliance with CMS requirements. Restoring these standards will be accomplished by phasing out some temporary emergency declaration waivers that have been in effect throughout the COVID-19 public health emergency (PHE). These temporary emergency waivers were designed to provide facilities with the flexibilities needed to respond to the COVID-19 pandemic.

During the PHE, CMS used a combination of emergency waivers, regulations, and sub-regulatory guidance to offer health care providers the flexibility needed to respond to the pandemic. In certain cases, these flexibilities suspended requirements in order to address acute and extraordinary circumstances. CMS has consistently monitored data within nursing homes and has used these data to inform decision making.

With steadily increasing vaccination rates for nursing home residents and staff, and with overall improvements seen in nursing homes' abilities to respond to COVID-19 outbreaks, CMS is taking steps to phase out certain flexibilities that are generally no longer needed to re-establish certain minimum standards while continuing to protect the health and safety of those residing in skilled nursing facilities/nursing facilities. Similarly, some of the same waivers are also being terminated for inpatient hospices, intermediate care facilities for individuals with intellectual disabilities, and ESRD facilities.

More Information:

- Full press release
- Quality, Safety, and Oversight memo

Join CMS for a Stakeholder Call on the Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Today, the Centers for Medicare & Medicaid Services (CMS) released a national policy for coverage of aducanumab (brand name Aduhelm™) and any future monoclonal antibodies directed against amyloid approved by the FDA with an indication for use in treating Alzheimer's disease. From the onset, CMS ran a transparent, evidence-based process that incorporated more than 10,000 stakeholder comments and more than 250 peer-reviewed documents into the determination.

As finalized in this two-part National Coverage Determination (NCD), Medicare will cover monoclonal antibodies that target amyloid (or plaque) for the treatment of Alzheimer's disease that receive traditional approval from the Food and Drug Administration (FDA) under coverage with evidence development (CED). CMS, as a part of this decision, will provide enhanced access and coverage for people with Medicare participating in CMS-approved studies, such as a data collection through routine clinical practice or registries. Registry data may be used to assess whether outcomes seen in carefully controlled clinical trials (e.g., FDA trials) are reproduced in the real-world and in a broader range of patients. Any new drugs in this class that receive FDA traditional approval may be available in additional care settings that people with Medicare can use, such as an outpatient department or an infusion center. Secondly, for drugs that FDA has not determined to have shown a clinical benefit (or that receive an accelerated FDA approval), Medicare will cover in the case of FDA or National Institutes of Health (NIH) approved trials. Under this NCD, CMS will support the FDA by covering the drug and any related services (including, in some cases, PET scans if required by trial protocol) for people with Medicare who are participating in these trials.

More Information:

- Complete press release
- Fact sheet on Medicare coverage policy for monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease
- Final NCD CED decision memorandum

Stakeholder Call

What: CMS invites you to join a stakeholder call on the Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Decision Follows Robust Stakeholder Input and Creates Pathway for Enhanced Access and Coverage of Drugs that Receive Traditional FDA Approval

When: April 11, 2022 at 11:00 AM ET

How to register.

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Improve the Health of Minority Populations with Covered Preventive Services

MLN Connects newsletter for Thursday, April, 7, 2022

News

- Fiscal Year 2021 Program for Evaluating Payment Patterns Electronic Reports
- Preventive Services & Health Equity: Improve the Health of Minority Populations

Compliance

- What's the Comprehensive Error Rate Testing Program?

Claims, Pricers, & Codes

- April 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.1
- Claim Status Category and Claim Status Codes Update

MLN Matters® Articles

- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
- Update to Chapter 7, "Home Health Services," of the Medicare Benefit Policy Manual (Pub 100-02)
- April 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677 — Revised

Publications

- Advanced Practice Registered Nurses, Anesthesiologist Assistants, & Physician Assistants — Revised

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The following billing and coding article has been revised:

- Billing and Coding: Removal of Benign Skin Lesions (A57113)

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April 6, 2022

Special Edition – Wednesday, April 6, 2022

Eligible Individuals Can Receive Second COVID-19 Booster Shot at No Cost

On April 6, CMS announced it will pay for a second COVID-19 booster shot of either the Pfizer-BioNTech or Moderna COVID-19 vaccines without cost sharing, as it continues to provide coverage for this critical protection from the virus. People with Medicare pay nothing to receive a COVID-19 vaccine, and there is no applicable copayment, coinsurance, or deductible. People with Medicaid coverage can also get COVID-19 vaccines, including boosters, at no cost.

The CDC recently updated its recommendations regarding COVID-19 vaccinations. Certain immunocompromised individuals and people ages 50 years and older who received an initial booster dose at least 4 months ago are eligible for another booster to increase their protection against severe disease from COVID-19. Additionally, the CDC recommends that adults who received a primary vaccine and booster dose of Johnson & Johnson's Janssen COVID-19 vaccine at least 4 months ago can receive a second booster dose of a Pfizer-BioNTech or Moderna COVID-19 vaccine.

The COVID-19 vaccine, including the booster doses, is the best defense against severe illness, hospitalization, and death from the virus. CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html and through the CMS COVID-19 Provider Toolkit.

People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

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April 4, 2022

Special Edition – Monday, April 4, 2022

Biden-Harris Administration Announces a New Way for Medicare Beneficiaries to Get Free Over-the-Counter COVID-19 Tests

On April 4, The Biden-Harris Administration announced that more than 59 million Americans with Medicare Part B, including those enrolled in a Medicare Advantage plan, now have access to FDA approved, authorized, or cleared over-the-counter COVID-19 tests at no cost. People with Medicare can get up to 8 tests per calendar month from participating pharmacies and health care providers for the duration of the COVID-19 public health emergency.

"With today's announcement, we are expanding access to free over-the-counter COVID-19 testing for people with Medicare Part B, including those enrolled in a Medicare Advantage plan. People with Medicare Part B will now have access to up to 8 FDA-approved, authorized or cleared over-the-counter COVID-19 tests per month at no cost. This is all part of our overall strategy to ramp -up access to easy-to-use, at-home tests free of charge," said HHS Secretary Xavier Becerra. "Since we took office, we have more than tripled the number of sites where people can get COVID-19 tests for free, and we're also delivering close to 250 million at-home, rapid tests to send for free to Americans who need them. Under the Biden-Harris Administration's leadership, we required state Medicaid programs, insurers and group health plans to make tests free for millions of Americans. With today's step, we are further expanding health insurance coverage of free over-the-counter tests to Medicare beneficiaries, including our nation's elderly and people with disabilities."

This is the first time that Medicare has covered an over-the-counter self-administered test at no cost to beneficiaries. This new initiative enables payment from Medicare directly to participating eligible pharmacies and other health care providers to allow Medicare beneficiaries to receive tests at no

cost, in addition to the 2 sets of 4 free at-home COVID-19 tests Americans can continue to order from covidtests.gov. National pharmacy chains are participating in this initiative, including: Albertsons Companies, Inc., Costco Pharmacy, CVS, Food Lion, Giant Food, The Giant Company, Hannaford Pharmacies, H-E-B Pharmacy, Hy-Vee Pharmacy, Kroger Family of Pharmacies, Rite Aid Corp., Shop & Stop, Walgreens, and Walmart.

“Testing remains a critical tool in mitigating the spread of COVID-19, and we are committed to making sure people with Medicare have the tools they need to stay safe and healthy,” said CMS Administrator Chiquita Brooks-LaSure. “By launching this initiative, the Biden-Harris Administration continues to demonstrate that we are doing everything possible to make over-the-counter COVID-19 testing free and accessible for millions more Americans.”

Providers and suppliers eligible to participate include certain types of pharmacies and other health care providers who are enrolled in Medicare and able to furnish ambulatory health care services such as preventive vaccines, COVID-19 testing, and regular medical visits. To ensure that people with Medicare have access to these tests, Medicare is not requiring participating eligible pharmacies and health care providers go through any new Medicare enrollment processes. If a health care provider currently provides ambulatory health care services such as vaccines, lab tests, or other clinic type visits to people with Medicare, then they are eligible to participate in this initiative.

“For the first time in its history, Medicare is paying for an over-the-counter test,” said Deputy Administrator Dr. Meena Seshamani, Director of the Center for Medicare at CMS. “This is because COVID-19 testing is a critical part of our pandemic response. Combined with the free over-the-counter tests available through covidtests.gov, this initiative will significantly increase testing access for Americans most vulnerable to COVID-19 and will provide valuable information for future payment policy supporting accessible, comprehensive, person-centered health care.”

A list of eligible pharmacies and other health care providers that have committed publicly to participate in this initiative can be found here. Because additional eligible pharmacies and health care providers may also participate, people with Medicare should check with their pharmacy or health care provider to find out whether they are participating.

This initiative adds to existing options for people with Medicare to access COVID-19 testing, including:

- Requesting free over-the-counter tests for home delivery at covidtests.gov. Every home in the U.S. is eligible to order 2 sets of 4 at-home COVID-19 tests.
- Access to no-cost COVID-19 tests through health care providers at over 20,000 testing sites nationwide. A list of community-based testing sites can be found here.
- Access to lab-based PCR tests and antigen tests performed by a laboratory when the test is ordered by a physician, non-physician practitioner, pharmacist, or other authorized health care professional at no cost through Medicare.
- In addition to accessing a COVID-19 laboratory test ordered by a health care professional, people with Medicare can also access one lab-performed test without an order and cost-sharing during the public health emergency.

People with Medicare can get additional information by contacting 1-800-MEDICARE and going to: https://www.medicare.gov/medicare-coronavirus. Medicare also maintains several resources to help ensure beneficiaries receive the correct benefits while also avoiding the potential for fraud or scams. More details—particularly on identifying scams due to COVID-19—can be found at https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse.

Pharmacies and other health care providers interested in participating in this initiative can get more information here: https://www.cms.gov/COVIDOTCtestsProvider.

More Information:

- Fact Sheet
- COVID-19 Over-the-Counter Tests webpage

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April 1, 2022

Billing Veklury (remdesivir) antiviral medication in outpatient settings

Effective for dates of service on or after April 1, additional diagnosis codes have been added for the billing of Veklury (remdesivir). Please carefully review our article for billing guidance.

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Reimbursement guidelines for radiopharmaceutical procedures

Did you know we have a provider specialty page for radiopharmaceutical procedures? Please review our article for details.

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March 31, 2022

Special Edition – Thursday, March 31, 2022

IPF & IRF Proposed FY 2023 Payment Rules

- Inpatient Psychiatric Facilities: Fiscal Year 2023 Proposed Rule — Submit Comments by May 31
- Inpatient Rehabilitation Facilities: Fiscal Year 2023 Proposed Rule — Submit Comments by May 31

Inpatient Psychiatric Facilities: Fiscal Year 2023 Proposed Rule — Submit Comments by May 31

On March 31, CMS issued the fiscal year 2023 inpatient psychiatric facility (IPF) prospective payment system proposed rule to update IPF payments, wage index, and policies. See a summary of key provisions.

Proposals include:

Updating payment rates by 2.7% with estimated payments to increase by 1.5% after productivity adjustment

Requesting comments on the IPF prospective payment system refinement analysis

Applying a permanent 5% cap on wage index decreases

We encourage you to review the rule, and submit formal comments by May 31, 2022.

Inpatient Rehabilitation Facilities: Fiscal Year 2023 Proposed Rule — Submit Comments by May 31

On March 31, CMS issued the fiscal year 2023 inpatient rehabilitation facility (IRF) prospective payment system proposed rule to update Medicare payment policies and rates. See a summary of key provisions.

Proposals include:

- Updating payment rates by 2.8%, with estimated overall payments to increase by 2.0% after productivity and outlier adjustments
- Applying a permanent 5% cap on annual wage index decreases
- Expanding quality data reporting on all IRF patients, regardless of payer

We encourage you to review the rule, and submit formal comments by May 31, 2022.

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Continuous Glucose Monitor: Provide Supplies for a Calendar Month

MLN Connects newsletter for Thursday, March 31, 2022

News

- Home Health Providers: Services Provided Data for April 2022 Refresh
- Continuous Glucose Monitor: Provide Supplies for a Calendar Month
- Cognitive Impairment: Medicare Provides Opportunities to Detect & Diagnose

Claims, Pricers, & Codes

- Hospice Web Pricer

Events

- Medicare Cost Report E-Filing System: Interim Rate & Settlement Documentation Webinar — April 26

MLN Matters® Articles

- April 2022 Update of the Ambulatory Surgical Center (ASC) Payment System
- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting & Reporting Data for the Private Payor Rate-Based Payment System — Revised

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March 30, 2022

Special Edition – Wednesday, March 30, 2022

Fiscal Year 2023 Hospice Payment Rate Update Proposed Rule — Comment by May 31

On March 30, CMS issued a proposed rule (CMS-1773-P) that would provide routine updates to hospice-based payments and the aggregate cap amount for fiscal year (FY) 2023 in accordance with existing statutory and regulatory requirements. This rule proposes to establish a permanent mitigation policy to smooth the impact of year-to-year changes in hospice payments related to changes in the hospice wage index.

CMS is committed to addressing consistent and persistent inequities in health outcomes by improving data collection to measure and analyze disparities across programs and policies that apply to the Hospice Quality Reporting Program (HQRP). This rule discusses the HQRP including the Hospice Outcomes and Patient Evaluation (HOPE) tool; provides an update on quality measures (QMs) that will be in effect in FY 2023 as well as future QMs; and also provides updates on the Consumer

Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey Mode Experiment. This rule also contains a request for information (RFI) on health equity and proposes updates to advancing a health information exchange.

Proposed Medicare Hospice Payment Policies:

This proposed rule proposes a permanent, budget neutral approach to smooth year-to-year changes in the hospice wage index. Specifically, we are proposing a permanent cap on negative wage index changes greater than a 5% decrease from the prior year (regardless of the underlying reason for the decrease) for hospices in the FY 2023 proposed rule.

Routine Annual Rate Setting Changes:

As proposed, hospices would see a 2.7% ($580 million) increase in their payments for FY 2023. The proposed 2.7% hospice payment update for FY 2023 is based on the estimated 3.1% inpatient hospital market basket update reduced by the productivity adjustment (0.4 percentage point). Hospices that fail to meet quality reporting requirements receive a 2-percentage point reduction to the annual market basket update for FY 2023.

The hospice payment update includes a statutory aggregate cap that limits the overall payments per patient that is made to a hospice annually. The proposed cap amount for FY 2023 is $32,142.65 (FY 2022 cap amount of $31,297.61 increased by 2.7%.

Hospice Quality Reporting Program:

This rule provides an update on the development of a patient assessment instrument, titled HOPE, which would contribute to a patient's plan of care when adopted. This includes an update on the BETA testing and derivatives that will be achieved during this phase of testing, such as burden estimates and timepoints for collection, as well as additional outreach efforts that will be conducted during and after BETA testing and during our future plans for adoption. CMS also discusses potential future quality measures within the HQRP based on HOPE and administrative data, including HOPE-based process measures and hybrid quality measures, which could be based upon multiple sources that include HOPE, claims, and other data sources.

This rule announces a potential future update to the CAHPS Hospice Survey, which is used to collect data on experiences of hospice care from primary caregivers of hospice patients. In particular, CMS is providing an update on a mode experiment whose goal was to test the effect of adding a web-based mode to the CAHPS Hospice Survey.

In this proposed rule, we are seeking information on our Health Equity Initiative within the HQRP by describing our current assessment of health equity within hospice. We are also seeking input on a potential future structural measure as well as responses to specific questions that would further inform future efforts.

More Information:

- Proposed rule: We'll accept public comments until May 31, 2022
- Hospice Center webpage

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE22001 - Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

  Make sure your billing staff knows about these changes:

- Regulatory changes for mental health visits in RHCs & FQHCs.
- Billing information for mental health visits done via telecommunications.

Revised:

- MM12439 - Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20- valent Conjugate Vaccine Code 90677

  CMS revised this article due to a revised CR 12439 which shows MACs will adjust certain processed and rejected claims with HCPCS code 90671 after April 4, 2022. CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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March 28, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12666 - April 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  Make sure your billing staff knows about:

  - The April 2022 Integrated Outpatient Code Editor (I/OCE).
  - New COVID-19 CPT codes.
  - The latest changes to HCPCS codes.

- MM12676 - Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  Make sure your billing staff knows about:

  - The latest update of the RARC and CARC code sets.
  - What you must do if you use MREP or PC Print.
  - Where to find the official code lists.

  If you use MREP or PC Print, be sure to get the latest version when available.

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March 25, 2022

Open claim issues

An issue occurred with cancel claims posting to the Common Working File (CWF). The issue began in January and impacted claims cancelled for 2022 dates of service.

The issue has been corrected to stop posting cancelled claims to CWF on March 21. We are working with CMS and the Fiscal Intermediary Shared System (FISS) for a solution to the cancel claims that have already been posted.

We are currently waiting for a resolution and will provide additional information when it is available.

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March 24, 2022

ICD-10: Comment on Proposed Procedure and Diagnosis Codes

MLN Connects newsletter for Thursday, March 24, 2022

News

- Additional Residency Positions: Apply by March 31
- Long-term Care Hospitals: March Preview Period Ends April 6
- Inpatient Rehabilitation Facilities: March Preview Period Ends April 6
- Home Health Quality Reporting Program: Review Your Preview Reports
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Register in the Open Payments System
- Long-term Care Facilities: Quality Measure Rating Threshold Changes
- Lipid Panel Testing: Comparative Billing Report in March

Compliance

- DMEPOS Standard Written Order Requirements

Claims, Pricers, & Codes

- ICD-10 Procedure Codes: Comment by April 8
- ICD-10 Diagnosis Codes: Comment by May 9

MLN Matters® Articles

- April Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)

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Limited systems availability - Friday, April 1 through Sunday, April 3

There will be Common Working File (CWF) "Dark" days from Friday, April 1, through Sunday, April 3, due to the April 2022 release upgrades. The interactive voice response (IVR) will have limited availability.

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The following billing and coding articles have been revised:

- Billing and Coding: Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents (A53049)
- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions (A53134)

The following billing and coding article has been retired:

- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)

.

March 21, 2022

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The February 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. A new question / answer has been added to the general information category and an update has been made to the return to provider category. Please take time to review these and other FAQs for answers to your questions.

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Prior authorization: Panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy), and related services

The A/B MAC Prior Authorization Collaboration Workgroup developed a new article on panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy), and related services. This new article has been added to our Prior authorization (PA) program for certain hospital outpatient department (OPD) services page. Please carefully review this information.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

MM12583 - Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)

Make sure your billing staff knows about:

- How to code for difelikefalin injection
- Modifier use for code J0879

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March 17, 2022

Kidney Health: Help Address Disparities

MLN Connects newsletter for Thursday, March 17, 2022

News

- Medicare Shared Savings Program: Application Deadlines for January 1, 2023, Start Date
- Kidney Health: Help Address Disparities

Claims, Pricers, & Codes

- April 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Federally Qualified Health Centers: Retroactive Claims Adjustments

- Home Health Web Pricer

Events

- Medicare Ground Ambulance Data Collection System: Q&A Session — March 29

MLN Matters® Articles

- April 2022 Update to the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS)

Publications

- Complying with Medicare Signature Requirements — Revised
- Medicare Preventive Services — Revised
- SBIRT Services — Revised

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Upcoming direct data entry changes

Effective April 1, the Fiscal Intermediary Shared System (FISS) maintainer is adding fields for pneumococcal pneumonia vaccine codes 90671 and 90677 to MAP175R. This screen is located in Inquiries-01, Beneficiary/CWF, option 10. The FISS Manual has been updated to reflect this change.

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Prior Authorization MAC Chat

You may now sign up for one-on-one sessions with prior authorization-related questions.

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March 14, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12654 - April Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  Make sure your billing staff knows about these changes:

  - The April 2022 quarterly update for the DMEPOS fee schedule.
  - Fee schedule amounts for new and existing codes.

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March 11, 2022

COVID-19 monoclonal antibody (mAb): Revised emergency use authorization (EUA) for EVUSHELD

On February 24, the FDA revised the EUA for tixagevimab co-packaged with cilgavimab (EVUSHELD) to change the initial dose for the authorized use as pre-exposure prophylaxis of COVID-19 in certain adults and pediatric patients. CMS created a new product code Q0221. For more information about dosage and administration, including information about dosing for patients who got the original lower dose, review the fact sheet (ZIP).

As a result of these changes, updates have been made to the following references:

- COVID-19 monoclonal antibodies
- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 monoclonal antibodies reimbursement

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March 10, 2022

COVID-19 Monoclonal Antibodies: Revised Emergency Use Authorization for EVUSHELD

MLN Connects newsletter for Thursday, March 10, 2022

News

- COVID-19 Monoclonal Antibodies: Revised Emergency Use Authorization for EVUSHELD
- Program for Evaluating Payment Patterns Electronic Reports for Short-term Acute Care Hospitals
- Quality Payment Program: 2020 Performance Information on Care Compare
- Skilled Nursing Facilities: Submit Technical Expert Panel Nominations by March 16
- Long-term Care Hospitals: Reissued March 2022 Preview Reports
- Inpatient Rehabilitation Facilities: Reissued March 2022 Preview Reports
- Teaching Hospitals: Direct Graduate Medical Education Resets
- Colorectal Cancer: Screening Saves Lives

Compliance

- Implanted Spinal Neurostimulators: Document Medical Records

Claims, Pricers, & Codes

- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 28.1, Effective April 1, 2022

MLN Matters® Articles

- Internet Only Manual Update, Pub. 100-04, Chapter 11, Sections 20.1.4 and 30.3 Regarding the Cancellation of an Election and Billing for Services
- Gap Billing Between Hospice Transfers — Revised

Publications

- Collaborative Patient Care is a Provider Partnership — Revised

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The following billing and coding articles have been revised:

- Billing and Coding: Information Regarding Uses, Including Off-Label Uses, of Anti-Vascular Endothelial Growth Factor (anti-VEGF) for The Treatment of Ophthalmological Diseases (A53121)
- Billing and Coding: Rezum® Procedure (A55352)

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March 8, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12631 - April 2022 Update to the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS)

  In this article, you'll learn about:

  - Coding needs for emergency use of Pfizer's PAXLOVID™ and Merck's Molnupiravir
  - Coding criteria for reprocessing inpatient claims involving PAXLOVID or Molnupiravir

  Make sure your billing staff knows about these changes.

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March 3, 2022

2022 Payment, Quality, & Policy Changes

MLN Connects newsletter for Thursday, March 3, 2022

News

- Ambulance Prior Authorization Model Expands April 1
- Nutrition-related Health Conditions: Recommend Medicare Preventive Services

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs and Biologicals

Events

- ICD-10 Coordination & Maintenance Committee Meeting — March 8–9

MLN Matters® Articles

- An Omnibus CR Covering: (1) Removal of Two National Coverage Determination (NCDs), (2) Updates to the Medical Nutrition Therapy (MNT) Policy, and (3) Updates to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) Conditions of Coverage
- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2020 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)

Publications

- Medicare Payment Systems — Revised

.

March 2, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12550 - Internet-Only Manual Updates for Critical Care Evaluation and Management Services
- CMS revised this article due to a revised change request (CR) 12550. The CR revision didn't affect the substance of the article. We did change the CR release date, transmittal number, and web addresses for the CR. All other information is the same.

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February 28, 2022

TIBCO Gateway required for all EDI SFTP customers

All secure file transfer protocol (SFTP) trading partners should now be connecting to us through the new EDI TIBCO Gateway. If you have not updated to TIBCO, you may experience financial hardship due to the inability to submit your Medicare claims.

The M2 Gateway was shut down **yesterday** February 28. For additional details, visit the EDI Gateway – Connecting to the Future webpage.

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February 25, 2022

Amniotic fluid and/or placental tissue biological injection claim denials

Important notice for providers billing amniotic fluid and/or placental tissue biological injections.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12628 - The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2020 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs)

  In this article, you'll learn about updated data used for:

  - The calculation of the disproportionate share (DSH) adjustment for IPPS hospitals and low-income patient (LIP) adjustment for IRFs.
  - Payments for certain LTCH discharges.

  Make sure your billing staff knows about these changes.

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February 24, 2022

CMS Released Skilled Nursing Facility & ESRD Web Pricers

MLN Connects newsletter for Thursday, February 24, 2022

News

- Podiatry Nail Debridement & Evaluation and Management Services: Comparative Billing Report
- Skilled Nursing Facilities: Submit Technical Expert Panel Nominations by March 16

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Non-Drug and Non-Biological Items and Services
- Skilled Nursing Facility Web Pricer
- ESRD: Web Pricer & Last PC Pricer

MLN Matters® Articles

- CWF Editing – National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) – July 2022
- Revisions to National Coverage Determination (NCD) 240.2 (Home Use of Oxygen) and 240.2.2 (Home Oxygen Use for Cluster Headache)
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – April 2022 Update

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COVID-19 monoclonal antibody (mAb): New product and administration codes for Bebtelovimab

Effective February 11, 2022, the FDA authorized the emergency use of the monoclonal antibody Bebtelovimab for the treatment of mild-to-moderate COVID-19 in adult and pediatric patients. CMS added new product code Q0222 and two new administration codes M0222 and M0223. CMS added fees for these codes to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 monoclonal antibodies reimbursement

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The following billing and coding article has been revised:

- Billing and Coding: Epidural Steroid Injections for Pain Management (A56681)

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February 23, 2022

Reminder: Clinical lab providers - Molecular Diagnostic Pathology survey (Gap-fill) ends March 3

We seek your input on establishing pricing under the Medicare program for the 2022 Gap-fill laboratory test codes. If you have not already done so, please complete our Molecular Diagnostic Pathology survey by March 3. Please complete a separate survey for each test you perform.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12613 - An Omnibus CR Covering: (1) Removal of Two National Coverage Determination (NCDs), (2) Updates to the Medical Nutrition Therapy (MNT) Policy, and (3) Updates to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) Conditions of Coverage

  In this article, you'll learn about:

  - Removal of 2 NCDs (NCD 180.2 and NCD 220.6)
  - Updates to the Medical Nutritional Therapy (MNT) policy
  - Updates to the conditions of coverage for Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR)

  Make sure your billing staff knows about these changes.

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February 22, 2022

TIBCO Gateway required for all EDI SFTP customers

All secure file transfer protocol (SFTP) trading partners should now be connecting to us through the new EDI TIBCO Gateway. If you have not yet updated to TIBCO, you may experience financial hardship due to the inability to submit your Medicare claims.

The M2 Gateway will be shut down on February 28.

For additional details, visit the "EDI Gateway – Connecting to the Future" page.

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February 18, 2022

Special Edition – Friday, February 18, 2022

COVID-19 Monoclonal Antibodies: FDA Authorized Bebtelovimab

On February 11, the FDA authorized the emergency use of the monoclonal antibody bebtelovimab for the treatment of mild-to-moderate COVID-19 in adult and pediatric patients when all of these apply:

- They have a positive COVID-19 test result
- They're at high-risk for progression to severe COVID-19
- Alternative COVID-19 treatment options approved or authorized by the FDA aren't accessible or clinically appropriate for them

CMS created new codes, effective February 11:

Q0222:

- Long descriptor: Injection, bebtelovimab, 175 mg
- Short descriptor: Bebtelovimab 175

M0222:

- Long Descriptor: Intravenous injection, bebtelovimab, includes injection and post administration monitoring

- Short Descriptor: Bebtelovimab injection

M0223:

- Long Descriptor: Intravenous injection, bebtelovimab, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency
- Short Descriptor: Bebtelovimab injection home

Visit the COVID-19 Monoclonal Antibodies webpage for more information.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12623 - Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2022 Update

  In this Article, you'll learn about:

  - April 2022 updates to the MPFS.
  - New payment files based on the Calendar Year (CY) 2022 MPFS Final Rule.

  Make sure your billing staff knows about these changes.

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February 17, 2022

Expanded Coverage: Lung Cancer Screening with Low Dose Computed Tomography

MLN Connects newsletter for Thursday, February 17, 2022

News

- CMS Expands Coverage of Lung Cancer Screening with Low Dose Computed Tomography
- There's Still Time to Recommend the Flu Shot

Compliance

- Surgical Dressings: Medicare Requirements

MLN Matters® Articles

- Gap Billing Between Hospice Transfers
- April 2022 Update to the Medicare Severity – Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Version 39.1 for the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for 2019 Novel Coronavirus (COVID-19) Vaccination Status and ICD-10 Procedure Coding System (PCS) Codes for Introduction or Infusion of Therapeutics and Vaccines for COVID-19 Treatment — Revised

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12611 - Common Working File (CWF) Editing - National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds

  In this article, you'll learn about new edits for autologous platelet-rich plasma (PRP) claims for diabetes and chronic ulcers.

  Make sure your billing staff knows about these changes.

.

The following billing and coding articles have been revised:

- Billing and Coding: Allergy Testing (A56558)
- Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing (A56423)
- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Billing and Coding: Hydration Therapy (A56634)

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Part A open claims issues

Prior authorization claims are being returned with reason code 39621 in error when the claim matches the prior authorization file. CMS is aware of this issue impacting all MACs. A correction is scheduled for April 4, 2022. Please review our open claim issues for more information.

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February 16, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12606 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) -- July 2022

  In this article, you'll learn about:

  - Newly available codes.
  - Separate NCD coding revisions.
  - Coding feedback.

  Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12606.

  Make sure your billing staff knows of these changes.

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The January 2022 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. A new question / answer has been added to the return to provider category. Please take time to review these and other FAQs for answers to your questions.

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February 11, 2022

Billing COVID-19 convalescent plasma in outpatient setting

Effective for dates of services on and after December 28, 2021, CMS created new HCPCS code C9507 for COVID-19 convalescent plasma use in the outpatient setting. Please review our article for billing guidance.

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February 10, 2022

COVID-19: New HCPCS Code for Convalescent Plasma in Outpatient Setting

MLN Connects newsletter for Thursday, February 10, 2022

News

- COVID-19: New HCPCS Code for Convalescent Plasma in Outpatient Setting
- Long-term Care Hospital Provider Preview Reports: Review Your Data by February 25
- Inpatient Rehabilitation Facility Provider Preview Reports: Review Your Data by February 25
- Skilled Nursing Facility Quality Reporting Program: January Refresh
- Nursing & Allied Health Medicare Advantage Payment - Revision to CY 2018
- Help Address Heart Health Disparities

Claims, Pricers, & Codes

- Inpatient Psychiatric Facility: Web Pricer & Last PC Pricer

Events

- Transitional Coverage for Emerging Technologies Listening Sessions — February 17 & March 31
- Provider Compliance Virtual Focus Group — February 24

Publications

- Getting Started with Hospice CASPER Quality Measure Reports — Revised

Multimedia

- COVID-19: Training for Frontline Nursing Home Staff & Management

.

The following billing and coding articles have been revised:

- Billing and Coding: Botulinum Toxins (A58423)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)
- Billing and Coding: Platelet Rich Plasma (A58808)

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February 9, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12578 - April 2022 Update to the Medicare Severity – Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Version 39.1 for the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for 2019 Novel Coronavirus (COVID-19) Vaccination Status and ICD-10 Procedure Coding System (PCS) Codes for Introduction or Infusion of Therapeutics and Vaccines for COVID-19 Treatment

  CMS revised this article to show changes to CR 12578. The CR revision added 2 additional ICD-10-PCS codes added in dark red font on page 3. CMS also revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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February 4, 2022

Billing for COVID-19 vaccine home administration

Effective for claims received on and after June 8, 2021, Medicare pays an additional $35 per dose for administering COVID-19 vaccine in the home using HCPCS Level II code M0201 for certain Medicare patients that have difficulties leaving their home or are hard to reach. Medicare only pays the additional amount for administering the COVID-19 vaccine in the home if the sole purpose of the visit is to administer a COVID-19 vaccine. Learn more by reviewing this article.

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COVID-19 vaccine and monoclonal antibody (mAb) infusion billing alerts

Updated information has been added to section C, multiple PTANs linked to single NPI claim issue regarding taxonomy information. Centralized and mass immunizers please take time to review the new information.

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February 3, 2022

Special Edition – Thursday, February 3, 2022

Biden-Harris Administration Will Cover Free Over-the-Counter COVID-19 Tests Through Medicare

CMS Developing Initiative to Enable Access to Eight Free Over-the-Counter COVID-19 Tests for Medicare Beneficiaries in Early Spring

As part of the Biden-Harris Administration's ongoing efforts to expand Americans' access to free testing, people in either Original Medicare or Medicare Advantage will be able to get over-the-counter COVID-19 tests at no cost starting in early spring. Under the new initiative, Medicare beneficiaries will be able to access up to eight over-the-counter COVID-19 tests per month for free. Tests will be available through eligible pharmacies and other participating entities. This policy will apply to COVID-19 over-the-counter tests approved or authorized by the U.S. Food and Drug Administration (FDA).

This is the first time that Medicare has covered an over-the-counter test at no cost to beneficiaries. There are a number of issues that have made it difficult to cover and pay for over-the-counter COVID-

19 tests. However, given the importance of expanding access to testing, CMS has identified a pathway that will expand access to free over-the-counter testing for Medicare beneficiaries. This new initiative will enable payment from Medicare directly to participating pharmacies and other participating entities to allow Medicare beneficiaries to pick up tests at no cost. CMS anticipates that this option will be available to people with Medicare in the early spring.

Until then, people with Medicare can access free tests through a number of channels established by the Biden-Harris Administration. Medicare beneficiaries can:

- Request four free over-the-counter tests for home delivery at covidtests.gov.
- Access COVID-19 tests through healthcare providers at over 20,000 free testing sites nationwide. A list of community-based testing sites can be found here.
- Access lab-based PCR tests and antigen tests performed by a laboratory when the test is ordered by a physician, non-physician practitioner, pharmacist, or other authorized health care professional at no cost. In addition to accessing a COVID-19 lab test ordered by a health care professional, people with Medicare can also already access one lab-performed test without an order, also without cost sharing, during the public health emergency.

In addition:

- Medicare Advantage plans may offer coverage and payment for over-the-counter COVID-19 tests as a supplemental benefit in addition to covering Medicare Part A and Part B benefits, so Medicare beneficiaries covered by Medicare Advantage should check with their plan to see if it includes such a benefit.
- All Medicare beneficiaries with Part B are eligible for the new benefit, whether enrolled in a Medicare Advantage plan or not.

For more information, please see these Frequently Asked Questions, https://www.cms.gov/files/document/covid-19-over-counter-otc-tests-medicare-frequently-asked-questions.pdf (PDF)

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Provider Compliance Virtual Focus Group — February 24

MLN Connects newsletter for Thursday, February 3, 2022

News

- COVID-19: Letter to Health Care Facility Administrators on Health Care Worker Vaccination Rule
- COVID-19 Vaccine & Monoclonal Antibody Products: Changes for Medicare Advantage Plan Claims Started January 1 — Reminder

Compliance

- Home Health Low Utilization Payment Adjustment Threshold: Bill Correctly

Claims, Pricers, & Codes

- SNF Consolidated Billing Codes for CY 2022

Events

- Provider Compliance Virtual Focus Group — February 24

MLN Matters® Articles

- Expedited Review Process for Hospital Inpatients in Original Medicare
- Internet-Only Manual Updates for Critical Care Evaluation and Management Services
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds — Revised

Publications

- Medicare Preventive Services — Revised

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February 1, 2022

Systematic migrations to the new EDI TIBCO Gateway started Monday

System migrations started yesterday for any trading partners who have not yet migrated to the new EDI TIBCO Gateway. A total of 400 trading partners a day will be migrated in numerical order. Once migrated, you will have 1 week to access the old M2 Gateway and to retrieve reports.

Individual notifications **will not** be provided when your trading partner is migrated. Please prepare by using the new EDI TIBCO Gateway today. Continued use of the M2 Gateway puts you at risk for unexpectedly losing access. This could cause financial hardship due to the inability to submit your claims.

For additional details on the required EDI Gateway migration, visit the "EDI Gateway – Connecting to the Future" webpage.

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January 31, 2022

The following LCDs which were posted for notice on December 16, 2021 are now effective. The related billing and coding articles for these LCDs are also now effective:

- Genetic Testing for Cardiovascular Disease (L39082)
  - Billing and Coding: Genetic Testing for Cardiovascular Disease (A58795)
- Surgical Treatment of Nails (L34887)
  - Billing and Coding: Surgical Treatment of Nails (A52998)

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January 28, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12612 - Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

  In this article, you'll learn about:

  - Instructions for the April 2022 update to the CLFS

- New codes effective April 1, 2022.

Make sure your billing staff knows about these changes.

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Attention Clinical lab providers - Molecular diagnostic pathology survey (Gap-fill)

We seek your input on establishing pricing under the Medicare program for the 2022 Gap-fill laboratory test codes. If you have not already done so, please complete our Molecular Diagnostic Pathology Survey by March 3. Please complete a separate survey for each test you perform.

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January 27, 2022

COVID-19: Tools to Determine if Vaccine Requirements Apply

MLN Connects newsletter for Thursday, January 27, 2022

News

- COVID-19: Tools to Determine if Vaccine Requirements Apply
- COVID-19 Vaccine Codes: Pfizer Pre-Diluted Vaccine for Patients Ages 12+ & Third Dose for Immunocompromised Patients Ages 5–11
- COVID-19: Vaccine Access in Long-term Care Settings
- Medicare Diabetes Prevention Program: New for Calendar Year 2022

Claims, Pricers, & Codes

- Acute Hospital Care at Home: New Occurrence Span Code and Revenue Code

MLN Matters® Articles

- April 2022 Update to the Medicare Severity - Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Version 39.1 for the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for 2019 Novel Coronavirus (COVID-19) Vaccination Status and ICD-10 Procedure Coding System (PCS) Codes for Introduction or Infusion of Therapeutics and Vaccines for COVID-19 Treatment
- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens
- CY2022 Telehealth Update Medicare Physician Fee Schedule
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits
- Internet-Only Manual Updates (IOM) for Critical Care, Split/Shared Evaluation and Management Services, Teaching Physicians, & Physician Assistants
- New Waived Tests

Publications

- Home Infusion Therapy Services Monitoring Report

.

The following billing and coding articles have been revised:

- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)
- Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (A57752)

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COVID-19 Vaccine codes: Pfizer pre-diluted vaccine for patients ages 12+ & third dose for immunocompromised patients ages 5–11

Effective January 3, the FDA amended the emergency use authorization (EUA) to allow for third pediatric doses (orange cap) for 5–11-year-old solid organ transplant patients or patients with a similar level of immunocompromise for the Pfizer-BioNTech COVID-19 vaccine. The new code (0073A) was developed describing the service to administer the vaccine.

In addition, the FDA authorized an additional pre-diluted formulation (gray cap) for patients 12-years old and older. A new code describing a new tris-sucrose formulation of the Pfizer BioNTech COVID-19 vaccine (91305) and an affiliated set of codes that describe the services to administer the first dose, second dose, third dose and booster dose (0051A, 0052A, 0053A, 0054A) respectively were developed.

CMS added the fees for these recently added codes to the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine, monoclonal antibodies, and treatment specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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January 25, 2022

Ambulatory surgical center (ASC) modifiers

A new article has been added to assist ASCs with proper modifier reporting.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12550 - Internet-Only Manual Updates for Critical Care Evaluation and Management Services

  In this article, you'll learn about:

  - Critical care updates for a patient in a global surgical period
  - The use of modifier FT

  Make sure your billing staff knows about these changes.

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Required changes for submitting electronic claims

The current connection to us is being replaced with a new EDI Gateway. Jurisdiction L EDI trading partners should begin sending electronic claim files through the TIBCO gateway and discontinue all use of the M2 gateway.

Automatic migrations to the TIBCO gateway begin after **January 28**, for trading partners who submit claim files through a network service vendor (NSV). We will migrate connections to the new gateway using a phased approach of 400 trading partners daily in submitter number order.

Once you are systematically migrated, you will have 1 week to retrieve EDI reports before being terminated from the current gateway. The current M2 Gateway connectivity will be **shut down on February 28**.

Online resources available:

- EDI Gateway – Connecting to the future – includes details on the migration dates and step by step instructions for establishing the new connection
- TIBCO Quick Steps – provides a summary of how to use the new gateway for Novitasphere portal trading partners
- Novitasphere Portal User Manual Supplement: Claim submission/ERA using TIBCO – step by step instructions with screen prints on how to submit claims files and retrieve reports through the new gateway for Novitasphere portal trading partners
- PC-ACE training module for use with Novitasphere Portal – presentation explaining how to setup and enter claims in the free PC-ACE software and then submit through the new TIBCO gateway for Novitasphere portal trading partners.

Note: PC-ACE is not compatible with Apple/MAC products.

Be sure you are ready by establishing the TIBCO gateway connection today.

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January 24, 2022

Bone Mass Measurement

Are you receiving BMM denials for medical necessity or for frequency of services? Not sure where to go to find your answers? Please review our article.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12546 - Expedited Review Process for Hospital Inpatients in Original Medicare

  In this article, you'll learn about:

  - How Medicare patients can appeal determinations that inpatient care is no longer necessary.
  - Medicare Claims Processing Manual updates concerning expedited reviews.

  Make sure your staff knows this is a reformatting of the current instructions and there are no policy or instructional changes.

January 21, 2022

Important reminder of clinical trial (NCT) number reporting requirement

An important reminder that it is mandatory to report a clinical trial number, also known as the NCT number, on claims for items/services provided in clinical trials/studies/registries, or under coverage with evidence development (CED). This is the number assigned by the National Library of Medicine (NLM) ClinicalTrials.gov website when a new study appears in the NLM Clinical Trials data base. This number is listed prominently on each specific study's page and is always preceded by the letters "NCT" on institutional claims and "CT" on professional claims. Contractors verify the validity of a trial/study/registry by consulting the CMS's Coverage Website.

IMPORTANT: Claims submitted without the 8-digit clinical trial number will be returned as unprocessable.

Note: The associated IDE number must still be reported on the claim form as well as the mandatory 8-digit NCT number.

Please refer to MLN Matters Article 8401 and CMS IOM Publication 100-04 Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, Section 68 - Investigational Device Exemption (IDE) Studies and Section 69 - Qualifying Clinical Trials for more details on reporting the 8-digit clinical trial number.

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The December 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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January 20, 2021

COVID-19: Long-term Care, RHCs, & FQHCs

MLN Connects newsletter for Thursday, January 20, 2022

News

- COVID-19: Vaccine Access in Long-term Care Settings
- There's Still Time: Recommend the Flu Shot
- Chiropractic Treatment of the Spine: Comparative Billing Report in January

MLN Matters® Articles

- Calendar Year (CY) 2022 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised
- New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE — Revised

Publications

- Rural Health Clinic — Revised

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The following articles have been revised to reflect the 2022 Annual CPT/HCPCS Code updates effective for dates of service on and after January 1, 2022:

- Billing and Coding: Acute Care: Inpatient, Observation and Treatment Room Services (A52985)
- Billing and Coding: Allergy Testing (A56558)
- Billing and Coding: Autonomic Function Tests (A54954)
- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Colon Capsule Endoscopy (CCE) (A58414)
- Billing and Coding: Endovenous Stenting (A56414)
- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A56938)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS) (A56633)
- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)
- Billing and Coding: Monitored Anesthesia Care (A57361)
- Billing and Coding: Pharmacogenomics Testing (A58801)
- Billing and Coding: Respiratory Pathogen Panel Testing (A58575)
- Billing and Coding: Vestibular and Audiologic Function Studies (A57434)
- Billing and Coding: Wireless Capsule Endoscopy (A57753)

The following LCD has been revised:

- Epidural Steroid Injections for Pain Management (L36920)

The following article has been retired:

- Billing and Coding: Isolated Ultrafiltration for Management of Fluid Overload in Cardiac Disease (A53126)

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January 19, 2022

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12578 - April 2022 Update to the Medicare Severity – Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Version 39.1 for the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for 2019 Novel Coronavirus (COVID-19) Vaccination Status and ICD-10 Procedure Coding System (PCS) Codes for Introduction or Infusion of Therapeutics and Vaccines for COVID-19 Treatment
- In this article, you'll learn about:
    * New ICD-10-Clinical Modification (CM) codes for reporting COVID-19 vaccination status.
    * Seven new ICD-10-PCS codes describing the introduction or infusion of therapeutics, including vaccines for COVID-19 treatments.
    * Updates for a new MCE edit.

Make sure your billing staff knows about these change

- MM12543 - Internet-Only Manual Updates (IOM) for Critical Care, Split/ Shared Evaluation and Management Visits, Teaching Physicians, and Physician Assistants

  In this article, you'll learn about CMS revisions to Medicare manuals for:

  - Critical care services
  - Split (or shared) Evaluation and Management (E/M) visits
  - Teaching Physician Services
  - Physician Assistant (PA) billing and payment

  Make sure your billing staff knows about these changes.

- MM12593 - Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

  In this article, you'll learn about calendar year 2022 changes to travel allowances when you bill:

  - On a per mileage basis using HCPCS code P9603
  - On a flat rate basis using HCPCS code P9604

  Make sure your billing staff knows about these changes.

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January 18, 2022

Action Needed: EDI Gateway changes – Due January 28, 2022

A new EDI Gateway is replacing the current connection to us. It will impact **all** jurisdiction L EDI Trading Partners. **Automated migrations** will begin January 31, 2022 and the current **M2 Gateway connectivity will be shut down** as of February 28, 2022.

Actions needed:

- **SFTP trading partners** - All providers, billing services, and clearinghouse who connect using a Network Service Vendor (NSV) need to setup an initial password to begin sending and retrieving files through the new TIBCO Gateway connection.
- **Novitasphere trading partners** - All providers and billing services who submit claims through Novitasphere will need to begin using the New Claim Submission/ERA link.

For additional details, visit our "EDI Gateway – Connecting to the Future" webpage.

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January 14, 2022

Frequently Asked Questions (FAQs)

Have questions and not sure where to turn? Check out our FAQs for answers to your questions.

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January 13, 2022

COVID-19: Long-term Care, Remdesivir, & Booster Doses

MLN Connects newsletter for Thursday, January 13, 2022

News

- COVID-19: Updated Materials for Visiting Nursing Homes During Omicron Surge
- COVID-19: Vaccine Access in Long-term Care Settings
- COVID-19: New HCPCS Code for Remdesivir Antiviral Medication – Updated NIH Treatment Guidelines Panel Link
- COVID-19: Pfizer Booster Doses for Ages 12+ & Immunocompromised Ages 5–11
- CMS Proposes Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease & National Stakeholder Call
- Additional Residency Positions: Apply by March 31
- Medicare Ground Ambulance Data Collection System: Updated Documents
- DMEPOS Requirement Updates Effective April 13
- RHC: AIR Payment Limit for CY 2022
- Non-Medical Factors Can Affect Patient Health

Compliance

- DMEPOS Items: Documenting Medical Records

Claims, Pricers, & Codes

- DMEPOS: Accreditation Claims Edits

Events

- National Stakeholder Call with the CMS Administrator — January 18

Publications

- Clinical Lab Fee Schedule — Revised

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Billing VEKLURY™ (remdesivir) antiviral medication in outpatient settings

CMS created new HCPCS code J0248 for VEKLURY™ (remdesivir) antiviral medication. J0248 is effective for dates of service on or after December 23, 2021, when administered in outpatient settings.

This information was released in the MLN Connects Special Edition for Friday, January 7, 2022. Please review our article for billing guidance.

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The following billing and coding article has been revised:

- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)

.

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12480 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) -- April 2022 (CR 1 of 2)

CMS revised the article to reflect a revised CR 12480. The CR revision didn't affect the substance of the article. CMS revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

- MM12558 - Calendar Year (CY) 2022 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  CMS revised this article to reflect a revised CR 12558. The CR revision shows the delay in the CLFS data reporting period for clinical diagnostic laboratory tests and the delay in the application of the 15% percent phase-in reduction. CMS revised the article to show those delays. The changes are in dark red font on pages 1-2. CMS also revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

- MM12357 - Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

  CMS revised this article to reflect a revised CR 12357. The CR revision didn't impact the substance of the article. CMS did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

- MM12457 - Skilled Nursing Facility (SNF) Claims Processing Update to Fiscal Year End (FYE) Edits

  CMS revised the article to reflect a revised CR 12457. The CR revision changed the effective and implementation dates. CMS made the same changes to the article. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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January 12, 2022

Satisfaction survey on approval letters

We're looking for ways to improve your experience during the Provider Enrollment process. With certain approval letters dated January 7, 2022 and after, we added a link to allow you to complete a satisfaction survey.

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January 7, 2022

Special Edition – Friday, January 7, 2022

COVID-19: New HCPCS Code for Remdesivir Antiviral Medication

Following the recent statement from the National Institutes of Health (NIH) COVID-19 Treatment Guidelines Panel regarding therapies for the COVID-19 Omicron variant, CMS created HCPCS code J0248 for VEKLURY™ (remdesivir) antiviral medication when administered in an outpatient setting. This code is available for use by all payers and is effective for dates of service on or after December 23, 2021:

- Long descriptor: Injection, remdesivir, 1 mg
- Short descriptor: Inj, remdesivir, 1 mg

Medicare Administrative Contractors (MACs) determine Medicare coverage when there is no national coverage determination, including in cases when providers use FDA-approved drugs for indications

other than what is on the approved label. The MACs consider the major drug compendia, authoritative medical literature and accepted standards of medical practice to determine medical necessity when considering coverage. Therefore, the MACs will determine Medicare coverage for HCPCS code J0248 for VEKLURY™ (remdesivir) administered in an outpatient setting.

Your MAC will share coverage and claims processing information for J0248. Contact your MAC if you have questions about coverage.

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COVID-19 vaccines and monoclonal antibodies (mAbs): New product and administration codes for EVUSHELD™ (tixagevimab co-packaged with cilgavimab)

Effective December 8, 2021, the FDA released the Emergency Use Authorization (EUA) for the emergency use of EVUSHELD™ (tixagevimab co-packaged with cilgavimab) for the pre-exposure prophylaxis of COVID-19 in certain adults and pediatric individuals. CMS added the new product code Q0220 and two new administration codes M0220 and M0221. CMS added the fees for these recently added codes to the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- 2021 COVID-19 monoclonal antibodies reimbursement
- 2021 COVID-19 monoclonal antibodies administration (mAb) for centralized billers, Indian Health Services, and Veterans Affairs

.

2022 COVID-19 vaccines and monoclonal antibodies (mAbs) reimbursement fees

CMS released updated fees for the COVID-19 vaccines and the mAbs on the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

As a result of these changes, the following articles have been created and added to our COVID-19 vaccine and monoclonal antibodies specialty page with these new fees:

- 2022 COVID-19 monoclonal antibodies reimbursement
- 2022 COVID-19 monoclonal antibodies administration (mAb) fees for centralized billers, Indian Health Services, and Veterans Affairs
- 2022 COVID-19 vaccine reimbursement
- 2022 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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COVID-19 vaccines and monoclonal antibodies (mAbs): Reminder for Medicare Advantage plan claims

Effective January 1, 2022, if you vaccinate or administer mAb treatments to patients enrolled in Medicare Advantage plans, claims must be submitted to the Medicare Advantage plan and not to Original Medicare. For more information, visit the CMS Medicare Billing for COVID-19 Vaccine Shot Administration and Monoclonal Antibody COVID-19 Infusion webpages.

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- COVID-19 vaccine and monoclonal antibody (mAb) infusion billing alerts
- COVID-19 vaccine and monoclonal antibody (mAb) infusion questions and answers.
- .

January 6, 2022

Provider Compliance Product List Updated

MLN Connects newsletter for Thursday, January 6, 2022

News

- COVID-19 Vaccine Access in Long-term Care Settings
- SNF VBP: Nominate Technical Expert Panel Members by January 16
- COVID-19 Vaccine & Monoclonal Antibody Products: Changes for MA Plan Claims Started January 1

Claims, Pricers, & Codes

- IPPS: Updated Web Pricer Features

Events

- Medicare Ground Ambulance Data Collection System: Q&A Session — January 18

MLN Matters® Articles

- January 2022 Update of the Ambulatory Surgical Center (ASC) Payment System
- Transvenous (Catheter) Pulmonary Embolectomy National Coverage Determination (NCD) Section 240.6
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2022
- Implementation of the Capital Related Assets Adjustment (CRA) for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End Stage Renal Disease Prospective Payment System (ESRD PPS) — Revised

Publications

- Original Medicare vs. Medicare Advantage
- Medicare Learning Network® (MLN) Provider Compliance Products — Revised
- Opioid Treatment Programs (OTPs) Medicare Enrollment — Revised

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Removal of HCPCS code 67911 from list of codes requiring prior authorization

Beginning with dates of service on or after January 7, 2022, CMS is removing 67911 (correction of lid retraction) from the list of codes that require prior authorization as a condition of payment. This service is not likely to be cosmetic in nature and commonly occurs secondary to another condition.

CMS has updated the full list of HCPCS codes included in the outpatient department (OPD) prior authorization (PA) program to reflect this change. Information has been updated in the PA program for certain hospital OPD services webpage article for general documentation requirements.

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January 5, 2022

December 2021 claim submission errors

The December 2021 Part A claim submission errors and resolutions for jurisdiction L are now available. Please take time to review these errors and avoid them on future claims. As a reminder, these reports will transition from monthly to quarterly beginning with the first quarter of 2022.

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Ambulatory surgical center (ASC) specialty page

New information has been added to the ASC specialty page regarding the 2022 fee schedules and payment information.

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December 29, 2021

The following billing and coding article has been revised:

- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)

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Webinar recordings

New webinar recordings are now available on our website! We recently added two new recordings to our on-demand page:

- 12/1 - LCD L36920: Epidural procedures for pain management
- 11/29 - Advance care planning

Visit our on-demand education page to view a full list of webinar recordings and other forms of self-paced education.

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Customer Contact Center claim status inquiries

Medicare guidelines, specifically, the internet-only manual (IOM), Publication 100-09 Chapter 6 Section 50.1 requires that providers call the interactive voice response system (IVR) to obtain claim status. Agents responding to calls via our toll-free service line are not allowed to provide claim status. To do so would be in violation of Medicare service guidelines.

We continue to receive a large volume of calls from you asking for claim status. In most cases, the calls are coming from entities representing Medicare providers. Because many of you have chosen to outsource your claims monitoring activities, you may not be aware that the entities representing you are calling the toll-free customer service line for claims status instead of using the IVR.

When claim status calls are made to the toll-free customer service line, it slows our response time for other calls. It is your responsibility to notify the entities representing you that claim status inquiries must be made via the IVR or our internet portal, **Novitasphere**.

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December 28, 2021

The Novitas Solutions' Medical Policy team has evaluated all active Local Coverage Articles for any impact in response to the 2022 Annual HCPCS/CPT Code Update. The following is a list of the impacted Articles. The revised Articles will be published to the Medicare Coverage Database and on our Website in January. Please continue to watch our website for updates.

- Billing and Coding: Acute Care: Inpatient, Observation and Treatment Room Services (A52985)
- Billing and Coding: Allergy Testing (A56558)
- Billing and Coding: Autonomic Function Tests (A54954)
- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Colon Capsule Endoscopy (CCE) (A58414)
- Billing and Coding: Endovenous Stenting (A56414)
- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A56938)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS) (A56633)
- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)
- Billing and Coding: Monitored Anesthesia Care (A57361)
- Billing and Coding: Pharmacogenomics Testing (A58801)
- Billing and Coding: Respiratory Pathogen Panel Testing (A58575)
- Billing and Coding: Vestibular and Audiologic Function Studies (A57434)
- Billing and Coding: Wireless Capsule Endoscopy (A57753)

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December 23, 2021

COVID-19 Vaccine Access in Long-Term Care Settings

MLN Connects® for Thursday, December 23, 2021

News

- COVID-19 Vaccine Access in Long-Term Care Settings
- DMEPOS Final Rule
- NPPES: Public Reporting of Digital Contact Information
- VBID Model: Hospice Benefit Component
- Federally Qualified Health Center CY 2022 PPS
- RHC: AIR Payment Limit for CY 2022

Compliance

- Surgical Dressings: Medicare Requirements

Claims, Pricers, & Codes

- January 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.0

MLN Matters® Articles

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 86328
- January 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677 — Revised
- Intravenous Immune Globulin Demonstration — Revised

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Provider enrollment applications

The most efficient way to submit a Medicare enrollment application is through PECOS.

If you decide to submit paper applications, upload and submit through our Provider Enrollment Gateway. You can also use this tool to submit responses to development requests, request a copy of enrollment correspondence, or to check the status of a previously uploaded application.

For more information, please visit our Provider Enrollment Gateway Help Guide.

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PECOS Multi-Factor Authentication (MFA) Requirement

Effective January 10, 2022, logging into PECOS will require multi-factor authentication (MFA). This MFA requirement is the same method used to log into the Identity and Access Management System (I&A). Individuals who already utilize the MFA requirement in I&A will not need to set up additional MFA devices in PECOS.

PECOS users will have the option to delay MFA implementation for 60 days from their first logon after January 10. All users must set up MFA devices by April 21.

For information on how to set up MFA devices in I&A, please refer to the I&A Quick Reference Guide.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12575 - Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2022

  In this article, you'll learn about:

  - Changes in the April 2022 quarterly release of the edit module for clinical diagnostic
  - laboratory services
  - How to access the NCD spreadsheet to view relevant changes

  Make sure your billing staff knows about these changes.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12347 - Implementation of the Capital Related Assets (CRA) Adjustment for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End Stage Renal Disease Prospective Payment System (ESRD PPS)

  CMS revised the article due to an updated Change Request (CR) that clarified language to the policy section that Capital Related Assets (CRA) reported on the claim cannot exceed the number of treatments billed. That change is in dark red font on pages 2 and 3 in this article. CMS also changed the CR transmittal date, transmittal number and the link to the transmittal. All other information is unchanged.

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December 22, 2021

2022 Medicare rates available

CMS has released the 2022 Medicare rates, Part A and B deductible and coinsurance rates, and Part A and B premium amounts. Please review our article Deductibles/co-insurances/therapy thresholds for the updated amounts. This information can also be found directly via the link on the home page of our website.

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December 21, 2021

Limited Systems Availability - Thursday, December 30, 2021, through Sunday, January 2, 2022

There will be Common Working File (CWF) "Dark" days from Thursday, December 30, 2021, through Sunday, January 2, 2022 due to the January 2022 release upgrades. The Interactive Voice Response (IVR) will have limited availability. Additionally, the Customer Contact Center will be closed December 31, 2021.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12537 - Transvenous (Catheter) Pulmonary Embolectomy National Coverage Determination (NCD) Section 240.6
  - CMS removed the NCD for Transvenous Pulmonary Embolectomy (TPE). In the absence of an NCD, your MAC will make coverage determinations for TPEs.
  - Make sure your billing staff knows about these changes.

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December 17, 2021

Special Edition – December 17, 2021

CMS Funding 1,000 New Residency Slots for Hospitals Serving Rural & Underserved Communities

Administration takes action to address access to care, workforce shortages in high-need areas

On December 17, CMS took a critical step to advance health equity and access, issuing a final rule that will enhance the health care workforce and fund additional medical residency positions in hospitals serving rural and underserved communities.

The Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) final rule with comment period establishes policies to distribute 1,000 new Medicare-funded physician residency slots to qualifying hospitals, phasing in 200 slots per year over five years. CMS estimates that funding for the additional residency slots, once fully phased in, will total approximately $1.8 billion over the next 10 years. In implementing a section of the Consolidated Appropriations Act (CAA), 2021, this is the largest increase in Medicare-funded residency slots in over 25 years. Other sections of the CAA being implemented further promote increasing training in rural areas and increasing graduate medical education payments to hospitals meeting certain criteria.

Read the full Press Release.

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Genetic testing for cardiovascular disease (L39083) and billing and coding article (A58795)

Important information you must know if you bill for genetic testing for cardiovascular disease, effective January 30, 2022.

Avoid negative impacts to your claims by reviewing the LCD L39082 and billing and coding article A58795 genetic testing for cardiovascular disease.

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New release! Prior Authorization (PA) Program for certain hospital outpatient department (OPD) services self-paced training course

Want to learn about the PA Program for certain hospital OPD services, but want to do it on your time? Participate in this new self-paced, free online course when and where it is most convenient for you! Visit our Online Course Catalogue to participate. A Novitas Learning Center account is required to participate.

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Unsolicited Voluntary Refunds Notification 2021

Medicare providers – please view this notice concerning voluntary refunds for 2021.

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Unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally receive checks. Substantial funds are returned to the trust fund each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:
The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Chapter 5, Section 410.10

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Claim submission errors

Our claim submission errors report is transitioning from a monthly report to a quarterly report beginning with the first calendar quarter of 2022.

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New Novitasphere Financial Feature - NOW AVAILABLE!

Real-time financial data from the Medicare accounting system, HIGLAS, is now available directly from our portal, Novitasphere. This new feature will allow you to review current account receivable balances, details and associated transactions related to Medicare debts. A short video demonstration of this new feature is available for you to see how it works and what information can be retrieved. Details are provided in the Claims Info section of the Novitasphere User Manuals.

If you are not yet utilizing the many useful features of Novitasphere, we request that you follow the instructions in the Novitasphere Enrollment eGuide to enroll today!

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December 16, 2021

2% Payment Adjustment (Sequestration) Changes

MLN Connects newsletter for Thursday, December 16, 2021

News

- Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Changes
- Flu Shot Disparities
- Opioid Treatment Programs: New Information for 2022
- Medicare Clinical Laboratory Fee Schedule Private Payor Data Reporting – Delayed until 2023
- PEPPERs for Short-Term Acute Care Hospitals
- COVID-19 Vaccine & Monoclonal Antibody Products: Changes for MA Plan Claims Starting January 1, 2022

Claims, Pricers, & Codes

- Pneumococcal Conjugate Vaccine, 15 Valent
- Average Sales Price Files: January 2022
- Skin Substitute Codes
- National Correct Coding Initiative Medicare Policy Manual: Annual Update

Events

- Medicare Ground Ambulance Data Collection System: Q&A Session — January 18

MLN Matters® Articles

- Calendar Year 2022 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

- Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08
- Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List — Revised

Publications

- Opioid Treatment Programs (OTPs) Medicare Billing & Payment — Revised

Information for Medicare Patients

- 2022 Medicare & You Handbook

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The following Local Coverage Determinations (LCDs) posted for comment on July 29, 2021 have been posted for notice. The LCDs and related Billing and Coding Articles will become effective January 30, 2022:

- Genetic Testing for Cardiovascular Disease (L39082)
  - Billing and Coding: Genetic Testing for Cardiovascular Disease (A58795)
- Surgical Treatment of Nails (L34887)
  - Billing and Coding: Surgical Treatment of Nails (A52998)

The following Response to Comments Articles contain summaries of all comments received and Novitas' responses:

- Response to Comments: Genetic Testing for Cardiovascular Disease (A58955)
- Response to Comments: Surgical Treatment of Nails (A58961)

The following LCD has been revised:

- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (L35038)

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November 2021 claim submission errors

The November 2021 Part A claim submission errors and resolutions for jurisdiction L are now available. Please take time to review these errors and avoid them on future claims.

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The November 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the claim denials and general information categories. Please take time to review these and other FAQs for answers to your questions.

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December 15, 2021

Medicare secondary payer (MSP) educational series

The questions and answers have been updated from the educational series. Please carefully review the information.

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December 14, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12252 - January 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  In this Article, you'll learn about:

  - New Covid-19 CPT vaccines and administration codes.
  - OPPS updates for January 2022.
  - New drugs, biologicals, and radiopharmaceuticals.

  Make sure your billing staff knows about these changes.

- MM12558 - Calendar Year (CY) 2022 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  In this article, you'll learn about:

  - Instructions for the CY 2022 Clinical Laboratory Fee Schedule.
  - Mapping for new codes for clinical laboratory tests.
  - Updates for laboratory costs subject to the reasonable charge payment.

  Make sure your billing staff knows about these changes.

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December 13, 2021

The following Local Coverage Determination (LCDs) which were posted for notice on October 28, 2021 are now effective. The related billing and coding articles for these LCDs are also now effective:

- Epidural Steroid Injections for Pain Management (L36920)
  - Billing and Coding: Epidural Steroid Injections for Pain Management (A56681)
- Pharmacogenomics Testing (L39063)
  - Billing and Coding: Pharmacogenomics Testing (A58801)
- Platelet Rich Plasma (L39068)
  - Billing and Coding: Platelet Rich Plasma (A58808)

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December 9, 2021

CY 2022 Medicare Deductible, Coinsurance, & Premium Rates

MLN Connects newsletter for Thursday, December 9, 2021

News

- PECOS: Multi-Factor Authentication Requirement Delayed
- HHS Seeks Public Comments to Advance Equity & Reduce Disparities in Organ Transplantation, Improve Life-Saving Donations, and Dialysis Facility Quality of Care
- Orthoses Referring Providers: Comparative Billing Report in December

Compliance

- Implanted Spinal Neurostimulators: Document Medical Records

MLN Matters® Articles

- Reduced Payment for Physical Therapy and Occupational Therapy Services Furnished in Whole or in Part by a Physical Therapist Assistant or an Occupational Therapy Assistant
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2022

Publications

- Independent Diagnostic Testing Facility (IDTF) — Revised

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The following billing and coding article has been revised:

- Billing and Coding: Removal of Benign Skin Lesions (A57113)

The following LCD has been revised and will become effective December 12, 2021:

- Biomarkers Overview (L35062)

The following billing and coding articles have been revised and will become effective December 12, 2021:

- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Biomarkers Overview (A56541)
- Billing and Coding: Epidural Steroid Injections for Pain Management (A56681)
- Billing and Coding: Pharmacogenomics Testing (A58801)

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December 7, 2021

Special Edition – Monday, December 6, 2021

Provider Requirements Under the No Surprises Act Special ODF — December 8

Wednesday, December 8 from 2 – 3 pm ET

CMS will host a Special Open Door Forum (SODF) to explain provider requirements under the No Surprises Act. Starting January 1, 2022,consumers will have new billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. These requirements generally apply to items and services provided to people enrolled in group health plans, group or individual health insurance coverage, Federal Employees Health Benefits plans, and the uninsured.

These requirements don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE that have other protections against high medical bills.

This SODF will include:

- Background and purpose
- Requirements for providers, facilities, and providers of air ambulance services starting January 1
- Enforcement provisions
- Resources and definitions
- Q&A session

How to Participate:

- Dial: 1-888-455-1397; conference ID # 8604468
- TTY services: Dial 7-1-1 or 800-855-2880

More Information:

- Presentation
- Provider Requirements and Resources webpage
- Questions: provider_enforcement@cms.hhs.gov

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Prior Authorization: Cervical fusion with disc removal

The A/B MAC Prior Authorization Collaboration Workgroup developed this article and it's been added to the prior authorization program for certain hospital outpatient department services webpage. Please review this information carefully.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12502 - Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08

  In this Article, you'll learn about:

  - A summary of changes to the Medicare Program Integrity Manual, Chapter 10 - Medicare Enrollment.
  - Changes affecting a variety of provider types, including PA enrollment.

  Make sure your billing staff knows about these changes.

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December 6, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12519 - Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

CMS revised this article due to a revised change request (CR) 12519. CMS added language to show that the originating site facility fee doesn't apply to Medicare telehealth services when the originating site is the patient's home.

For mental telehealth services there must be a non-telehealth service every 12 months (instead of 6 months) after initiating telehealth. the CR release date, transmittal number, and the web address of the CR has also been changed. All other information is the same.

New:

- MM12521 - Calendar Year 2022 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  In this article, you'll learn about:

  - The Calendar Year 2022 annual update for the DMEPOS fee schedule.
  - Fee schedule amounts for new and existing codes, as applicable.
  - Changes to DMEPOS payment policies.

  Make sure your billing staff knows about these changes.

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December 2, 2021

Special Edition – Thursday, December 2, 2021

CMS Encourages People with Medicare to get COVID-19 Vaccine Booster Shot

As part of the Biden-Harris Administration's ongoing efforts to ensure that Americans are vaccinated against COVID-19 and to reduce stress across the nation's health care system, the Centers for Medicare & Medicaid Services (CMS) is encouraging those with Medicare who are fully vaccinated to get a booster dose of the COVID-19 vaccine. Data shows that a COVID-19 vaccine booster dose increases immune response, which improves protection against COVID-19.

CMS is doing the following to encourage those with Medicare to get fully vaccinated and get their booster dose:

Sending a letter to people with Medicare: All of the 63 million people who currently have Medicare will receive a letter encouraging them to get their COVID-19 vaccine booster as soon as possible.

Conducting campaigns and paid advertising: This outreach will focus on those with Medicare who are not fully vaccinated against COVID-19 and will include reminders about getting the annual flu shot.

Including 1-800 MEDICARE reminders: Approximately two million people call 1-800-MEDICARE each month. They will hear a reminder to get their COVID-19 boosters at the beginning of their call.

Including a message in Medicare Summary Notices: For people with Original Medicare, CMS will include a COVID-19 booster message in their Medicare Summary Notice (the explanation of benefits people receive when a claim is filed) over the next several months.

- **Sending email reminders**: CMS will send COVID-19 vaccine booster reminder emails to the more than 14 million people that receive Medicare emails.
- **Delivering consistent communication via social media**: The @MedicareGov Twitter handle will continue to tweet about the importance of COVID-19 vaccine boosters.
- **Engaging local and national partners**: CMS is contacting more than 500 organizations, with a potential reach of more than five million members, and supplying them resources from

Department of Health & Human Services (HHS) and the Centers for Disease Control and Prevention (CDC). The agency is also offering webinars to allow partners to interact with experts on encouraging COVID-19 vaccination.

- **Conducting outreach to health plans**: CMS and CDC are continuing their outreach to health plans to help them understand best practices for encouraging COVID-19 vaccinations and parameters for coverage of COVID-19 vaccines and boosters.
- **Conducting outreach to nursing homes**: CMS continues to work with nursing homes to increase COVID-19 vaccine and booster uptake. These efforts include deploying Quality Improvement Organizations (QIOs)--operated under the Medicare Quality Improvement Program--to assist nursing homes with low rates of initial and booster vaccinations and disparities in access to vaccinations. CMS will continue to explore additional outreach efforts to further support nursing homes.
- Conducting media outreach: CMS Administrator Chiquita Brooks-LaSure and other CMS leaders are encouraging COVID-19 vaccine boosters as part of their Medicare open enrollment outreach.

People with Medicare pay nothing when they get the COVID-19 vaccine and booster and there is no applicable copayment, coinsurance, or deductible. In addition, thanks to the American Rescue Plan (ARP), nearly all Medicaid and CHIP beneficiaries must receive coverage of COVID-19 vaccines and boosters without cost-sharing. COVID-19 vaccines and boosters will also be covered without cost-sharing for eligible consumers of most health insurance issuers in the commercial market. People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html and through the CMS COVID-19 Provider Toolkit.

CDC guidance on when to get a COVID-19 vaccine booster based on the last vaccine dose is available at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.

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National Influenza Vaccination Week

MLN Connects newsletter for Thursday, December 2, 2021

News

- National Influenza Vaccination Week
- Clinical Laboratory Fee Schedule: CY 2022 Final Payment Determinations
- Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder
- Ambulance Prior Authorization Model Expands February 1

Claims, Pricers, & Codes

- Hospital Inpatient EHR Reductions
- ICD-10: New Diagnosis & Procedure Codes Effective April 1, 2022

MLN Matters® Articles

- 2022 Annual Update to the Therapy Code List

- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2022
- Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2022
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

Publications

- Ordering External Breast Prostheses & Supplies — Revised
- Checking Medicare Eligibility — Revised

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Timely filing guidelines

The timely filing requirements and the reason code 39011 claim submission error tips articles have been revised. Please review these articles to avoid issues related to timely filing on future claims.

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December 1, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12507 - Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2022

  CMS has released the CY 2022 Medicare rates, Part A and B deductible and coinsurance rates, and Part A and B premium amounts. Make sure your billing staff knows about these changes.

- MM12397 - Reduced Payment for Physical Therapy and Occupational Therapy Services Furnished in Whole or In Part by a Physical Therapist Assistant or an Occupational Therapy Assistant

  In this article, you'll learn about:

  - Changes in payments due to Section 53107 of the Bipartisan Budget Act of 2018 (BBA of 2018)
  - A payment reduction for services provided by physical therapy assistants (PTAs) and occupational therapy assistants (OTAs).
  - Modifiers CQ and CO needed on claims for PTA and OTA services.

  Make sure your billing staff knows of these updates.

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November 29, 2021

The following billing and coding article has been revised:

- Billing and Coding: Non-Coronary Vascular Stents (A56365)

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November 24, 2021

Provider Relief Fund Reporting Deadline

MLN Connects newsletter for Wednesday, November 24, 2021

News

- Provider Relief Fund Reporting Deadline: November 30, 2021
- HIV: Talk to Your Patients About Prevention & Screening
- Home Health & Hospice: Medicare Provider Resources
- COVID-19: Pfizer & Modena Booster Shots for 18 Years and Older
- **Compliance**
- DMEPOS Standard Written Order Requirements

Claims, Pricers, & Codes

- IPPS, IRF & LTCH: New Web Pricer Released for FY 2022

MLN Matters® Articles

- Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List
- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2019 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs)
- Claims Processing Instructions for the New Pneumococcal 20-valent Conjugate Vaccine Code 90677
- New Waived Tests
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) — April 2022

Publications

- Medicare Provider Compliance Tips
- National Expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model

Multimedia

- CLFS Data Reporting Clinical Diagnostic Laboratory Tests Webinar Materials

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November 18, 2021

COVID-19: Changes to Nursing Home Visitation & Survey Activities

MLN Connects newsletter for Thursday, November 18, 2021

News

- CMS Repeals MCIT/R&N Rule; Will Consider Other Coverage Pathways to Enhance Access to Innovative Medical Devices
- Changes to Nursing Home Visitation COVID-19 (Revised) & COVID-19 Survey Activities
- Annual Medicare Participation Open Enrollment Period
- It's Not Too Late to Vaccinate
- Post-Acute Care QRP: Job Aids & Pocket Guides
- Quality Payment Program: 2020 Doctors & Clinicians Preview Period Open Until December 14
- Lung Cancer Awareness: Help Your Patients Reduce Their Risk

Claims, Pricers, & Codes

- Upcoming Quarterly Update to Home Health Grouper

Events

- Medicare Ground Ambulance Data Collection System: Q&A Session — December 14

MLN Matters® Articles

- 2022 Annual Update of Per-Beneficiary Threshold Amounts
- Low Utilization Payment Adjustment (LUPA) Add-on Amounts for Home Health (HH) Occupational Therapy Visits

Information for Medicare Patients

- CMS Announces 2022 Medicare Part B Premiums

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The following LCDs have been revised:

- Non-Coronary Vascular Stents (L35084)
- Trigger Point Injections (L35010)

The following Billing and Coding Articles have been revised:

- Billing and Coding: Allergy Testing (A56558)
- Billing and Coding: Non-Coronary Vascular Stents (A56365)

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Pharmacogenomics testing

Please review important billing information on pharmacogenomics testing, effective December 12, 2021. Please refer to our article for additional information.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12478 - Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  In this article, you'll learn about:

  - The latest update of the RARC and CARC code sets.

- What you must do if you use MREP or PC Print.
- Where to find the official code lists.

Make sure your billing staff knows about these changes. If you use MREP or PC Print, be sure to get the latest version when available.

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Open claim issues

Inpatient claims with a discharge date on or after October 1, 2021, are incorrectly receiving value code Q5. This issue is being researched. We will provide updates as they are available.

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The October 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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Provider Enrollment Applications

It is best practice to submit your applications online through Provider Enrollment, Chain and Ownership System (PECOS). PECOS is the quickest, most efficient way to submit a Medicare enrollment application.

If you decide to submit paper applications instead, they can be uploaded and submitted using our Provider Enrollment Gateway. This tool can also be used to submit responses to development requests, requesting a copy of enrollment correspondence, or to check the status of a previously uploaded application. For more information, please visit our Provider Enrollment Gateway help guide.

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Pharmacogenomics Testing L39063 and A58801

Avoid negative impacts to your claims - review LCD L39063 and billing and coding article A58801

Important information you must know if you bill for pharmacogenomics testing, effective December 12.

Genetic testing holds the potential to provide great value in improving health outcomes for all individuals. The scope of this LCD includes testing to determine how genes affect the body's response to certain medicines, known as pharmacogenetic, or pharmacogenomic testing.

The LCD provides guidance on when pharmacogenetics testing will be considered medically reasonable and necessary, when its considered not medically necessary, the provider qualifications, the summary and analysis of evidence and FDA alerts. The billing and coding article provides guidance to the covered codes, limited coverage on certain codes, and codes that are non-covered.

When billing Part B claims, the drug, or drugs in consideration for use that require the use of the PHARMACOGENOMICS (PGx) test must be submitted in the applicable detail line 2400 loop.

When more than two codes from the list within the billing and coding article are submitted for the same beneficiary on the same date of service, the claims processing system will reject every code submitted after the first two services. However, fi a lab runs more than two distinct procedural services from this list within the billing and coding article on a single date of service, then the lab must

use the 59 modifier with each additional service billed as an attestation that it is a distinct procedural service. Billing the 59 modifier may results in a request for medical records.

Claims inappropriately billed may be rejected or denied. Read the LCD L39063 and billing and coding article A58801 in their entirety to make sure you're billing and coding these services correctly.

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November 17, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12519 - Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

  In this article, you'll learn about:

  - Updates to payment policies and Medicare payment rates for services physicians and non-physician practitioners provide that Medicare pays for with the MPFS in CY 2022.
  - Updates to Medicare telehealth services and telehealth origination site facility fee payment amounts.
  - Billing for physician assistant services and other policy changes related to Medicare Part B.

  Make sure your billing staff knows about these changes.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12516 - The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year FY) 2019 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs)

  In this article, you'll learn about:

  - Updated data that decides the disproportionate share adjustment for IPPS hospitals.
  - The low-income patient adjustment for IRFs.
  - Payments, as applicable, for LTCH discharges.

  Make sure your billing staff knows about these changes.

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November 16, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12499 - Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2022

  In this article, you'll learn about:

- Updates for calendar year (CY) 2022 to the ESRD PPS base rate, budget neutrality factor, and outlier threshold.
- Updates to the AKI dialysis payment rate.
- Updates for the Capital Related Assets (CRA) for Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES).

Make sure your billing staff knows about these changes.

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November 12, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12403 - National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds

  Make sure your billing staff knows that CMS will nationally cover autologous platelet-rich plasma for the treatment of chronic non-healing diabetic wounds under specific conditions.
- MM12246 - 2022 Annual Update to the Therapy Code List

  In this article, you'll learn about:
  - Updated calendar year 2022 therapy code list.
  - 5 CPT codes added to the list.
  - Some of the requirements for using those codes.

  Make sure your billing staff knows about these updates.

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November 11, 2021

Diabetes Resources for You & Your Patients

MLN Connects newsletter for Thursday, November 11, 2021

News

- Provider Enrollment Application Fee for CY 2022
- LTCH & IRF: CY 2022 QRP Updates
- Critical Care E/M Services: Comparative Billing Report in November
- Diabetes Resources for You & Your Patients

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: 510(k)-Cleared Wound Care Products

Events

- HCPCS Public Meeting — December 1 & 2

MLN Matters® Articles

- Medicare Part B CLFS: Revised Information for Laboratories on Collecting & Reporting Data for the Private Payor Rate-Based Payment System

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The following billing and coding articles have been revised:

- Billing and Coding: Diagnostic Colonoscopy (A58428)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)

The following billing and coding article has been revised and will become effective on December 12, 2021:

- Billing and Coding: Platelet Rich Plasma (A58808)

November 10, 2021

Molecular Pathology and Genetic Testing A58917

Please review important billing information on molecular pathology and genetic testing, effective November 8. Please refer to our article for additional information

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November 9, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12470 - 2022 Annual Update of Per-Beneficiary Threshold Amounts

  Updates to the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for calendar year 2022 (CY 2022).

  The CY 2022 KX modifier threshold amounts are:

  - $2,150 for Physical Therapy, and Speech-Language Pathology services combined.
  - $2,150 for Occupational Therapy services.

  Make sure your billing staff knows about these changes.

November 8, 2021

The following billing and coding article is now effective:

- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12344 - Skilled Nursing Facility (SNF) Claims Processing Updates

CMS revised this article to reflect a revised change request (CR) 12344. The CR added a note that is on page 1. The CR release date, transmittal number, and the web address of the CR was also changed. All other information is the same.

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November 5, 2021

COVID-19 vaccines and monoclonal antibodies (mAbs): New Pfizer vaccine for children and changes for Medicare Advantage plan claims

Effective October 29, 2021, the FDA amended the emergency use authorization (EUA) for the Pfizer-BioNTech COVID-19 vaccine to authorize a pediatric dose for patients 5-11 years old. A new code describing the product for the new Pfizer pediatric vaccine (91307) and new codes to administer the Pfizer pediatric vaccine (0071A - first dose and 0072A - second dose) have been established. CMS added the fees for these codes to their COVID-19 Vaccines and Monoclonal Antibodies webpage.

Effective January 1, 2022, if you vaccinate or administer mAb treatments to patients enrolled in Medicare Advantage plans, claims must be submitted to the Medicare Advantage plan and not to Original Medicare.

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- 2021 COVID-19 vaccine reimbursement
- 2021 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs
- COVID-19 vaccine and monoclonal antibody (mAb) infusion billing alerts
- COVID-19 vaccine and monoclonal antibody (mAb) infusion questions and answers

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Part A claims issues log

We identified an issue for claims billed with tetanus or hepatitis B vaccines where claims were incorrectly returned to provider with reason code 32200. As a result, some providers may have tried to add condition code A6 and then received reason code 31438. This issue has been resolved.

Claims returned with reason code 32200 can be resubmitted. If condition code A6 was added to the claim and then returned with reason code 31438, remove A6 and resubmit the claim.

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November 4, 2021

Special Edition – Thursday, November 4, 2021

Biden-Harris Administration Issues Emergency Regulation Requiring COVID-19 Vaccination for Health Care Workers

National requirement protects patients at nearly 76,000 providers and covers more than 17 million health care workers

The Biden-Harris Administration is requiring COVID-19 vaccination of eligible staff at health care facilities that participate in the Medicare and Medicaid programs. The emergency regulation issued by the Centers for Medicare & Medicaid Services (CMS) today protects those fighting this virus on the front lines while also delivering assurances to individuals and their families that they will be protected when seeking care.

“Ensuring patient safety and protection from COVID-19 has been the focus of our efforts in combating the pandemic and the constantly evolving challenges we’re seeing,” said CMS Administrator Chiquita Brooks-LaSure. “Today’s action addresses the risk of unvaccinated health care staff to patient safety and provides stability and uniformity across the nation’s health care system to strengthen the health of people and the providers who care for them.”

The prevalence of COVID-19, in particular the Delta variant, within health care settings increases the risk of unvaccinated staff contracting the virus and transmitting the virus to patients. When health care staff cannot work because of illness or exposure to COVID-19, the strain on the health care system becomes more severe and further limits patient access to safe and essential care. These requirements will apply to approximately 76,000 providers and cover over 17 million health care workers across the country. The regulation will create a consistent standard within Medicare and Medicaid while giving patients assurance of the vaccination status of those delivering care.

Facilities covered by this regulation must establish a policy ensuring all eligible staff have received the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine prior to providing any care, treatment, or other services by December 5, 2021. All eligible staff must have received the necessary shots to be fully vaccinated – either two doses of Pfizer or Moderna or one dose of Johnson & Johnson – by January 4, 2022. The regulation also provides for exemptions based on recognized medical conditions or religious beliefs, observances, or practices. Facilities must develop a similar process or plan for permitting exemptions in alignment with federal law.

CMS accelerated outreach and assistance efforts encouraging individuals working in health care to get vaccinated following the Administration’s announcement that it would expand the requirement for staff vaccination beyond nursing homes to include additional providers and suppliers. Since the Administration’s announcement, nursing home staff vaccination rates have increased by approximately nine percentage points – from 62 to 71 percent. This increase is encouraging, and this regulation will help to ensure even greater improvement in the vaccination rate among health care workers.

A recent White House report describes the evidence that vaccine requirements work. An analysis of health care systems, educational institutions, public-sector agencies, and private businesses shows that organizations with vaccination requirements have seen their vaccination rates increase by more than 20 percentage points and have routinely seen their share of fully vaccinated workers rise above 90%.

States and individual health systems have historically addressed vaccination requirements for diseases such as influenza and hepatitis B. Today, more than 2,500 hospitals, or 40 percent of all U.S. hospitals, have announced COVID vaccination requirements for their workforce. They span all 50 states, the District of Columbia, and Puerto Rico. The report also found that vaccination requirements have not led to widespread resignations in the health care workforce and that the requirements are an essential tool to protect patients and health care personnel.

CMS will ensure compliance with these requirements through established survey and enforcement processes. If a provider or supplier does not meet the requirements, it will be cited by a surveyor as being non-compliant and have an opportunity to return to compliance before additional actions occur.

CMS's goal is to bring health care providers into compliance. However, the Agency will not hesitate to use its full enforcement authority to protect the health and safety of patients.

The requirements apply to: Ambulatory Surgical Centers, Hospices, Programs of All-Inclusive Care for the Elderly, Hospitals, Long Term Care facilities, Psychiatric Residential Treatment Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, Home Health Agencies, Comprehensive Outpatient Rehabilitation Facilities, Critical Access Hospitals, Clinics (rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services), Community Mental Health Centers, Home Infusion Therapy suppliers, Rural Health Clinics/Federally Qualified Health Centers, and End-Stage Renal Disease Facilities.

CMS is taking necessary action to establish critical safeguards for the health of all people, their families, and the providers who care for them. CMS knows that everyone working in health care wants to do what is best to keep their patients safe. Yet, unvaccinated staff pose both a direct and indirect threat to the very patients that they serve. Vaccines are a crucial scientific tool in preserving and restoring efficient operations across the nation's health care system while protecting individuals. This new requirement presents an opportunity to continue driving down COVID-19 infections, stabilize the nation's health care system, and ensure safety for anyone seeking care.

To view the interim final rule with comment period, visit: https://www.federalregister.gov/public-inspection/2021-23831/medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-vaccination

To view a list of frequently asked questions, visit: www.cms.gov/files/document/cms-omnibus-staff-vax-requirements-2021.docx

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COVID-19: Changes for Medicare Advantage Plan Claims Starting January 1

MLN Connects newsletter for Thursday, November 4, 2021

News

- COVID-19 Vaccines for Children
- COVID-19 Vaccine & Monoclonal Antibody Products: Changes for MA Plan Claims Starting January 1, 2022
- Multi-Factor Authentication Requirement for PECOS

Events

- Medicare Clinical Laboratory Fee Schedule Private Payor Data Collection & Reporting Webinar — November 10
- COVID-19 Vaccine Webinar for Rural Communities — November 15

MLN Matters® Articles

- Manual Updates for Clarification on the Election Statement Addendum and Extension of the Hospice Cap Calculation Methodology
- Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

Publications

- Medicare Billing: 837P & Form CMS-1500

Multimedia

- PAC Quality Reporting Programs: Updated 3-Course Training Series for Section GG

.

The following Billing and Coding article has been revised and will become effective November 8, 2021:

- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)

November 3, 2021

Special Edition – Tuesday, November 2, 2021

3 Final Payment Rules

- CMS Physician Payment Rule Promotes Greater Access to Telehealth Services, Diabetes Prevention Programs
- CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care
- Biden-Harris Administration Improves Home Health Services for Older Adults and People with Disabilities

CMS Physician Payment Rule Promotes Greater Access to Telehealth Services, Diabetes Prevention Programs

Final Rule Advances Health Equity, Person-Centered Care

On November 2, CMS is announcing actions that will advance its strategic commitment to drive innovation to support health equity and high quality, person-centered care. CMS' Calendar Year (CY) 2022 Physician Fee Schedule (PFS) final rule will promote greater use of telehealth and other telecommunications technologies for providing behavioral health care services, encourage growth in the diabetes prevention program, and boost payment rates for vaccine administration. The final rule also advances programs to improve the quality of care for people with Medicare by incentivizing clinicians to deliver improved outcomes.

"Promoting health equity, ensuring more people have access to comprehensive care, and providing innovative solutions to address our health system challenges are at the core of what we do at CMS," said CMS Administrator Chiquita Brooks-LaSure. "The Physician Fee Schedule final rule advances all these strategic priorities and helps build a better Medicare program for the future."

Expanding Use of Telehealth and Other Telecommunications Technologies for Behavioral Health Care

The final rule makes significant strides in expanding access to behavioral health care – especially for traditionally underserved communities – by harnessing telehealth and other telecommunications technologies. In line with legislation enacted last year, CMS is eliminating geographic barriers and allowing patients in their homes to access telehealth services for diagnosis, evaluation, and treatment of mental health disorders.

"The COVID-19 pandemic has highlighted the gaps in our current health care system and the need for new solutions to bring treatments to patients, wherever they are," said Brooks-LaSure. "This is especially true for people who need behavioral health services, and the improvements we are enacting will give people greater access to telehealth and other care delivery options."

CMS is bringing care directly into patients' homes by providing certain mental and behavioral health services via audio-only telephone calls. This means counseling and therapy services, including treatment of substance use disorders and services provided through Opioid Treatment Programs, will be more readily available to individuals, especially in areas with poor broadband infrastructure.

In addition, for the first time outside of the COVID-19 public health emergency (PHE), Medicare will pay for mental health visits furnished by Rural Health Clinics and Federally Qualified Health Centers via telecommunications technology, including audio-only telephone calls, expanding access for rural and other vulnerable populations.

Promoting Growth in Medicare Diabetes Prevention Program

Prediabetes impacts over 88 million American adults, with many at risk for developing type 2 diabetes within five years. Many traditionally underserved communities including African Americans, Hispanic/Latino Americans, American Indians, Pacific Islanders, and some Asian Americans face an elevated risk of developing type 2 diabetes.

As the U.S. marks Diabetes Awareness Month this November, CMS is taking steps to improve its Medicare Diabetes Prevention Program (MDPP) expanded model, which was developed to help people with Medicare with prediabetes from developing type 2 diabetes.

Under the expanded model, local suppliers provide structured, coach-led sessions in community and health care settings using a Centers for Disease Control and Prevention-approved curriculum to provide training in dietary change, increased physical activity, and weight loss strategies. CMS is waiving the Medicare enrollment fee for all organizations that apply to enroll as an MDPP supplier on or after January 1, 2022. CMS has been waiving this fee during the COVID-19 PHE for new MDPP suppliers and has witnessed increased supplier enrollment. Next, CMS is shortening the MDPP services period to one year instead of two years. This change will make delivery of MDPP services more sustainable, reduce the administrative burden and costs to suppliers, and improve patient access by making it easier for local suppliers to participate and reach their communities. Finally, CMS is restructuring payments so MDPP suppliers receive larger payments for participants who reach milestones for attendance.

CMS expects these changes will result in more MDPP suppliers, increased access to MDPP services for people with Medicare in rural areas, and a decrease in the number of individuals with diabetes in both urban and rural communities.

Increased Access to Medical Nutrition Therapy Services

The PFS final rule also streamlines access to Medical Nutrition Therapy (MNT), which includes services provided by registered dietitians or nutrition professionals to help people with Medicare better manage their diabetes or renal disease. MNT establishes goals, a care plan, and interventions, as well as plans for follow-up over multiple visits to assist with behavioral and lifestyle changes relative to help address an individual's nutrition needs and medical condition or disease(s).

CMS removed a requirement that limited who could refer people with Medicare to MNT services, allowing any physician (M.D. or D.O.) to do so. This change should particularly benefit people living in rural areas as the MNT services are provided to eligible individuals with no out of pocket costs and may be provided via telehealth.

Encouraging Proven Vaccines to Protect Against Preventable Illness

As the COVID-19 pandemic has so starkly demonstrated, access to safe and effective vaccines is vital to public health. CMS will maintain the current payment rate of $40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends. Effective January 1 of the year following the year in which the PHE ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the

administration of other Part B preventive vaccines. CMS will also continue to facilitate vaccinations for common diseases such as influenza, pneumonia, and hepatitis B.

This year Medicare reviewed payments for vaccinations to ensure doctors and other health professionals are paid appropriately for providing vaccinations. This final rule will nearly double Medicare Part B payment rates for influenza, pneumococcal, and hepatitis B vaccine administration from roughly $17 to $30. CMS hopes this change will increase access to these potentially life-saving injections and lead to greater vaccination uptake.

Expanded Pulmonary Rehabilitation Coverage Under COVID

As part of CMS' continuing efforts to address the current PHE, the agency finalized expanded coverage of outpatient pulmonary rehabilitation services, paid under Medicare Part B, to individuals who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks. This goes beyond CMS' PFS proposed rule which would have focused the expanded coverage to those hospitalized with COVID-19. CMS also finalized a temporary extension of certain cardiac and intensive cardiac rehabilitation services available via telehealth for people with Medicare until the end of December 2023.

Advancing the Quality Payment Program and MIPS Value Pathways

To further improve the quality of care for people with Medicare, the PFS final rule makes several key changes to CMS' Quality Payment Program (QPP), a value-based payment program that promotes the delivery of high-value care by clinicians through a combination of financial incentives and disincentives.

For example, CMS finalized a higher performance threshold that clinicians will be required to exceed in 2022 to be eligible for positive payment incentives. This new threshold was determined in accordance with statutory requirements for the QPP's Merit-based Incentive Payment System (MIPS).

CMS is also moving forward with the next evolution of QPP and officially introducing the first seven MIPS Value Pathways (MVPs) * subsets of connected and complementary measures and activities, established through rulemaking, that clinicians can report on to meet MIPS requirements. MVPs are designed to ensure more meaningful participation for clinicians and improved outcomes for patients by more effectively measuring and comparing performance within different clinician specialties and providing clinicians more meaningful feedback. This initial set of MVP clinical areas include: rheumatology, stroke care and prevention, heart disease, chronic disease management, lower extremity joint repair (e.g., knee replacement), emergency medicine, and anesthesia.

To incentivize high-quality care for professionals that are often a key point of contact for underserved communities with acute health care needs, CMS has also revised the current eligible clinician definition to include clinical social workers and certified nurse-midwives among those participating in MIPS.

Ensuring Accurate Payments Through Clinical Labor Update

CMS recognizes the importance of making accurate payments for services provided under Medicare to ensure the integrity of the program as well as to support continued access to care. For the first time in nearly 20 years, CMS is updating the clinical labor rates that are used to calculate practice expense under the PFS. As a result, payments to primary care specialists that involve more clinical labor, such as family practice, geriatrics, and internal medicine specialties, are expected to increase. This increase will to drive greater person-centered care for these services particularly for disadvantaged groups and underserved communities. There will be a four-year transition period to implement the clinical labor pricing update, which will help maintain payment stability and mitigate any potential negative effects on health care providers by gradually phasing in the changes over time.

Increasing Access to Physician Assistants' Services

Finally, CMS is implementing a recent statutory change that authorizes Medicare to make direct Medicare payments to Physician Assistants (PAs) for professional services they furnish under Part B. For the first time, beginning January 1, 2022, PAs will be able to bill Medicare directly. As a result, more individuals with Medicare will have access to these services as PAs will have the same opportunity as certain other Medicare practitioners to bill Medicare for professional services.

More Information:

- CY 2022 Physician Fee Schedule Final Rule
- CY 2022 Physician Fee Schedule Final Rule fact sheet
- CY 2022 Quality Payment Program final changes fact sheet
- Medicare Diabetes Prevention Program final changes fact sheet

CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care

On November 2, in keeping with President Biden's Competition Executive Order, CMS is releasing a final rule that will further advance its commitment to increasing price transparency, holding hospitals accountable and ensuring consumers have the information they need to make fully informed decisions regarding their health care. The Calendar Year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule with Comment Period will strengthen enforcement of price transparency requirements for hospitals, and increase Medicare beneficiary quality and safety by halting the phased elimination of the Inpatient Only (IPO) list for surgical procedures.

"CMS is committed to promoting and driving price transparency, and we take seriously concerns we have heard from consumers that hospitals are not making clear, accessible pricing information available online, as they have been required to do since January 1, 2021," said CMS Administrator Chiquita Brooks-LaSure. "We are also taking actions to enhance patient safety and quality care."

Price Transparency

Beginning January 1, 2022, CMS will increase the penalty for some hospitals that do not comply with the Hospital Price Transparency final rule. Specifically, CMS is setting a minimum civil monetary penalty of $300 per day that will apply to smaller hospitals with a bed count of 30 or fewer, and a penalty of $10 per bed per day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of $5,500. Under this approach, for a full calendar year of noncompliance, the minimum total penalty amount would be $109,500 per hospital, and the maximum total penalty amount would be $2,007,500 per hospital.

Hospital price transparency helps people know what a hospital charges for the items and services they provide, an important factor given that health care costs can cause significant financial burdens for consumers. While enforcement activities are necessary to drive compliance with price transparency, CMS is also committed to working with hospitals to help them meet those requirements.

Enhancing Beneficiary Protections

CMS is also enhancing beneficiary protections by finalizing policies that will allow for a more evidence-based approach in determining whether procedures should be payable in the outpatient setting. In the CY 2021 OPPS/ASC final rule, CMS finalized a policy to eliminate the IPO list over a three-year period, removing 298 services in the first phase of the elimination. A large number of stakeholder comments opposed elimination of the list, primarily due to safety concerns with performing certain procedures in an outpatient setting.

For CY 2022, CMS is halting the elimination of the IPO list and, after clinical review of the services removed from the list in CY 2021, CMS is adding all but a small number of procedures back to the list. CMS is also reinstating the ASC Covered Procedures List (CPL) criteria that were in effect in CY 2020 and adopting a process for stakeholders to nominate procedures they believe meet the requirements to be added to the ASC CPL.

Health Equity, Access to Emergency Care in Rural Areas and Lessons from COVID-19

In the OPPS/ASC Payment System proposed rule, CMS also issued Requests for Information (RFIs) and solicited comments on a number of potential proposals and actions to further the vision of advancing health equity, driving high-quality, person-centered care, and promoting affordability and sustainability. The comments will help inform future rulemaking around these topics. Future rulemaking will include additional opportunities for public comments.

- Health equity: CMS received input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable by including additional demographic data points (e.g., race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+, and socioeconomic status).
- Access to emergency care in rural areas: the proposed rule included an RFI on Rural Emergency Hospitals (REHs). CMS received robust comments in response to this RFI and looks forward to taking each of those comments into consideration during the rulemaking process for the development of the REH requirements.
- Lessons from COVID-19: CMS solicited comments on the extent to which hospitals are using flexibilities offered during the COVID-19 public health emergency (PHE) to provide mental health services remotely and whether CMS should consider changes to account for shifting practice patterns. In addition, comments were received on the collection and reporting of COVID-19 vaccination status of hospital outpatient department and ASC staff, and making this information available to the public so consumers know how many workers are vaccinated in different health care settings.

More Information:

- OPPS/ASC Payment System Final Rule
- CY 2022 OPPS/ASC Payment System Final Rule fact sheet

Biden-Harris Administration Improves Home Health Services for Older Adults and People with Disabilities

Final rule accelerates shift from volume-based incentives to quality-based incentives and advances coordination of care through Quality Reporting Programs

On November 2, CMS issued a final rule that furthers CMS' strategic commitment to drive innovation that promotes comprehensive, person-centered care for older adults and people with disabilities by accelerating the shift from paying for home health services based on volume, to a system that incentivizes value and quality. The final rule will also strengthen CMS' data collection efforts to identify and address health disparities and use of care among people who are dually eligible for Medicare and Medicaid, people with disabilities, people who identify as LGBTQ+, religious minorities, people who live in rural areas, and people otherwise adversely affected by persistent poverty or inequality.

The Calendar Year 2022 Home Health Prospective Payment System (PPS) Final Rule addresses challenges facing Medicare beneficiaries who receive health care at home. The final rule finalizes nationwide expansion of the successful Home Health Value-Based Purchasing (HHVBP) Model to incentivize quality of care improvements.

“CMS is committed to helping people get the care they need, where they need it,” said CMS Administrator Chiquita Brooks-LaSure. “This final rule will improve the delivery of home health services for people with Medicare. It will also improve our data collection efforts, helping us to identify health disparities and advance health equity.”

The CMS Innovation Center (Innovation Center) launched the original HHVBP Model on January 1, 2016, to determine whether CMS could improve the quality and delivery of home health care services to people with Medicare by offering financial incentives to providers that offer better quality of care with greater efficiency. The original HHVBP Model comprised all Medicare-certified home health agencies (HHAs) providing services across nine randomly selected states. The Third Annual Evaluation Report of the participants’ performance from 2016-2018 showed an average 4.6 percent improvement in HHAs’ quality scores and an average annual savings of $141 million to Medicare.

The final policies promulgated in this rule expand the HHVBP Model nationally, with the first performance year beginning January 1, 2023. The HHVBP Model is one of four Innovation Center models that have met the requirements to be expanded in duration and scope since 2010. Starting in 2025, CMS will adjust fee-for-service payments to Medicare-certified HHAs based on the quality of care provided to beneficiaries during the CY 2023 performance year. Throughout 2022, CMS will provide technical assistance to HHAs to ensure they understand how performance will be assessed. Overall, these policies support the Agency’s commitment to advancing value-based care by providing incentives for HHAs to improve the beneficiary experience and quality of care.

Additionally, the final rule will advance CMS’ coordination of care efforts through improvements to the Home Health Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, and Inpatient Rehabilitation Facility Quality Reporting Program and finalizes the mandatory COVID-19 reporting requirements for Long Term Care facilities (nursing homes) established as a part of the May 2020 and May 2021 Interim Final Rules beyond the current COVID-19 public health emergency (PHE) until December 31, 2024. The rule removes or replaces several quality measures to reduce burden and increase focus on patient outcomes. CMS is also finalizing its proposals to begin collecting data on two measures promoting coordination of care in the Home Health Quality Reporting Program effective January 1, 2023 as well as measures under Long-Term Care Hospital Quality Reporting Program and Inpatient Rehabilitation Quality Reporting Program effective October 1, 2022. The effective dates position the agency to support the recent Executive Order 13985 of January 20, 2021, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.

Finally, this rule implements provisions of the Consolidated Appropriations Act, 2021 that establish survey and enforcement requirements for hospice programs serving Medicare beneficiaries. These provisions will require the use of multidisciplinary survey teams, prohibition of surveyor conflicts of interest, and expansion of surveyor training to include accrediting organizations (AOs). The provisions also establish a hospice program complaint hotline and create the authority for CMS to impose enforcement remedies for noncompliant hospice programs. These changes will strengthen oversight, enhance enforcement, and establish consistent and transparent survey requirements in hospice care.

More Information:

- HH PPS proposed rule
- HH PPS proposed rule fact sheet

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November 2, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12480 - International Classification of Diseases, 10th Revision (ICD-10) and other coding revisions to National Coverage Determinations (NCDs) -- April 2022 (CR 1 of 2)

  This article tells you about updates of ICD-10 conversions and other coding updates specific to NCDs. These changes result from:

  - Newly available codes
  - Separate NCD coding revisions
  - Coding feedback

  CMS isn't including any policy changes in this ICD-10 quarterly update. They cover NCD policy changes using the current, longstanding NCD process. Make sure your billing staff knows about these changes.

- MM12482 - International Classification of Diseases, 10th Revision (ICD-10) and other coding revisions to National Coverage Determination (NCDs) -- April 2022 (CR 2 of 2 for April 2022)

  This article tells you about updates of ICD-10 conversions and other coding updates specific to NCDs. These changes result from:

  - Newly available codes
  - Separate NCD coding revisions
  - Coding feedback received

  CMS isn't including any policy changes in this ICD-10 quarterly update. They cover NCD policy changes using the current, longstanding NCD process. Make sure your billing staff knows of these changes.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12439 - Claims processing instructions for the new pneumococcal 20-valent conjugate vaccine code 90677

  In this article, you'll learn about:

  - A new code for a pneumococcal vaccine.
  - Where to find pricing for the code.
  - The basis for Medicare's payment to institutional providers for this code.

  Make sure your billing staff knows about new vaccine code 90677, which is effective for dates of service on or after October 1, 2021.

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Resuming required application fees

The application fee will be required for institutional providers and suppliers who are initially enrolling, revalidating, and adding additional practice locations, submitted after October 31. Please refer to the application fee requirement chart to determine if an application fee is required for your scenario.

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November 1, 2021

October 2021 claim submission errors

The October 2021 Part A claim submission errors and resolutions for jurisdiction L are now available. Please take time to review these errors and avoid them on future claims.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12357 - Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

  CMS revised this article to reflect a revised CR 12357. The CR revision didn't impact the substance of the article. CMS did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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Changes to amount in controversy for appeals in 2022

CMS has announced the dollar amount that must remain in controversy to sustain appeal rights beginning January 1, 2022. Please read this article for details.

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October 29, 2021

Special Edition – Friday, October 29, 2021

CMS Takes Decisive Steps to Reduce Health Care Disparities Among Patients with Chronic Kidney Disease and End-Stage Renal Disease

CMS is taking action to close health equity gaps by providing Medicare patients living with End-Stage Renal Disease (ESRD) with greater access to care. Through the ESRD Prospective Payment System (PPS) annual rulemaking, CMS is making changes to the ESRD Quality Incentive Program (QIP) and the ESRD Treatment Choices (ETC) Model, and updating ESRD PPS payment rates. The changes to the ETC Model policies aim to encourage dialysis facilities and health care providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with lower socioeconomic status, making the model one of the agency's first CMS Innovation Center models to directly address health equity.

"Today's final rule is a decisive step to ensure people with Medicare with chronic kidney disease have easy access to quality care and convenient treatment options," said CMS Administrator Chiquita Brooks-LaSure. "Enabling dialysis providers to offer more dialysis treatment options for Medicare patients will catalyze better health outcomes, greater autonomy and better quality of life for all patients with kidney disease."

According to CMS Office of Minority Health's studies on racial, ethnic and socioeconomic factors, disadvantaged people with Medicare have higher rates of ESRD. They are also more likely to experience higher hospital readmissions and costs, as well as more likely to receive in-center hemodialysis (vs. home dialysis). Studies also indicate non-white ESRD patients are less likely to receive pre-ESRD kidney care, become waitlisted for a transplant, or receive a kidney transplant.

CMS is improving access to home dialysis for patients of all socioeconomic backgrounds. For example, CMS is finalizing changes to the ETC Model to test a new payment incentive that rewards ESRD facilities and clinicians who manage dialysis patients for achieving significant improvement in the home dialysis rate and kidney transplant rate for lower-income beneficiaries. In addition, CMS is approving the first ever technology under a recently established policy that allows for enhanced payments for innovative technologies that represent a substantial clinical improvement relative to existing options. This approval will help ESRD facilities offer an additional option to beneficiaries for home dialysis at this critical time in the pandemic.

Consistent with President Biden's Executive Order 13985 on "Advancing Racial Equity and Support for Underserved Communities through the Federal Government," CMS is addressing health inequities and improving patient outcomes in the U.S. through improved data collection for better measurement and analysis of disparities across programs and policies. In response to the proposed rule, CMS received valuable feedback on potential opportunities to collect and leverage diverse sets of data such as race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+ and socioeconomic status, to better measure disparities. CMS also received feedback on various methodical approaches to advance equity through the ESRD Quality Incentive Program (ESRD QIP). This valuable stakeholder feedback will help guide future rulemaking to improve health equity.

The rule finalizes policies for the ESRD QIP that address the circumstances of the COVID-19 public health emergency and functionality challenges relating to the implementation of a new data collection system. These challenges include a special scoring and payment policy under which no facility will receive a payment reduction under the ESRD QIP for the upcoming year, especially since such payment reductions would have been based on performance during the height of the pandemic in 2020.

CMS' proposed rule included several requests for information (RFIs) for the agency to consider as part of its goal to increase access to dialysis treatments at home. Commenters' responses to the RFIs included specific suggestions for improving Acute Kidney Injury (AKI) payment and the ESRD PPS.

More Information:

- Fact sheet
- Final rule

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COVID-19 vaccines: New booster dose for Janssen (Johnson & Johnson)

Effective October 20, 2021, the FDA amended emergency use authorizations for the Janssen (Johnson & Johnson) COVID-19 vaccines to allow for use of a single booster dose for certain populations.

A new code to administer this new booster dose of Janssen (0034A) has been established.

CMS added the fee for this recently added code to the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

As a result of this addition, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- 2021 COVID-19 vaccine reimbursement
- 2021 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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October 28, 2021

Make a Strong Flu Shot Recommendation — it's Critical

MLN Connects newsletter for Thursday, October 28, 2021

News

- Make a Strong Flu Shot Recommendation — it's Critical
- Make Health Information Understandable During Health Literacy Month
- Ambulance Fee Schedule: CY 2022 Ambulance Inflation Factor

Compliance

- Home Health LUPA Threshold: Bill Correctly

Events

- Medicare Ground Ambulance Data Collection System Webinar: Reporting Revenue — October 28
- Medicare Ground Ambulance Data Collection System Webinar: Hospitals & Other Providers — November 4

MLN Matters® Articles

- April 2022 Update to the Java Medicare Code Editor (MCE) for New Edit 20 — Unspecified Code Edit
- Skilled Nursing Facility (SNF) Claims Processing Update to Fiscal Year End (FYE) Edits

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The following Local Coverage Determinations (LCDs) posted for comment on June 10, 2021 have been posted for notice. The LCDs and related Billing and Coding Articles will become effective December 12, 2021:

- Epidural Steroid Injections for Pain Management (L36920)
  - Billing and Coding: Epidural Steroid Injections for Pain Management (A56681)
- Pharmacogenomics Testing (L39063)
  - Billing and Coding: Pharmacogenomics Testing (A58801)
- Platelet Rich Plasma (L39068)
  - Billing and Coding: Platelet Rich Plasma (A58808)

The following Response to Comments Articles contain summaries of all comments received and Novitas' responses:

- Response to Comments: Epidural Steroid Injections for Pain Management (A58926)
- Response to Comments: Pharmacogenomics Testing (A58929)
- Response to Comments: Platelet Rich Plasma (A58923)

The following Billing and Coding Articles have been revised:

- Billing and Coding: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (A57618)
- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (A57600)

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COVID-19 vaccines: New booster dose for Moderna

Effective October 20, 2021, the FDA amended emergency use authorizations for the Moderna COVID-19 vaccine to allow for use of a single booster dose for certain populations.

A new code describing one-half of the applicable dosing of the Moderna vaccine (91306) and a new code to administer this new booster dose of Moderna (0064A) have been established.

CMS added the fees for these recently added codes to the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

As a result of this addition, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- 2021 COVID-19 vaccine reimbursement
- 2021 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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Election of cost reimbursement for CRNA services

Rural hospitals and critical access hospitals (CAHs) or hospitals/CAHs reclassified to a rural area, can qualify for reasonable cost reimbursement of anesthesia services performed by a qualified non-physician anesthetist if they meet certain criteria and obtain approval for the certified registered nurse anesthetist (CRNA)/anesthesiologist assistant cost reimbursement. Pease read this article for details.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12373 - Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

  In this Article, you'll learn about:

  - FY 2022 IPPS updates.
  - FY 2022 LTCH PPS updates.
  - Update to those hospitals that CMS excludes from the IPPS.

  Make sure your billing staff knows about the FY 2022 changes.

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October 25, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12457 - Skilled Nursing Facility (SNF) Claims Processing Update to Fiscal Year End (FYE) Edits

  In this MLN Matters Article, you will learn about:

  - A correction CMS is making to SNF claims editing
  - The details of the corrected Fiscal Year Ending (FYE) edit
  - How the revised edit affects you

  Make sure your billing staff knows about this change.

- MM12471- April 2022 Update to the Java Medicare Code Editor (MCE) for New Edit 20–Unspecified Code Edit

  This article tells you about Medicare system changes necessary to update the MCE to accept a new MCE edit 20. Make sure your billing staff knows how to handle this new edit.

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October 22, 2021

Special Edition – Friday, October 22, 2021

COVID-19: Moderna & Jansen (J&J) Booster Shots

Effective October 20, 2021, FDA amended the emergency use authorizations for the Moderna and Jansen (Johnson & Johnson) COVID-19 vaccines to allow for use of a single booster dose for certain populations.

Get the most current list of billing codes, payment allowances and effective dates.

More Information:
CMS News Alert
COVID-19 provider toolkit including:

- Payment rates for administering vaccines
- How to bill correctly

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October 21, 2021

Cognitive Assessment: Resources to Answer Patient Questions

MLN Connects newsletter for Thursday, October 21, 2021

View this edition as a: Webpage | PDF

Claims, Pricers, & Codes

- LTCH: New Web Pricer Released

Events

- Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model National Expansion Special ODF — October 28

MLN Matters® Articles

- Claim Status Category and Claim Status Codes Up**date**
- New/Modifications to the Place of Service (POS) Codes for Telehealth

Publications

- A Prescriber's Guide to Medicare Prescription Drug (Part D) Opioid Policies

Information for Medicare Patients

- Cognitive Assessment: Resources to Answer Patient Questions

.

The following Billing and Coding Articles have been revised:

- Billing and Coding: Allergy Testing (A56558)
- Billing and Coding: Botulinum Toxins (A58423)

The following Local Coverage Article has been revised:

- Self-Administered Drug Exclusion List: (A53127)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12349 - Modifications/Improvements to Value-Based Insurance Design (VBID) Model – Implementation

  CMS revised this article to reflect a revised CR12349. The CR revision didn't impact the substance of the article. CMS did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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Provider specialty: Opioid treatment program

We have added A Prescriber's Guide to Medicare Prescription Drug (Part D) Opioid Policies to this specialty page.

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October 20, 2021

Claims billed for monoclonal antibodies products are being returned to providers in error *

Novitas identified an issue for claims billed with monoclonal antibodies HCPCS codes Q0240, M0240, M0241, M0244, M0246, Q0247, M0247, M0248, Q0249, M0249, and M0250. These services are being returned to providers (RTP) with reason code 32415 or 31498 in error. Impacted claims should be resubmitted for processing. Please review our open claim issues for more information.

.

October 15, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12299 - Claim Status Category and Claim Status Codes Update

  This article updates, as needed, the claim status and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response and the ASC X12 277 health care claim acknowledgment transactions. Make sure your billing staffs know about the updates.

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The following billing and coding articles have been revised to reflect the annual ICD-10 code updates effective for dates of service on and after October 1, 2021.

- Billing and Coding: Ambulance Services (Ground Ambulance) (A54574)
- Billing and Coding: Assays for Vitamins and Metabolic Function (A56416)
- Billing and Coding: Bariatric Surgical Management of Morbid Obesity (A56422)
- Billing and Coding: Barium Swallow Studies, Modified (A56589)
- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: BRCA1 and BRCA2 Genetic Testing (A56542)
- Billing and Coding: Controlled Substance Monitoring and Drugs of Abuse Testing (A56645)
- Billing and Coding: Flow Cytometry (A56676)
- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A56938)
- Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) (A56725)
- Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Billing and Coding: Monitored Anesthesia Care (A57361)
- Billing and Coding: Nerve Conduction Studies and Electromyography (A54095)
- Billing and Coding: Oximetry Services (A57205)
- Billing and Coding: Psychiatric Codes (A57130)
- Billing and Coding: Pulmonary Function Testing (A57320)
- Billing and Coding: Routine Foot Care (A52996)
- Billing and Coding: Trigger Point Injections (A57751)
- Billing and Coding: Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) (A57414)
- Billing and Coding: Vestibular and Audiologic Function Studies (A57434)

In addition to the ICD-10-CM revisions, the following billing and coding article has been revised in response to an inquiry.

- Billing and Coding: Respiratory Pathogen Panel Testing (A58575)

The following Billing and Coding Article has been revised:

- Billing and Coding: Spinal Cord Stimulation (Dorsal Column Stimulation) (A57023)

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October 14, 2021

Pneumococcal Conjugate Vaccine, 20 Valent

MLN Connects newsletter for Thursday, October 14, 2021

View this edition as a: Webpage | PDF

News

- Pneumococcal Conjugate Vaccine, 20 Valent
- DATA 2000 Waiver Training Payments Still Available for Rural Health Clinics

Compliance

- Non-Physician Outpatient Services Provided Before or During Inpatient Stays: Bill Correctly

Events

- Medicare Ground Ambulance Data Collection System Webinar: Volunteer Organizations — October 14
- Medicare Ground Ambulance Data Collection System Webinar: Public Safety Organizations — October 21

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2022
- January 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files & Revisions to Prior Quarterly Pricing Files
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) — January 2022
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 28.0, Effective January 1, 2022
- National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy – This CR Rescinds and Fully Replaces CR 11783 — Revised

Multimedia

- Health Equity Web-Based Trainings
- SNF Quality Reporting Program: Section O: O0100. Special Procedures, Treatments, and Programs Web-Based Training

.

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The September 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the claim denials category. Please take time to review these and other FAQs for answers to your questions.

.

October 12, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12307 - Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)

  This article updates the diagnosis codes eligible for the ESRD PPS co-morbidity payment adjustment, effective October 1, 2021. Make sure your billing staff knows about these code updates.

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Prior Authorization: Implantation of spinal neurostimulator

The A/B MAC Prior Authorization Collaboration Workgroup developed this new article on implantation of spinal neurostimulator. The article has been added to the prior authorization program for certain hospital outpatient department services webpage. Please ensure you carefully review this information.

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October 11, 2021

Frequently Asked Questions (FAQs)

Have questions and not sure where to turn? Check out our FAQs for answers to your questions.

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October 8, 2021

Attention Providers

The 09/30/2021 Credit Balance reporting quarter has officially begun and we're already seeing large numbers of rejected reports for multiple reasons. Please make sure to verify the following fields on your CMS-838 Credit Balance Report certification are completed before faxing or submitting through the Portal:

- PTAN indicated (not NPI or other identifier, preferable with no dash)
- Name of facility
- VALID quarter ending date (03/31/YEAR, 06/30/YEAR, 09/30/YEAR, or 12/31/YEAR). The quarter ending date must be present (not blank), and the date must be in its entirety.
- ONE box checked in lower left (checking multiple boxes will be rejected)
- **SIGN** your report

Please make sure there is a return fax number on your submission as you will be notified by fax should your report be rejected.

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October 7, 2021

Enter Your Digital Contact Information Into NPPES Now

MLN Connects newsletter for Thursday, October 7, 2021

View this edition as a: Webpage | PDF

News

- Medicare-Dependent Hospital COVID-19 Waiver: Modification
- Organ Procurement Organization Performance Report
- NPPES: Add Digital Contact Information
- Hospice QRP Claims-Based Measures: FAQs
- Breast Cancer: Talk to Your Patients about Screening

Claims, Pricers, & Codes

- Drugs & Biologics: HCPCS Level II Application Summaries & Coding Decisions

Events

- Medicare Ground Ambulance Data Collection System Webinar: Labor Costs — October 7
- Medicare Ground Ambulance Data Collection System: Q&A Session — October 12
- Hospice Quality Reporting Program Forum — October 19

MLN Matters® Articles

- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022 — Revised

Publications

- Medicare DMEPOS Payments While Inpatient — Revised

Multimedia

- Modernizing Health Care to Improve Physical Accessibility

.

The following Billing and Coding Article has been added and will become effective November 8, 2021:

- Billing and Coding: Molecular Pathology and Genetic Testing (A58917)

.

October 6, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12468 - Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2022

  This article tells you about changes in the January 2022 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staff knows of these changes.

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October 5, 2021

Subject Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12469 - January 2022 Quarterly Average Sales Price [ASP] Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  Make sure your billing staff knows about these quarterly updates to Medicare's ASP and Not Otherwise Classified (NOC) Part B drug pricing files.

.

October 4, 2021

September 2021 claim submission errors

The September 2021 Part A claim submission errors and resolutions for jurisdiction L are now available. Please take time to review these errors and avoid them on future claims.

.

October 1, 2021

The following Billing and Coding article has been revised:

- Billing and Coding: Biomarkers for Oncology (A52986)

The Novitas Solutions medical policy team has evaluated all active Local Coverage Determinations (LCDs) and Local Coverage Articles for any impact in response to the 2022 Annual ICD-10 Code Update. The following is a list of the impacted articles. The revised articles will be published to the Medicare Coverage Database and on the Novitas Website in the middle of October. Please continue to watch our website for updates.

- Billing and Coding: Ambulance Services (Ground Ambulance) (A54574)
- Billing and Coding: Assays for Vitamins and Metabolic Function (A56416)
- Billing and Coding: Bariatric Surgical Management of Morbid Obesity (A56422)
- Billing and Coding: Barium Swallow Studies, Modified (A56589)
- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: BRCA1 and BRCA2 Genetic Testing (A56542)
- Billing and Coding: Controlled Substance Monitoring and Drugs of Abuse Testing (A56645)
- Billing and Coding: Flow Cytometry (A56676)
- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A56938)
- Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) (A56725)
- Billing and Coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Billing and Coding: Monitored Anesthesia Care (A57631)
- Billing and Coding: Nerve Conduction Studies and Electromyography (A54095)
- Billing and Coding: Oximetry Services (A57205)
- Billing and Coding: Psychiatric Codes (A57130)
- Billing and Coding: Pulmonary Function Testing (A57320)

- Billing and Coding: Respiratory Pathogen Panel Testing (A58575)
- Billing and Coding: Routine Foot Care (A52996)
- Billing and Coding: Trigger Point Injections (A57751)
- Billing and Coding: Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) (A57414)
- Billing and Coding: Vestibular and Audiologic Function Studies (A57434)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12357 - Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

  CMS revised this article to reflect a revised CR 12357. They also changed the release date, transmittal number, and the web address of the CR. All other information is the same.

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September 30, 2021

Flu Season is Here: Protect Your Patients, Yourself, & Your Loved Ones

MLN Connects newsletter for Thursday, September 29, 2021

View this edition as a: Webpage | PDF

News

- Flu Season is Here: Protect Your Patients, Yourself, & Your Loved Ones
- Clinical Laboratory Fee Schedule Updates

Compliance

- Post-Acute Care Transfers: Bill Correctly

MLN Matters® Articles

- October 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.3
- October 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- October Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Multimedia

- Part C Organization Determination, Appeals, & Grievances — Revised

.

September 29, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12399 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--January 2022

CMS changed the release date, transmittal number, and the web address of the CR. All other information is the same.

- MM12417 - Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022

  CMS revised this article, which corrected the fixed dollar loss threshold amount to $16,040. CMS changed the release date, transmittal number, and the web address of the CR. All other information remains the same.

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September 28, 2021

COVID-19 vaccines: New booster dose of Pfizer vaccine

On September 22, 2021, the FDA amended the emergency use authorization for the Pfizer-BioNTech (PDF) COVID-19 vaccine to allow a single booster dose for certain populations.

A new code describing the service to administer a booster dose of Pfizer BioNTech COVID-19 vaccine (0004A) has been established. CMS added the fee for this code to the CMS COVID-19 vaccines and monoclonal antibodies webpage.

As a result of this addition, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- 2021 COVID-19 vaccine reimbursement
- 2021 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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September 27, 2021

Special Edition – Monday, September 27, 2021

Flu & Pneumococcal Vaccines: Expanded SNF Enforcement Discretion for Certain Pharmacy Billing

Effective September 20, 2021, CMS exercised enforcement discretion for Skilled Nursing Facility (SNF) consolidated billing provisions related to flu and pneumococcal vaccines. This allows Medicare-enrolled immunizers, including pharmacies, to bill directly and get direct reimbursement from the Medicare program (including vaccine administration and product), whether these vaccines are administered at the same time (co-administered) with a COVID-19 vaccine or at different times. Visit the SNF: Enforcement Discretion Relating to Certain Pharmacy Billing webpage.

Vaccinations for respiratory illnesses reduce the impact and resulting burdens on the health care system during the COVID-19 PHE. The CDC recommends that patients in post-acute care facilities get the flu vaccine during the COVID-19 pandemic.

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September 24, 2021

Special Edition – Friday, September 24, 2021

CMS Will Pay for COVID-19 Booster Shots, Eligible Consumers Can Receive at No Cost

Coverage without cost-sharing available for eligible people with Medicare, Medicaid, CHIP, and Most Commercial Health Insurance Coverage

Following the FDA's recent action that authorized a booster dose of the Pfizer COVID-19 vaccine for certain high-risk populations and a recommendation from the CDC, CMS will continue to provide coverage for this critical protection from the virus, including booster doses, without cost sharing.

Beneficiaries with Medicare pay nothing for COVID-19 vaccines or their administration, and there is no applicable copayment, coinsurance, or deductible. In addition, thanks to the American Rescue Plan Act of 2021, nearly all Medicaid and CHIP beneficiaries must receive coverage of COVID-19 vaccines and their administration, without cost-sharing. COVID-19 vaccines and their administration, including boosters, will also be covered without cost-sharing for eligible consumers of most issuers of health insurance in the commercial market. People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

"The Biden-Harris Administration has made the safe and effective COVID-19 vaccines accessible and free to people across the country. CMS is ensuring that cost is not a barrier to access, including for boosters," said CMS Administrator Chiquita Brooks-LaSure. "CMS will pay Medicare vaccine providers who administer approved COVID-19 boosters, enabling people to access these vaccines at no cost."

CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available on the CDC COVID-19 Vaccination Program Provider Requirements and Support webpage and through the CMS COVID-19 Provider Toolkit.

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September 23, 2021

COVID-19: Compare Nursing Homes by Vaccination Rate

MLN Connects newsletter for Thursday, September 23, 2021

View this edition as a: Webpage | PDF

News

- CMS Launches New Medicare.gov Feature to Compare Nursing Homes by Vaccination Rate
- Drugs of Abuse Testing: Comparative Billing Report in September
- Cardiovascular Disease: Talk to your Patients about Screening

Compliance

- DMEPOS Items: Ordering or Referring Practitioner Requirements

Claims, Pricers, & Codes

- ESRD Facilities: Bill Correctly for Cinacalcet Oral Drug

MLN Matters® Articles

- Claims Processing Instructions for National Coverage Determination 20.33 – Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation
- National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds
- October 2021 Update of the Ambulatory Surgical Center (ASC) Payment System
- Medicare Clarifies Recognition of Interstate License Compact Pathways — Revised

Publications

- Medicare Vision Services — Revised
- Power Mobility Devices — Revised
- Transitional Care Management Services — Revised

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12432 - October 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.3

  This article tells you there are changes, effective October 1, 2021, for claims processing for:

  - Hospital outpatient departments
  - Community mental health centers
  - All non-Outpatient Prospective Payment System (OPPS) hospital providers
  - Limited services when provided in an HH agency (HHA) that isn't under the HH PPS
  - A hospice patient for the treatment of a non-terminal illness

  Make sure your billing staff knows the content of these updates.

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Online Registration Now Available for the October 7, 2021, Contractor Advisory Committee (CAC) Meeting

Due to the public health crisis this meeting will be held via Webinar only.

Online registration for the Thursday, October 7, 2021, CAC Meeting is now available and will close at 3:30 p.m. Eastern Time (ET) on Wednesday, October 6, 2021. The purpose of the meeting is to obtain advice from CAC members regarding the strength of published evidence for multiparametric MRI in non-alcoholic fatty liver disease (NAFLD).

The CAC provides a formal mechanism for healthcare professionals to be informed of the evidence used in developing the Local Coverage Determination (LCD) and promotes communications between the Medicare Administrative Contractor (MAC) and the healthcare community. CAC members will serve in an advisory capacity as representatives of their constituency to review the quality of the evidence used in the development of the LCD. The final decision on all issues rests with the Contractor Medical Directors (CMDs). More information regarding CAC meetings is available on Novitas' website.

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September 22, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12453 - October Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  Make sure your billing staff knows about the changes to the DMEPOS fee schedule for October.

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September 21, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12436 - October 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  Make sure your billing staffs know about these OPPS updates.

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September 20, 2021

Special Edition – Monday, September 20, 2021

Help CMS Improve Your Experience with Provider Resources

CMS is conducting a study to help us improve your experience with resources about the Medicare program and correct billing. Please share your thoughts with us by taking this survey. Responses are confidential, and the survey should take about 10 minutes to complete. Thank you for your time.

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September 17, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12451 - October 2021 Update of the Ambulatory Surgical Center (ASC) Payment System

  CMS is making changes in the October 2021 ASC payment system update, which includes HCPCS updates. Make sure your billing staff are aware these changes.

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September 16, 2021

COVID-19 Vaccines: Act Now

MLN Connects newsletter for Thursday, September 16, 2021

View this edition as a: Webpage | PDF

News

- COVID-19 Vaccines: Act Now
- IRF Review Choice Demonstration: Submit Comments by October 8

Compliance

- Medicare Quarterly Provider Compliance Newsletter
- Surgical Dressings: Medicare Requirements

Claims, Pricers, & Codes

- Average Sales Price Files: October 2021

Events

- National Stakeholder Call with the CMS Administrator — September 17

MLN Matters® Articles

- 2022 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Annual Clotting Factor Furnishing Fee Update 2022
- Home Health Notices of Admission – Additional Manual Instructions
- Implement Operating Rules – Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule – Update from Council for Affordable Quality Health Care (CAQH) CORE
- Influenza Vaccine Payment Allowances – Annual Update for 2021-2022 Season
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to Home Health (HH) Grouper
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2021 Update

Publications

- DMEPOS Accreditation — Revised
- Independent Diagnostic Testing Facility (IDTF) — Revised

Multimedia

- Part D Coverage Determinations, Appeals, & Grievances Web-Based Training — Revised

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The August 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12361 - Claims Processing Instructions for National Coverage Determination 20.33 - Transcatheter Edge-to-Edge Repair [TEER] for Mitral Valve Regurgitation

  Make sure your billing staff knows about this change in Medicare's TEER coverage.

- MM12403 - National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds

  Make sure your billing staff knows that CMS will nationally cover autologous Platelet-Rich Plasma for the treatment of chronic non-healing diabetic wounds under specific conditions.

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September 13,2021

LCD comment period closed

The comment period is now **closed** for the following proposed LCDs. Comments received will be reviewed by our contractor medical directors. The response to comments articles and finalized billing and coding articles will be related to the final LCDs when they are posted for notice.

- Genetic Testing for Cardiovascular Disease (DL39082)
- Surgical Treatment of Nails (DL34887)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12435 - Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

  This Article tells you about the quarterly update to the CLFS, effective October 1, 2021. Make sure your billing staff knows about these changes.

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September 10, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12422 - Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2021 Update

  This article informs you of the October 2021 updates to the MPFS. Make sure your billing staff knows these updates.

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September 9, 2021

Special Edition – Thursday, September 9, 2021

Biden-Harris Administration to Expand Vaccination Requirements for Health Care Settings

New action will protect patients of the 50,000 providers and over 17 million health care workers in Medicare and Medicaid certified facilities

The Biden-Harris Administration will require COVID-19 vaccination of staff within all Medicare and Medicaid-certified facilities to protect both them and patients from the virus and its more contagious Delta variant. Facilities across the country should make efforts now to get health care staff vaccinated to make sure they are in compliance when the rule takes effect.

The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Centers for Disease Control and Prevention (CDC), announced that emergency regulations requiring vaccinations for nursing home workers will be expanded to include hospitals, dialysis facilities, ambulatory surgical settings, and home health agencies, among others, as a condition for participating in the Medicare and Medicaid programs. The decision was based on the continued and growing spread of the virus in health care settings, especially in parts of the U.S. with higher incidence of COVID-19.

“There is no higher priority for us than patient health and safety. As the Delta variant strengthens, the Biden-Harris Administration is committed to doing everything we can to keep patients, and those who care for them, safe,” said U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra. “There is no question that staff, across any health care setting, who remain unvaccinated pose both direct and indirect threats to patient safety and population health. Ensuring safety and access to all patients, regardless of their entry point into the health care system, is essential.”

Nursing homes with an overall staff vaccination rate of 75% or lower experience higher rates of preventable COVID infection. In CMS’s review of available data, the agency is seeing lower staff vaccination rates among hospital and End Stage Renal Disease (ESRD) facilities. To combat this issue, CMS is using its authority to establish vaccine requirements for all providers and suppliers that participate in the Medicare and Medicaid programs. Vaccinations have proven to reduce the risk of severe illness and death from COVID-19 and are effective against the Delta variant. CMS will continue to work closely with all Medicare and Medicaid certified facilities to ensure these new requirements are met.

“We know that those working in health care want to do what is best for their patients in order to keep them safe,” said CMS Administrator Chiquita Brooks-LaSure. “As the Delta variant continues to spread, we know the best defense against it lies with the COVID-19 vaccine. Data show that the higher the level of vaccination rates among providers and staff, the lower the infection rate is among patients who are dependent upon them for care. Now is the time to act. I’m urging everyone, but especially those fighting this virus on the front lines, to get vaccinated and protect themselves, their families, and their patients from COVID-19.”

CMS is developing an Interim Final Rule with Comment Period that will be issued in October. CMS expects certified Medicare and Medicaid facilities to act in the best interest of patients and staff by complying with new COVID-19 vaccination requirements. Health care workers employed in these facilities who are not currently vaccinated are urged to begin the process immediately. Facilities are urged to use all available resources to support employee vaccinations, including employee education and clinics, as they work to meet new federal requirements.

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SNF: WBT & COVID-19 Reminder

MLN Connects newsletter for Thursday, September 9, 2021

View this edition as a: Webpage | PDF

News

- PEPPERs for Short-term Acute Care Hospitals
- Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments: Payment Update

- Prostate Cancer: Talk to Your Patients about Screening

Compliance

- DMEPOS Items: Medical Record Documentation

Events

- Medicare Ground Ambulance Data Collection System: Q&A Session — September 14

MLN Matters® Articles

- Medicare FFS Response to the PHE on the COVID-19 — Revised

Publications

- Medicare Mental Health — Revised

Multimedia

- SNF Consolidated Billing Web-Based Training — Revised

.

The following LCD has been revised:

- Cataract Extraction (including Complex Cataract Surgery) (L35091)

The following Billing and Coding Article has been revised:

- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)

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Multi-Jurisdictional CAC Meeting to be held September 29, 2021

WPS Government Health Administrators, along with National Government Services (NGS), Novitas Solutions, CGS Administrators, First Coast Service Options, and Noridian Healthcare Solutions will host a multi-jurisdictional Contractor Advisory Committee (CAC) Meeting via webinar on September 29, 2021, from 2:00 p.m.–4:00 p.m. CT (3:00 p.m. - 5:00 p.m. ET). Discussions will focus on transcranial magnetic stimulation (TMS) for the treatment of obsessive-compulsive disorder (OCD).

The Centers for Medicare & Medicaid Services (CMS) assigned Medicare Administrative Contractors (MACs) with the task of developing Local Coverage Determinations (LCDs). The purpose of the CAC meeting is to provide a formal mechanism for healthcare professionals to be informed of the evidence used in developing an LCD, for reconsideration consideration, and promote communications between the MACs and the healthcare community. The CAC panel will discuss the clinical literature related to TMS for OCD presented by the requestor of this reconsideration to cover OCD and rate their confidence in a series of key questions. Discussions will occur between CAC panelists and Contractor Medical Directors. The public may attend via webinar; however, questions from the public will not be entertained.

Registration is required. Please register here.

Once registered you will receive access information via email prior to the meeting. Lines will remain muted throughout the conference except for the invited CAC panelists and the MAC hosts.

View meeting details and register now from the WPS Contractor Advisory Committee Meetings web page or from the Novitas Multi-Jurisdictional CAC Meeting web page.

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Nurse Practitioner Supporting Documentation

When initially enrolling a Nurse Practitioner, there are two supporting documents required to process the application listed below:

- Copy of the Nurse Practitioner's certification
- Copy of the Master's degree or transcript to support the degree

These documents must be included so that we can verify the requirements to enroll the Nurse Practitioner in Medicare. Please review our article for more information.

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Don't forget to sign your Medicare enrollment application!

Signatures are a very vital step in the Provider Enrollment process. Your signature validates that the information provided on the application is current and correct.

If you are submitting a Provider Enrollment, Chain and Ownership System (PECOS) web application, we encourage you to sign the application electronically. Using the electronic signature option allows a faster turnaround time.

If you choose not to sign electronically, you may upload your certification statement. Signing your application before submitting prevents development and delay of your application. Your application cannot be finalized without a signature.

For more information, please visit our article PECOS Web Application Signatures.

August 2021 claim submission errors

The August 2021 Part A claim submission errors and resolutions for jurisdiction L are now available. Please take time to review these errors and avoid them on future claims.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12367 - 2022 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

  This article tells you that CMS will provide your MAC with files for the automated payments of HPSA bonuses for dates of service from January 1, 2022, through December 31, 2022. Make sure your billing staff knows about this update.

- MM12420 - Annual Clotting Factor Furnishing Fee Update 2022

  Make sure your billing staff knows the clotting factor furnishing fee for 2022 is $0.239 per unit.

- MM12421 - Influenza Vaccine Payment Allowances - Annual Update for 2021-2022 Season

  Make sure your billing staff knows about Medicare’s payment allowances for the seasonal flu shots available on the CMS Seasonal Influenza Vaccines Pricing webpage.

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September 8, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12428 - Implement Operating Rules – Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule – Update from Council for Affordable Quality Health Care (CAQH) CORE

  CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2021. This is based on the CARC and RARC updates as posted at the official ASC X12 website on or about July 1, 2021. This also includes updates based on the market-based review that CAQH CORE conducts once every two years to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them. Make sure your billing staff knows of these updates.

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As a reminder, the comment period for the following Proposed Local Coverage Determinations (LCDs) is currently open and will close on September 11, 2021. We encourage you to submit your comments as soon as possible.

- Genetic Testing for Cardiovascular Disease (DL39082)
- Surgical Treatment of Nails (DL34887)

Submit Comments

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September 2, 2021

Ambulance Prior Authorization Model Implementation Dates

MLN Connects newsletter for Thursday, September 2, 2021

View this edition as a: Webpage | PDF

News

- Ambulance Prior Authorization Model Implementation Dates
- In Response to Hurricane Ida PHE, CMS Announces Support for Residents of Louisiana & Mississippi
- Provider Enrollment Activities Resume in October
- Hospice Quality Reporting Program: Public Reporting Key Dates
- DME Suppliers: Payment for Respiratory Equipment Affected by Recent Recall
- Healthy Aging: Recommend Services for Your Patients

Compliance

- DMEPOS Standard Written Order Requirements

Claims, Pricers, & Codes

- HCPCS Level II Application Submission: Launch of MEARISTM
- HCPCS Level II Application Submission Deadlines

MLN Matters® Articles

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2022

Publications

- Medicare Provider Enrollment — Revised

.

August 26, 2021

Health Care Code Sets: ICD-10 — Revised

MLN Connects newsletter for Thursday, August 26, 2021

View this edition as a: Webpage | PDF

News

- Impact of the PHE on Telehealth: Comparative Billing Report in August
- COVID-19 Monoclonal Antibody EUA Updates: Casirivimab & Imdevimab

Events

- FY 2022 Hospice Final Rule: What Hospices Need to Know Webinar — August 31

Publications

- Health Care Code Sets: ICD-10 — Revised

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12399 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--January 2022

  This article tells you about updates of ICD-10 conversions and other coding updates specific to NCDs. These changes result from:

  - Newly available codes
  - Separate NCD coding revisions
  - Coding feedback received

  CMS isn't including any policy changes this ICD-10 quarterly update. CMS covers NCD policy changes using the current, longstanding NCD process. Make sure your billing staff knows of these changes.

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COVID-19 monoclonal antibodies: Additional product and administration codes for casirivimab and imdevimab

Effective July 30, 2021, the FDA revised the EUA for casirivimab and imdevimab to allow its use for post-exposure prophylaxis (PEP) for certain patients who have been exposed to (or are at high risk of exposure to) a person with COVID-19. CMS has issued a new product code for casirivimab and imdevimab of 600 mg (Q0240), and 2 new codes for the administration of repeat doses of casirivimab and imdevimab (M0240 and M0241).

CMS added the fees for these recently added codes to the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

Information has been added to the CMS Monoclonal Antibody COVID-19 Infusion for the COVID-19 mAb codes Q0240, M0240 and M0241.

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- 2021 COVID-19 monoclonal antibodies reimbursement
- 2021 COVID-19 monoclonal antibodies administration (mAb) fees for centralized billers, Indian Health Services, and Veterans Affairs

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August 25, 2021

Appeals Corner Newsletter - August 2021

Novitas is partnering with C2C Solutions to encourage participation in the Qualified Independent Contractor (QIC) Part A East Telephone Discussion Demonstration. We have created an appeals newsletter to offer educational assistance to prevent future appeal submissions as well as suggested tips on how to avoid unfavorable appeal decisions

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Are you using the correct form?

Did you know that submitting an outdated or old form can cause a delay or even a rejection of your request? Novitas' mailroom has noticed an increase in the number of improper requests with outdate forms, please ensure you are reviewing our Forms catalog to access the most up-to-date form for your submission. We also offer many of our forms for electronic submission via Novitasphere, our free, secure internet portal.

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August 24, 2021

Special Edition – Tuesday, August 24, 2021

CMS Expands Medicare Payments for At-Home COVID-19 Vaccinations

Part of Biden-Harris Administration Vaccine Outreach, CMS Boosts Vaccine Access in Smaller Group Homes, Assisted Living Facilities, and Other Group Living Situations

As part of the Biden-Harris Administration's ongoing commitment to increasing access to vaccinations and improving health equity, CMS is expanding opportunities for people to receive COVID-19 vaccinations in their home. To ensure Medicare beneficiaries who have difficulty leaving their homes or are otherwise hard-to-reach can receive the vaccination, health care providers can now receive additional payments for administering vaccines to multiple residents in one home setting or communal setting of a home.

This announcement aims to further boost the administration of COVID-19 vaccination – including second and third doses – in smaller group homes, assisted living facilities, and other group living situations by allowing vaccine providers to receive the increased payment up to 5 times when fewer

than 10 Medicare beneficiaries get the vaccine on the same day in the same home or communal setting. This policy will help ensure that at-risk patients in smaller settings have the same opportunities as others to receive the vaccination.

“We are doing everything we can to remove barriers to vaccinations, including ensuring appropriate payment levels for vaccine providers to connect with more people in their communities who are unable to receive the vaccine in a traditional setting,” said CMS Administrator Chiquita Brooks-LaSure. “We’ve seen the difference that vaccinations have in communities, and we are calling on providers to join us as we continue to increase vaccination rates across the country. Today’s actions ensure that everyone has the ability to be vaccinated against COVID-19, including older adults with mobility or transportation challenges and other at-risk individuals.”

While many Medicare beneficiaries are able to receive a COVID-19 vaccine at a retail pharmacy or from a health care provider, some people have great difficulty leaving their homes or cannot easily access vaccination in these settings. These individuals are often at-risk patients who could require complex care if they contracted COVID-19 and needed to be hospitalized. To better serve this group, Medicare previously increased the total payment amount for at-home vaccination from approximately $40 to approximately $75 per vaccine dose, in certain circumstances.

Delivering COVID-19 vaccination to access-challenged and hard-to-reach individuals poses some unique challenges, such as ensuring appropriate vaccine storage temperatures, handling, and administration. Along with the CDC guidance, this announcement helps vaccine providers meet these challenges and successfully administer vaccinations.

The additional payment amount also accounts for the clinical time needed to monitor a beneficiary after the vaccine is administered, as well as the upfront costs associated with administering the vaccine safely and appropriately in a beneficiary’s home. The payment rate for administering each dose of a COVID-19 vaccine, as well as the additional in-home payment amount, is geographically adjusted based on where the service is furnished.

How to Find a COVID-19 Vaccine:

As states and the federal government continue to break down barriers – like where vaccines can be administered – resources for connecting communities to vaccination options remain key. Unvaccinated individuals and those looking to assist friends and family can:

Visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby

Text GETVAX (438829) for English or VACUNA (822862) for Spanish for near-instant access to details on three vaccine sites in the local area

Call the National COVID-19 Vaccination Assistance Hotline at 1-800-232-0233 (TTY: 1-888-720-7489) for assistance in English and Spanish

Coverage of COVID-19 Vaccines:

The federal government is providing the COVID-19 vaccine free of charge or with no cost-sharing for Medicare beneficiaries. As a condition of receiving free COVID-19 vaccines from the federal government, vaccine providers cannot charge patients any amount for administering the vaccine.

Because no patient can be billed for COVID-19 vaccinations, CMS and its partners have provided a variety of information online for providers vaccinating all Americans regardless of their insurance status:

Original Medicare and Medicare Advantage:Beneficiaries with Medicare pay nothing for COVID-19 vaccines or their administration, and there is no applicable copayment, coinsurance or deductible.

Medicaid and the Children’s Health Insurance Program (CHIP):State Medicaid and CHIP agencies must cover COVID-19 vaccine administration with no cost sharing for nearly all beneficiaries during the COVID-19 Public Health Emergency (PHE) and (generally) for over a year after it ends. For the

very limited number of Medicaid beneficiaries who are not eligible for this coverage (and do not receive it through other coverage they might have), providers may submit claims for reimbursement for administering the COVID-19 vaccine to underinsured individuals through the COVID-19 Coverage Assistance Fund, administered by the Health Resources and Services Administration (HRSA), as discussed below. Under the American Rescue Plan Act of 2021 (ARP), signed by President Biden on March 11, 2021, the federal matching percentage for state Medicaid and CHIP expenditures on COVID-19 vaccine administration is currently 100% (as of April 1, 2021), and will remain 100% for more than a year after the COVID-19 PHE ends. The ARP also expands coverage of COVID-19 vaccine administration under Medicaid and CHIP to additional eligibility groups. CMS recently updated the Medicaid vaccine toolkit to reflect the enactment of the ARP.

Private Plans:The vaccine is free for people enrolled in most private health plans. The COVID-19 vaccines and the administration are covered without cost sharing for most enrollees, and such coverage must be provided both in-network and out-of-network during the PHE. Current regulations provide that out-of-network rates must be reasonable as compared to prevailing market rates, and the rules reference using the Medicare payment rates as a potential guideline for insurance companies. In light of CMS's action, CMS expects health insurance issuers and group health plans to continue to ensure their rates are reasonable when compared to prevailing market rates. Under the conditions of participation in the CDC COVID-19 Vaccination Program, providers cannot charge plan enrollees any administration fee or cost sharing, regardless of whether the COVID-19 vaccine is administered in-network or out-of-network.

For individuals who are underinsured, vaccine providers may submit claims for reimbursement for administering the COVID-19 vaccine through the COVID-19 Coverage Assistance Fund administered by HRSA after the claim to the individual's health plan for payment has been denied or only partially paid.

For individuals who are uninsured, vaccine providers may submit claims for reimbursement for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by HRSA. See information on the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program.

More information on Medicare payment for COVID-19 vaccine administration – including a list of billing codes, payment allowances and effective dates – is available on the Medicare COVID-19 Vaccine Shot Payment webpage.

More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available on the CDC COVID-19 Vaccination Program Provider Requirements and Support webpage

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August 19, 2021

Medicare Fraud & Abuse: Revised Online Course

MLN Connects newsletter for Thursday, August 18, 2021

View this edition as a: Webpage | PDF

News

- Immunization: Medicare Covers Vaccines

Compliance

- Chiropractic Services: Comply with Medicare Billing Requirements

Events

- Medicare Ground Ambulance Data Collection System: Instrument Walkthrough Webinar — August 26
- Medicare Ground Ambulance Data Collection System: Q&A Session — September 14

MLN Matters® Articles

- Implementation of the Capital Related Assets Adjustment (CRA) for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End Stage Renal Disease Prospective Payment System (ESRD PPS)
- Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2022
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2022
- Modifications/Improvements to Value-Based Insurance Design (VBID) Model – Implementation
- Skilled Nursing Facility (SNF) Claims Processing Updates
- Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

Publications

- IRF & LTCH: Q&A Basics

Multimedia

- Medicare Fraud & Abuse: Prevent, Detect, Report Web-Based Training — Revised

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August 18, 2021

COVID-19 Vaccines Additional Doses: Codes & Payment Information

Effective August 12, 2021, CMS will pay to administer additional doses of COVID-19 vaccines consistent with the FDA EUAs, using CPT code 0003A for the Pfizer vaccine and 0013A for the Moderna vaccine.

CMS added the fees for the recently added CPT codes 0003A and 0013A to the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

Information has been added to the CMS Medicare COVID-19 Vaccine Shot Payment for the administration of the COVID-19 vaccines 0003A and 0013A

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibodies billing for Part B
- 2021 COVID-19 vaccine reimbursement

- 2021 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs

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Chimeric Antigen Receptor (CAR) T-cell therapy (NCD 110.4)

Effective for dates of service (DOS) on or after August 7, 2019, CMS will cover the treatment for cancer with autologous T-cells expressing at least one CAR when administered at a Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategies (REMS) approved facility. This new NCD for CAR T-cell therapy is detailed in MLN Matters (MM) article, MM12177, which provides the instruction to be implemented September 20, 2021, rescinding, and replacing MM11783.

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August 16, 2021

Special Edition – Monday, August 16, 2021

COVID-19 Vaccines Additional Doses: Codes & Payment

The FDA amended the emergency use authorizations (EUAs) for both the Pfizer BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine to allow for an additional dose in certain immunocompromised people.

Effective August 12, 2021, CMS will pay to administer additional doses of COVID-19 vaccines consistent with the FDA EUAs, using CPT code 0003A for the Pfizer vaccine and CPT code 0013A for the Moderna vaccine. We'll pay the same amount to administer this additional dose as we did for other doses of the COVID-19 vaccine (approximately $40 each).

We'll hold and then process all claims with these codes after we complete claims system updates (no later than August 27).

Learn more about Medicare COVID-19 vaccine:

- COVID-19 Vaccine Codes
- Payment

.

August 13, 2021

Special Edition – Friday, August 13, 2021

COVID-19 Vaccine Additional Dose

Medicare stands ready to pay for administering an additional dose of COVID-19 vaccine consistent with the FDA emergency use authorization (EUA). We'll pay the same amount to administer this additional dose as we did for other doses of the COVID-19 vaccine (approximately $40 each). We'll share more information in the coming days about billing and coding.

For more information:

- View the FDA announcement
- CMS COVID-19 Provider Toolkit

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The July 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these and other FAQs for answers to your questions.

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The following Billing and Coding Articles have been revised:

- Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing (A56423)
- Billing and Coding: Diagnostic Colonoscopy (A58428)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)

The following Billing and Coding Article has been added and will become effective September 13, 2021:

- Billing and Coding: Tetanus Immunization (A58872)

The following Billing and Coding Article has been retired:

- Billing and Coding: Implantable Automatic Defibrillators (A56355)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12347 - Implementation of the Capital Related Assets Adjustment (CRA) for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End Stage Renal Disease Prospective Payment System (ESRD PPS)

  Make sure your billing staff knows to use the AX modifier and relevant revenue codes to report CRA for TPNIES.

- MM12364 - Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2022

  This article discusses annual updates to the IRF PPS rates. Make sure your billing staff knows of these rate updates effective for claims with discharges that fall within October 1, 2021, through September 30, 2022.

- MM12417 - Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022

  This article discusses the changes for FY 2022. Make sure that your billing staff knows about the changes that apply to discharges occurring from October 1, 2021, through September 30, 2022.

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August 12, 2021

COVID-19: Vaccinate Your Patients

MLN Connects newsletter for Thursday, August 12, 2021

View this edition as a: Webpage | PDF

News

- COVID-19: Vaccinate Your Patients
- CMS Resumes Targeted Probe & Educate Program

Compliance

- Cardiac Device Credits: Medicare Billing

Claims, Pricers, & Codes

- Non-Drug & Non-Biological Items and Services: HCPCS Application Summaries & Coding Decisions

MLN Matters® Articles

- Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)
- Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF))
- New Waived Tests
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2022

Multimedia

- SNF Section K: Height, Weight, and Nutritional Approaches Web-Based Training

.

Part A open claims issues

Please review updates to two claims issues located on our open claims issues page.

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August 11, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12344 - Skilled Nursing Facility (SNF) Claims Processing Updates

  This article tells you about updates to SNF edits to bypass services related to an emergency room encounter when there is a revenue code of 250 on the same claim. CR 12344 also updates certain Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) edits for overlapping claims when there is a no-pay hospital claim during an interrupted stay. Make sure your billing staff knows about these changes.

- MM12357 - Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

  Make sure your billing staff knows to report the GV modifier on claims when billing for hospice attending physician services during a patient's hospice election.

- MM12366 - Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2022

  This article tells you there's an update to the payment rates CMS uses for the SNF PPS for FY 2022. Make sure your billing staff is aware of this update.

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Assist us in Developing Local Coverage Determinations – Volunteer as a CAC Member!

The parameters of who may serve as a Medicare Contractor Advisory Committee (CAC) member were expanded by Change Request 10901 and the companion MLN Matters article. Novitas Solutions invites you to volunteer as a CAC member or alternate to represent your organization during our CAC meetings.

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August 9, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12009 - Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)

  This article explains the updates to the Medicare General Information, Eligibility, and Entitlement, Pub. 100-01, Medicare Benefit Policy Manual, Pub. 100-02, and Medicare Claims Processing Manual, Pub. 100-04, regarding SNFs. These changes clarify existing content. No policy, processing, or system changes are anticipated. Make sure your billing staff is aware of these updates.

- MM12079 - Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

  This article informs you of updates to various sections of Chapter 8 of the Medicare Claims Processing Manual (Pub. 100-04) – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims. Make sure your billing staff is aware of these updates.

- MM12349 - Modifications/Improvements to Value-Based Insurance Design (VBID) Model – Implementation

  This article tells you about modifications to CR11754. That CR is testing the inclusion of the Medicare hospice benefit into MA through the VBID Model (Hospice Benefit Component) for Calendar Year (CY) 2022. Unless otherwise stated, all requirements in CR11754 remain the same. CMS will test the Hospice Benefit Component of the Model through 2024.

- MM12353 - Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF))

  This article tells you about updates to Chapter 1, section 110 of the Medicare Benefit Policy Manual. These updates:

  - Clarify some existing content related to IRFs.
  - Correct various omissions and minor technical errors.
  - Provide information on new, finalized IRF policies.
  - Explain waivers and flexibilities issued during the public health emergency for COVID-19.

Make sure your billing staff is aware of these changes. CR12353 includes the relevant manual content.

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August 6, 2021

Register now for our ask-the-contractor (ACT) webinar!

ACT webinars provide a venue for you to ask us your specific questions concerning billing and Medicare policies or procedures. We host ACTs on a quarterly basis.

The format of the ACT will now be conducted in a roundtable forum. We will provide background information and relevant Medicare guidelines and then open the floor to questions from our audience regarding the presentation topic. We invite you to attend to have your Part A Medicare questions answered about the topics listed below.

The next quarterly JL Part A ACT is scheduled for August 18, 2021. Topics that will be discussed at this meeting include:

- Overview of Hospice Regulations and Coverage:
  - Hospice coverage
  - Home Health and Hospice Medicare contractors
  - Verification of Hospice election
  - Hospital billing during the Hospice election period
- Part A Top Billing Inquiries:
  - Review of claims center
  - Reason code errors and resolutions

We want to hear from you and answer your questions about these topics. Register now to participate by visiting our Event Calendar!

To view a full topic listing for this event, click here.

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August 4, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12254 - National Coverage Determination (NCD) Removal

  CMS revised this article to reflect a revised change request (CR) 12254. The CR revision didn't impact the substance of the article. The CR release date, transmittal number, and the web address of the CR has been updated. All other information is the same.

- MM12206 - Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions in Maryland Waiver (MW) Hospitals for Medicare Advantage (MA) Beneficiaries

  CMS revised this article to reflect a revised change request (CR) 12206. The CR revision didn't impact the substance of the article. The CR release date, transmittal number, and the web address of the CR has been updated. All other information is the same.

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August 2, 2021

July 2021 claim submission errors

The July 2021 Part A claim submission errors and resolutions for jurisdiction L are now available. Please take time to review these errors and avoid them on future claims.

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July 29, 2021

Online Registration Available for August 13, 2021, Open Meeting and Proposed LCDs Now Posted

Online registration for the August 13, 2021, Open Meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, August 11, 2021. **IMPORTANT: During this unprecedented time, our Open Meeting will be held via Webinar only.** The Novitas Solutions Proposed Local Coverage Determinations (LCDs) are now posted.

Open Meetings are to allow interested parties the opportunity to make presentations of information and offer comments related to new Proposed LCDs and/or the revised portion of a Proposed LCD that are in the 45-day open comment period. Interested parties may also request to attend as an observer. If you are interested in attending as a presenter or observer, please view our Proposed Local Coverage Determination Open Meetings page for specific guidelines and other helpful information.

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The following proposed LCDs have been posted for comments. The comment period will end on September 11, 2021; however, you are encouraged to submit your comments as soon as possible.

- Genetic Testing for Cardiovascular Disease (DL39082)
- Surgical Treatment of Nails (DL34887)

Submit Comments

The following draft billing and coding articles are related to the above proposed LCDs.

- Billing and Coding: Genetic Testing for Cardiovascular Disease (DA58795)
- Billing and Coding: Surgical Treatment of Nails (DA52998)

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Appeals Corner Newsletter - July 2021

Novitas is partnering with C2C Solutions to encourage participation in the Qualified Independent Contractor (QIC) Part A East Telephone Discussion Demonstration. We have created an appeals newsletter to offer educational assistance to prevent future appeal submissions as well as suggested tips on how to avoid unfavorable appeal decisions.

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July 28, 2021

#StayConnected Workshop Series: Post Claim Submission

Stay connected by attending the Novitas Solutions Post Claim Submission Workshop series. This six-part webinar series provides an overview of the options available for claim corrections,

redetermination requests, overpayment process and reviewing the remittance advice codes. This workshop is a three-day event offering numerous classes, during multiple sessions, dedicated to providing you with the knowledge necessary to be a successful Medicare provider. CEUs are available for successful webinar participation.

- Tuesday, August 10, 2021, at 10:00 AM EST “Part A Options for Claim Corrections”
- Tuesday, August 10, 2021, at 2:00 PM EST “Journey Through the Part A Appeal Process”
- Wednesday, August 11, 2021, at 10:00 AM EST “Part B Options for Claim Corrections”
- Wednesday, August 11, 2021, at 2:00 PM EST “Journey Through the Part B Appeal Process”
- Thursday, August 12, 2021, at 10:00 AM EST “Understanding Claim Processing Remittance Advice Codes”
- Thursday, August 12, 2021, at 2:00 PM EST “Journey Through the Overpayment Process”

Register for this event or check out our full listing of upcoming Workshop events by visiting our Event Calendar.

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Part A Open Issues Log

The Centers for Medicare & Medicaid Services (CMS) has been made aware of an issue with cost sharing applying on Coronavirus (COVID-19) vaccine and monoclonal antibodies claims with Condition Codes (CC) MA and 78 when Healthcare Common Procedure Coding System (HCPCS) codes 0001A, 0002A, 0011A, 0012A, 0031A, M0239, M0243, M0244, M0245 and M0246 are present on type of bill (TOB) 12X or 13X. Coinsurance or deductible should not be applied to these HCPCS codes. Any claims incorrectly processed prior to the hold location being established will be identified and automatically reprocessed after the correction is installed in October. No provider action is needed.

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July 26, 2021

Qualified Independent Contractor (QIC) Appeals Demonstration July 2021 Newsletter

C2C Innovative Solutions has added their July 2021 Newsletter to the Part A East Appeals Demonstration webpage. Please take time to review the Part A East Appeals Demonstration Article for answers to any questions you may have regarding the telephone demonstration.

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The comment period is now closed for the following Proposed Local Coverage Determinations. Comments received will be reviewed by our Contractor Medical Directors. The Response to Comments Article and finalized Billing and Coding Article will be related to the final LCD when it is posted for notice.

- Epidural Procedures for Pain Management (DL36920)
- Pharmacogenomics Testing (DL39063)
- Platelet Rich Plasma (DL39068)

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July 22, 2021

COVID-19: EUA for Tocilizumab Monoclonal Antibody Product

MLN Connects newsletter for Thursday, July 22, 2021

View this edition as a: Webpage | PDF

News

- COVID-19: EUA for Tocilizumab Monoclonal Antibody Product
- Medicare Ground Ambulance Data Collection System FAQs
- Wound Debridement: Comparative Billing Report in July
- 3 Ways to Protect Your Medicare Enrollment Information
- Americans with Disabilities Act: 31st Anniversary
- Viral Hepatitis: Medicare Covers Preventive Services
- **Compliance**
- Polysomnography Services: Bill Correctly

Claims, Pricers, & Codes

- ICD-10-CM Diagnosis Code Files for FY 2022

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2021
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- October 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 27.3, Effective October 1, 2021
- Section 50 in Chapter 30 of Publication (Pub.) 100-04 Manual Updates
- National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy — Revised

Publications

- Critical Access Hospital — Revised
- Medicare Advance Written Notices of Noncoverage — Revised
- Rural Health Clinic — Revised

Multimedia

- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training — Revised

.

Addition of Tocilizumab Monoclonal Antibody (mAb) Product

On June 24, 2021, the FDA released an Emergency Use Authorization (EUA) for tocilizumab, a COVID-19 mAb product. CMS created new HCPCS codes Q0249, M0249, and M0250, effective June 24, 2021, for tocilizumab and its administration in the inpatient setting (type of bill 12X). Please carefully review information added to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- 2021 COVID-19 monoclonal antibodies reimbursement
- 2021 COVID-19 monoclonal antibodies administration (mAb) for centralized billers, Indian Health Services, and Veterans Affairs

.

July 21, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12177 - National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy - This CR Rescinds and Fully Replaces CR 11783

  CMS revised the article to reflect a revised change request that added CPT code C9076 (Breyanzi). You'll find the substantive content update in dark red font on page 3. CMS also revised the implementation date, the CR release date, transmittal number, and the web address of the transmittal. All other information is the same.

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Top inquiries FAQs for DE, DC, MD, NJ, & PA

The June 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the general information category. Please take time to review these and other FAQs for answers to your questions.

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July 19, 2021

Special Edition – Monday, July 19, 2021

CMS Proposes Rule to Increase Price Transparency, Access to Care, Safety & Health Equity

CMS is proposing actions to address the health equity gap, ensure consumers have the information they need to make fully informed decisions regarding their health care, improve emergency care access in rural communities, and use lessons learned from the COVID-19 pandemic to inform patient care and quality measurements.

In accordance with President Biden's Competition Executive Order, CMS is further strengthening its efforts to increase price transparency, holding hospitals accountable and ensuring consumers have the information they need to make fully informed decisions regarding their health care.

"As President Biden made clear in his executive order promoting competition, a key to price fairness is price transparency," said HHS Secretary Xavier Becerra. "No medical entity should be able to throttle competition at the expense of patients. I have fought anti-competitive practices before, and

strongly believe health care must be in reach for everyone. With today's proposed rule, we are simply showing hospitals through stiffer penalties: concealing the costs of services and procedures will not be tolerated by this Administration."

"CMS is committed to addressing significant and persistent inequities in health outcomes in the United States and today's proposed rule helps us achieve that by improving data collection to better measure and analyze disparities across programs and policies," said CMS Administrator Chiquita Brooks-LaSure. "We are committed to finding opportunities to meet the health needs of patients and consumers where they are, whether it's by expanding access to onsite care in their communities, ensuring they have access to clear information about health care costs, or enhancing patient safety."

The proposed rule includes the following actions:

Price Transparency:

Hospital price transparency helps Americans know what a hospital charges for the items and services they provide. CMS takes seriously concerns it has heard from consumers that hospitals are not making clear, accessible pricing information available online, as they have been required to do since January 1, 2021.

CMS proposes to increase the penalty for some hospitals that do not comply with Hospital Price Transparency final rule. Specifically, CMS is proposing to set a minimum civil monetary penalty of $300/day that would apply to smaller hospitals with a bed count of 30 or fewer and apply a penalty of $10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of $5,500. Under this proposed approach, for a full calendar year of noncompliance, the minimum total penalty amount would be $109,500 per hospital, and the maximum total penalty amount would be $2,007,500 per hospital.

Based on information that hospitals have made public this year, there is wide variation in prices – even within the same hospital or the same system, depending on what each insurance plan has negotiated with that hospital. CMS is committed to ensuring consumers have the information they need to make fully informed decisions regarding their health care, since health care prices can cause significant financial burdens for consumers.

Health Equity:

CMS is seeking input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable. This includes soliciting comments on potential collection of data and analysis and reporting of quality measure results by a variety of demographic data points including, but not limited to, race, Medicare/Medicaid dual eligible status, disability status, LGBTQ+, and socioeconomic status.

Access to Emergency Care in Rural Areas:

Since 2010, 138 rural hospitals have closed – disproportionately within communities with a higher proportion of people of color and communities with higher poverty rates. Rural communities experience shorter life expectancy, higher mortality, and have fewer local providers, leading to worse health outcomes than in other communities.

Rural hospital closures deprive people living in rural areas of crucial services, including access to emergency care. To address these concerns, Congress enacted Section 125 of the Consolidated Appropriations Act of 2021 (CAA), which establishes a new provider type for Rural Emergency Hospitals (REHs). REHs will be required to furnish emergency department services and observation care and may provide other outpatient medical and health services as specified by the Secretary through rulemaking. In this proposed rule, CMS is requesting information to inform the development of requirements that would apply to REHs. This new provider designation will apply to items and services furnished on or after January 1, 2023.

CMS is seeking feedback on a wide-range of issues to help inform policy proposals for the CY 2023 rulemaking cycle, including feedback on the potential services to be provided by REHs; health and safety standards and quality measures to be established for REHs; and payment provisions for this provider type.

COVID-19 Lessons:

To incorporate lessons learned from the COVID-19 pandemic, CMS is seeking comment on the extent to which hospitals are using flexibilities offered during the COVID-19 public health emergency to provide mental health services remotely and whether CMS should consider changes to account for shifting practice patterns. In addition, CMS is proposing changes to measure how many of our nation's front-line healthcare workers in hospital outpatient departments and Ambulatory Surgical Centers (ASCs) are vaccinated against COVID-19 and to make this information available to the public so consumers know how many workers are vaccinated in different health care settings.

Improving Patient Experience and Outcomes:

The Radiation Oncology (RO) Model aims to improve the quality of care for cancer patients receiving radiotherapy and move toward a simplified and predictable payment system. The RO Model tests whether prospective, site neutral, modality agnostic, episode-based payments to physician group practices, hospital outpatient departments, and freestanding radiation therapy centers for radiotherapy episodes of care reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

CMS is proposing changes to the RO Model, which aim to improve the experience of patients receiving radiation treatment, while incorporating evidence-based best practices to help providers improve patient outcomes.

Patient Safety:

CMS is increasing Medicare beneficiary safety by reversing changes made for 2021 regarding the care setting for which Medicare will pay for surgical procedures that may pose risk to patients.

Specifically, the agency is proposing to halt the phased elimination of the Inpatient-Only (IPO) list—procedures that Medicare will only make payment for when provided in the inpatient setting. There are some services designated as inpatient only that, given their clinical intensity, would not be expected to be performed in the outpatient setting. CMS adopted a policy for 2021 to eliminate this list over a phased period and removed musculoskeletal procedures from the list in 2021.

This change happened without individually evaluating whether the procedures met the long-standing criteria previously used to determine if a procedure could be safely removed. Some of the musculoskeletal services removed includes services like limb amputations and invasive spinal procedures.

CMS reviewed each procedure code of services that were removed and found none met criteria for removal, with insufficient supporting evidence that the service can be safely performed on the Medicare population in the outpatient setting.

CMS is proposing to add them back on to the list in 2022, and is seeking comment on whether to maintain the longer-term objective of eliminating the IPO list, maintaining the IPO list, or maintaining the list but continue to streamline the list of services. The latter would continue systematic scaling of the list back to ensure inpatient-only designations are consistent with current standards of practice.

CMS is also proposing to reinstate the patient safety criteria it uses to evaluate whether a procedure should be payable in the ASC setting that were removed in 2021. CMS is proposing to adopt a nomination process whereby the publicly can formally nominate procedures it believes are safe to perform for the Medicare population in the ASC setting.

More Information:

- Proposed rule
- Fact sheet

Hospital outpatient department (OPD) prior authorization (PA) exemption process

The exemption process article has been revised to include clarification of the process and to add frequently asked questions developed by the A/B Medicare Administrative Contractor Prior Authorization Collaboration Workgroup. Please ensure you carefully review this information.

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As a reminder, the comment period for the following Proposed Local Coverage Determinations (LCDs) is currently open and will close on July 24, 2021. We encourage you to submit your comments as soon as possible.

- Epidural Procedures for Pain Management (DL36920)
- Pharmacogenomics Testing (DL39063)
- Platelet Rich Plasma (DL39068)
  - Submit Comments

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12384 - Changes to the Laboratory National Coverage Determination [NCD] Edit Software for October 2021

  Make sure that your billing staff is aware of these changes.

Revised:

- MM12254 - National Coverage Determination (NCD) Removal

  CMS revised this article to reflect a revised change request (CR) 12254. The CR revision didn't impact the substance of the article. the CR release date, transmittal number, and the web address has been revised. All other information is the same.

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July 15, 2021

Cognitive Assessment: Resources for Providers

MLN Connects newsletter for Thursday, July 15, 2021

View this edition as a: Webpage | PDF

News

- Cognitive Assessment: Resources for Providers
- CMS Opens National Coverage Determination Analysis on Treatment for Alzheimer's Disease
- PEPPERs for HHAs and PHPs

Compliance

- IRF Services: Follow Medicare Billing Requirements

Claims, Pricers, & Codes

- ICD-10-CM Codes: FY 2022

Multimedia

- Medicare Billing: Form CMS-1500 and 837 Professional Web-Based Training — Revised
- Medicare Billing: Form CMS-1450 and 837 Institutional Web-Based Training — Revised

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12242 - Section 50 in Chapter 30 of Publication (Pub.) 100-04 Manual Updates

  This Article reorganizes, makes edits, and other changes to the advance beneficiary notice of non-coverage section in the Medicare Claims Processing Manual, Chapter 30, Section 50. The revised chapter is part of change request 12242. Make sure your billing staff is aware of these changes.

- MM12340 - Quarterly Update to the National Correct Coding Initiative [NCCI] Procedure-to-Procedure [PTP] Edits, Version 27.3, Effective October 1, 2021

  Change request 12340 provides the quarterly update to the NCCI PTP edits. Please be sure your billing staff is aware of the updates.

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July 14, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12302 - Implement Operating Rules – Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule – Update from Council for Affordable Quality Health Care (CAQH) CORE

  This Article tells you about Medicare system updates based on the CORE 360 Uniform use of CARC, RARC, and CAGC rule publications. Please make sure your billing staff is aware of these updates.

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July 13, 2021

Special Edition – Tuesday, July 13, 2021

CMS Proposes Physician Payment Rule to Improve Health Equity, Patient Access

CMS is proposing changes to address the widening gap in health equity highlighted by the COVID-19 Public Health Emergency (PHE) and to expand patient access to comprehensive care, especially in underserved populations. In CMS's annual Physician Fee Schedule (PFS) proposed rule, the agency

is recommending steps that continue the Biden-Harris Administration's commitment to strengthen and build upon Medicare by promoting health equity; expanding access to services furnished via telehealth and other telecommunications technologies for behavioral health care; enhancing diabetes prevention programs; and further improving CMS's quality programs to ensure quality care for Medicare beneficiaries and to create equal opportunities for physicians in both small and large clinical practices.

"Over the past year, the public health emergency has highlighted the disparities in the U.S. health care system, while at the same time demonstrating the positive impact of innovative policies to reduce these disparities," said CMS Administrator Chiquita Brooks-LaSure. "CMS aims to take the lessons learned during this time and move forward toward a system where no patient is left out and everyone has access to comprehensive quality health services."

CMS Seeks Feedback on Health Equity Data Collection:

CMS is committed to addressing the significant and persistent inequities in health outcomes in the U.S. by improving data collection to better measure and analyze disparities across programs and policies. In the proposed PFS rule, CMS is soliciting feedback on the collection of data, and on how the agency can advance health equity for people with Medicare (while protecting individual privacy), potentially through the creation of confidential reports that allow providers to look at patient impact through a variety of data points - including, but not limited to, LGBTQ+, race and ethnicity, dual-eligible beneficiaries, disability, and rural populations. Access to these data may enable a more comprehensive assessment of health equity and support initiatives to close the equity gap. In addition, hospitals and health care providers may be able to use the results from the disparity analyses to identify and develop strategies to promote health equity.

Expanding Telehealth and Other Telecommunications Technologies for Behavioral and Mental Health Care:

In the proposed rule, CMS is reinforcing its commitment to expanding access to behavioral health care and reducing barriers to treatment. CMS is proposing to implement recently enacted legislation that removes certain statutory restrictions to allow patients in any geographic location and in their homes access to telehealth services for diagnosis, evaluation, and treatment of mental health disorders. Along with this change, CMS is proposing to expand access to mental health services for rural and vulnerable populations by allowing, for the first time, Medicare to pay for mental health visits when they are provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to include visits furnished through interactive telecommunications technology. This proposal would expand access to Medicare beneficiaries, especially those living in rural and other underserved areas.

To further expand access to care, CMS is proposing to allow payment to eligible practitioners when they provide certain mental and behavioral health services to patients via audio-only telephone calls from their homes when certain conditions are met. This includes counseling and therapy services provided through Opioid Treatment Programs. These changes would be particularly helpful for those in areas with poor broadband infrastructure and among people with Medicare who are not capable of, or do not consent to the use of, devices that permit a two-way, audio/video interaction for their health care visits.

"The COVID-19 pandemic has put enormous strain on families and individuals, making access to behavioral health services more crucial than ever," said Brooks-LaSure. "The changes we are proposing will enhance the availability of telehealth and similar options for behavioral health care to those in need, especially in traditionally underserved communities."

Boosting Participation in the Medicare Diabetes Prevention Program:

CMS is proposing a change to expand the reach of the Medicare Diabetes Prevention Program (MDPP) expanded model. MDPP was developed to help people with Medicare with prediabetes from

developing type 2 diabetes. The expanded model is implemented at the local level by MDPP suppliers: organizations who provide structured, coach-led sessions in community and health care settings using a Centers for Disease Control and Prevention approved curriculum to provide training in dietary change, increased physical activity, and weight loss strategies.

Approximately one in three American adults (over 88 million) have prediabetes, and more than eight in 10 do not even know they have it. Many are at risk for developing type 2 diabetes within five years. Several underserved communities * including African Americans, Hispanic/Latino Americans, American Indians, Pacific Islanders, and some Asian Americans * are at particularly high risk for type 2 diabetes.

During the COVID-19 PHE, CMS has been waiving the Medicare enrollment fee for new MDPP suppliers and has observed increased supplier enrollment. CMS is proposing to waive this fee for all organizations that submit an application to enroll in Medicare as an MDPP supplier on or after January 1, 2022. Additionally, CMS is proposing changes to make delivery of MDPP services more sustainable and to improve patient access by making it easier for local suppliers to participate and reach their communities by proposing to shorten the MDPP services period to one year instead of two years. This proposal would reduce the administrative burden and costs to suppliers. CMS is also proposing to restructure payments so MDPP suppliers receive larger payments for participants who reach milestones for attendance and weight loss.

Advancing the Quality Payment Program:

CMS is taking further steps to improve the quality of care for people with Medicare through changes to the agency's Quality Payment Program (QPP), a value-based payment program that promotes the delivery of high-value care by clinicians through a combination of financial incentives and disincentives.

CMS is proposing to require clinicians to meet a higher performance threshold to be eligible for incentives. This new threshold aligns with the requirements established for the QPP's Merit-based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act of 2015.

To ensure more meaningful participation for clinicians and improved outcomes for patients, CMS is moving forward with the next evolution of QPP and proposing its first seven MIPS Value Pathways (MVPs) - subsets of connected and complementary measures and activities, established through rulemaking, used to meet MIPS reporting requirements. The initial set of proposed MVP clinical areas include: rheumatology, stroke care and prevention, heart disease, chronic disease management, lower extremity joint repair (e.g., knee replacement), emergency medicine, and anesthesia. MVPs will more effectively measure and compare performance across clinician types and provide clinicians more meaningful feedback. CMS is also proposing to revise the current eligible clinician definition to include clinical social workers and certified nurse-midwives, as these professionals are often on the front lines serving communities with acute health care needs.

Additionally, CMS is proposing to implement a recent statutory change that authorizes Medicare to make direct Medicare payments to Physician Assistants (PAs) for professional services they furnish under Part B. Beginning January 1, 2022, for the first time, PAs would be able to bill Medicare directly, thus expanding access to care and reducing the administrative burden that currently requires a PA's employer or independent contractor to bill Medicare for a PA's professional services.

Updating Vaccine Payment Rates:

The COVID-19 pandemic has highlighted the importance of access to vaccines. The Biden-Harris Administration has taken steps to increase American's access to COVID-19 vaccinations and is committed to meeting people where they are and making it as easy as possible for all Americans to get vaccinated. That commitment extends to other, more common vaccinations.

Medicare payments to physicians and mass immunizers for administering flu, pneumonia, and hepatitis B vaccines have decreased by around 30% over the last seven years. In the PFS proposed rule, CMS is requesting feedback to help update payment rates for administration of preventive vaccines covered under Part B. In addition to seeking information on the types of health care providers who furnish vaccines and their associated costs, CMS is looking for feedback on its recently adopted payment add-on of $35 for immunizers who vaccinate certain underserved patients in the patient's home. CMS is also seeking comments on the treatment of COVID-19 monoclonal antibody products as vaccines, and whether those products should be treated like other monoclonal antibody products after the COVID-19 PHE.

Proposal to Phase Out Coinsurance for Colorectal Screening Additional Services:

CMS is also proposing to implement a recent statutory change to provide a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services (e.g., removal of polyps). Currently, the addition of any procedure beyond the planned colorectal screening (for which there is no coinsurance) results in a patient having to pay coinsurance.

Under the proposed change, beginning January 1, 2022, the amount of coinsurance patients will pay for such additional services would be reduced over time, so that by January 1, 2030, it would be down to zero.

More Information:

- Proposed rule
- Medicare PFS Proposed Rule fact sheet
- QPP fact sheet
- MDPP Expanded Model fact sheet

July 12, 2021

The following LCDs and related billing and coding articles, as applicable, are now effective:

- Allergen Immunotherapy (L36240)
  - Billing and Coding: Allergen Immunotherapy (A56538)
- Allergy Testing (L36241)
  - Billing and Coding: Allergy Testing (A56558)
- Cataract Extraction (including Complex Cataract Surgery (L35091)
  - Billing and Coding: Cataract Extraction (including Complex Cataract Surgery) (A56615)
- Cosmetic and Reconstructive Surgery (L35090)
  - Billing and Coding: Cosmetic and Reconstructive Surgery (A56587)
- Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (L35130)
- Respiratory Pathogen Panel Testing (L38916)
  - Billing and Coding: Respiratory Pathogen Panel Testing (A58575)

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July 9, 2021

LCD Search Enhancement

We are pleased to announce that a search enhancement has been added to the Local Coverage Determination (LCD) and Article Indexes (Active, Proposed and Retired). A new search box has been added above each LCD/Article Index table. This convenient tool will look for a direct word match within the title, for the LCD or Article number, or for a CPT/HCPCS code listed in the index. You can find our new search tool on the website here. Our Medical Policy Search Tool continues to be available for more advanced searches of LCDs and Articles.

The following LCDs have been retired:

- Co-Management of Surgical Procedures (L34862)
- Prostate Mapping Biopsy (L35009)

The following billing and coding articles have been revised:

- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Billing and Coding: Diagnostic Colonoscopy (A58428)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)

The following Billing and Coding articles have been retired:

- Billing and Coding: Co-Management of Surgical Procedures (A52989)
- Billing and Coding: Prostate Mapping Biopsy (A56966)

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July 8, 2021

COVID-19 Accelerated and Advance Payments: Updated FAQs

MLN Connects newsletter for Thursday, July 8, 2021

View this edition as a: Webpage | PDF

News

- COVID-19 Accelerated and Advance Payments: Updated FAQs
- COVID-19 Snapshot: Impact on the Medicare Population

Compliance

- Hospice Aide Services: Enhancing RN Supervision

MLN Matters® Articles

- July Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- October Quarterly Update to 2021 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement — Revised

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Frequently Asked Questions (FAQs)

Have questions and not sure where to turn? Check out our FAQs for answers to your questions.

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July 6, 2021

June 2021 claim submission errors

The June 2021 Part A claim submission errors and resolutions for jurisdiction L are now available. Please take time to review these errors and avoid them on future claims.

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July 2, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12345 - July Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  This article tells you about the changes to the DMEPOS fee schedules that Medicare updates on a quarterly basis, when necessary. Make sure your billing staff is aware of these changes.

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#StayConnected Workshop Series: New Provider Roadmap

Stay connected with Medicare updates and requirements by attending the Novitas Solutions New Provider Roadmap Workshop Series. Novitas Solutions is dedicated to providing you with the knowledge necessary to be a successful Medicare provider. We are hosting a free webinar series that highlights important information for new providers and support staff. This six-part webinar series provides an overview of the Medicare program, basic billing instructions, an overview of the appeal process and a tour of the resources available on the Novitas Solutions and Centers for Medicare and Medicaid Services (CMS) websites. Feel free to attend all classes in the series or an individual class based on your schedule and area of interest.

- Monday, July 19, 2021, at 10:00 AM EST “Exploring the Novitas and Centers for Medicare & Medicaid Services (CMS) Websites”
- Tuesday, July 20, 2021, at 10:00 AM EST “Understanding the Basics of the Medicare Program”
- Wednesday, July 21, 2021, at 10:00 AM EST “Introduction to Part A Medicare Billing”
- Wednesday, July 21, 2021, at 12:30 PM EST “Introduction to Part B Medicare Billing”
- Thursday, July 22, 2021, at 10:00 AM EST “Introduction to the Part A Medicare Appeal and Claim Correction Process”
- Thursday, July 22, 2021, at 12:00 PM EST “Introduction to the Part B Medicare Appeal and Claim Correction Process”

Register for this event or check out our full listing of upcoming Workshop events by visiting our Event Calendar.

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July 1, 2021

Special Edition – Thursday, July 1, 2021

CMS Proposes Changes to Reduce Health Care Disparities Among Patients with Chronic Kidney Disease and End-Stage Renal Disease

Proposed changes mark Innovation Center's first direct effort to close health equity gaps

CMS proposed actions that aim to close health equity gaps by providing Medicare patients battling End-Stage Renal Disease (ESRD) with greater access to care, through the ESRD Prospective Payment System (PPS) annual rulemaking. This proposed rule would update ESRD PPS payment rates, make changes to the ESRD Quality Incentive Program (QIP), and modify the ESRD Treatment Choices (ETC) Model. The proposed changes to the ETC Model policies would aim to encourage dialysis providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with lower socioeconomic status, making the model the agency's first CMS Innovation Center model to directly address health equity.

According to CMS Office of Minority Health studies on racial, ethnic, and socioeconomic factors, disadvantaged Medicare patients suffer from ESRD at higher rates. They are also more likely to experience higher hospital readmissions and costs, as well as receive in-center hemodialysis because their kidneys are no longer able to perform their function. Studies also indicate non-white ESRD patients are less likely to receive pre-ESRD kidney care, become waitlisted for a transplant or receive a kidney transplant.

"Health equity is at the center of our work here at CMS," said CMS Administrator Chiquita Brooks-LaSure. "Today's proposed rule is grounded in measures to ensure people with Medicare who suffer from chronic kidney disease have easy access to quality care and convenient treatment options. When CMS encourages dialysis providers to offer more options for Medicare patients to receive dialysis treatments, it can be life changing and lead to better health outcomes, greater autonomy and better quality of life for patients with kidney disease."

The proposed changes to the ETC Model build on the current model by proposing to test a new health care approach that rewards ESRD facilities and managing clinicians participating in the model for achieving significant improvement in the rates of home dialysis and kidney transplants for lower income beneficiaries. If finalized, these changes would take effect Jan. 1, 2022.

Consistent with President Biden's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, CMS is addressing health inequities and improving patient outcomes in the U.S. through improved data collection for better measurement and analysis of disparities across programs and policies. CMS is soliciting feedback in this proposed rule on opportunities to collect and leverage diverse sets of data. This includes race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+ and socioeconomic status. It also includes new methodological approaches to advance equity through the ESRD Quality Incentive Program (ESRD QIP).

The rule includes proposals under the ESRD QIP to address the circumstances of the COVID-19 Public Health Emergency (PHE), such as not scoring or reducing payment to any facility in 2022 based on data from 2020. Regarding COVID-19 vaccination measures, the proposed rule requests stakeholder feedback on the feasibility of incorporating COVID-19 Healthcare Provider and Patient Vaccination measures in the ESRD QIP measure set. Currently, nearly 90% of all dialysis facilities are reporting vaccination data performance to the Center for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). CMS is evaluating options for publicly reporting the data on official CMS datasets that compare the quality of care provided in Medicare-certified dialysis facilities nationwide.

CMS' proposed rule includes several requests for information for the agency to consider as part of its goal to increase access to dialysis treatments at home. Currently, Medicare will only pay for dialysis at an ESRD facility for patients with Acute Kidney Injury (AKI). CMS is soliciting comments regarding

potentially modifying the site of renal dialysis services for patients with AKI and payment for AKI in the home setting.

More Information:

- Proposed rule
- Fact Sheet

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Quality Payment Program: 2021 APM Incentive Payments

MLN Connects newsletter for Thursday, July 1, 2021

View this edition as a: Webpage | PDF

News

- Quality Payment Program: 2021 APM Incentive Payments

Compliance

- Inhalant Drugs: Bill Correctly

Events

- Organ Procurement Organization Conditions for Coverage Webinar — July 7

MLN Matters® Articles

- July 2021 Update of the Ambulatory Surgical Center [ASC] Payment System

Publications

- Medicare Preventive Services — Revised

Multimedia

- LTCH QRP: Achieving a Full APU — May 27 Webinar Materials

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Appeals Corner Newsletter June 2021

Novitas is partnering with C2C Solutions to encourage participation in the Qualified Independent Contractor (QIC) Part A East Telephone Discussion Demonstration. We have created an appeals newsletter to offer educational assistance to prevent future appeal submissions as well as suggested tips on how to avoid unfavorable appeal decisions.

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July 30, 2021

Use Novitas resources during July holiday closures

Novitas wants to remind our provider community about upcoming limited availability. There will be Common Working File (CWF) “dark” days from Friday, July 2, 2021, through Sunday, July 4, 2021, due to the July release upgrades. Also, our offices are closed Monday, July 5, 2021, for the holiday.

We will reopen Tuesday, July 6, 2021; however, we typically experience higher call volumes the day after “dark” days and holidays. We recommend contacting Novitas prior to the “dark” day and holiday or to use other resources provided by Novitas for your day-to-day operations.

Novitas resources and tools

Novitas provides many resources for our provider community that they can access online and telephonically for patient eligibility and claim status. We recommend you use these resources before, during, and after the holiday to avoid longer hold times from higher call volumes.

You can use the free internet portal, Novitasphere, for patient eligibility, claim status and many other functions.

Please view the Novitasphere webpage and the user guide for more information:

- Part A (JH) (JL)
- Part B (JH) (JL)

You can also use the Interactive Voice Response (IVR) system for patient eligibility, claim status, and many other functions.

Please view the IVR webpage and user guide for more information:

- JH telephone number 1-855-252-8782:
  - Part A
  - Part B
- JL telephone number 1-877-235-8073:
  - Part A
  - Part B

Note: The IVR will have limited availability during the “dark” days.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12272 - October Quarterly Update to 2021 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

  CMS revised this article due to a revised change request (CR). The CR revision adds codes J7200, J7204 and Q5123 to the list of codes we exclude from SNF CB. You'll find substantive content updates in dark red font on pages 2 and 3, although the initial article already listed code J7200. All other information is the same.

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June 28, 2021

Special Edition – Monday, June 28, 2021

CMS to Improve Home Health Services for Older Adults and People with Disabilities

Proposed rule would accelerate shift from volume-based incentives to quality-based incentives

CMS issued a proposed rule that accelerates the shift from paying for home health services based on volume, to a system that incentivizes value and quality. The rule also seeks feedback on ways to attain health equity for all patients through policy solutions, including enhancing reports on Medicare/Medicaid dual eligible, disability status, people who are LGBTQ+; religious minorities;

people who live in rural areas; and people otherwise adversely affected by persistent poverty or inequality.

The CY 2022 Home Health Prospective Payment System (HH PPS) proposed rule addresses challenges facing Americans with Medicare who receive health care at home. The proposed rule also outlines nationwide expansion of the Home Health Value-Based Purchasing (HHVBP) Model to incentivize quality of care improvements without denying or limiting coverage or provision of Medicare benefits for all Medicare consumers, and updates to payment rates and policies under the HH PPS.

“Homebound Medicare patients face a unique set of challenges and barriers to getting the care they need,” said CMS Administrator Chiquita Brooks-LaSure. “Today’s announcement is a reaffirmation of our commitment to these older adults and people with disabilities who are counting on Medicare for the health care they need. This proposed rule would streamline service delivery and value quality over quantity – at a time when Americans need it most.”

The CMS Innovation Center (CMMI) developed the HHVBP Model, which began January 1, 2016, to determine whether payment incentives for providing better quality of care with greater efficiency would improve the quality and delivery of home health care services to people with Medicare. The HHVBP Model’s current participants comprise all Medicare-certified home health agencies (HHAs), providing services across nine randomly selected states. The Third Annual Evaluation Report of the participants’ performance from 2016-2018 showed an average 4.6% improvement in HHAs’ quality scores and an average annual savings of $141 million to Medicare.

CMS announced January 8, 2021 that the HHVBP model met the statutory requirements for expansion. CMS is proposing to expand the HHVBP Model nationwide effective January 1, 2022. By expanding the HHVBP Model, CMS seeks to improve the beneficiary experience by providing incentives for HHAs to provide better quality of care with greater efficiency.

Additionally, the proposed rule would improve the Home Health Quality Reporting Program by removing or replacing certain quality measures to reduce burden and increase focus on patient outcomes. CMS would also begin collecting data on two measures promoting coordination of care in the Home Health Quality Reporting Program effective January 1, 2023 as well as measures under Long Term Care Hospital and Inpatient Rehabilitation Quality Reporting Programs effective October 1, 2022. This would position the agency with data to monitor outcomes across diverse populations and support the recent Executive Order 13985 of January 20, 2021, entitled “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.”

More Information:

- Proposed rule
- Fact Sheet

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As a reminder, the comment period for the following Proposed Local Coverage Determinations (LCDs) is currently open and will close on July 24, 2021. We encourage you to submit your comments as soon as possible.

- Epidural Procedures for Pain Management (DL36920)
- Pharmacogenomics Testing (DL39063)
- Platelet Rich Plasma (DL39068)

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Attention providers: Continue billing for HCPCS code C9065

HCPCS code C9065 was established as a temporary code to report the drug Romidepsin in the outpatient prospective payment system (OPPS) until a permanent J-code was established. HCPC C9065 was set to be terminated on June 30; however, a permanent J-code has not yet been established. For services on or after July 1, please continue using HCPCS code C9065 on your OPPS claims to report the drug Romidepsin.

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June 25, 2021

Upcoming direct data entry (DDE) screen changes

Effective July 1, the Fiscal Intermediary Shared System (FISS) maintainer is adding the following in DDE:

- Option 'F1' under the Inquiry Menu (MAP1702) for the new OUD Demo 99 screen.
- OCE flag '10' to claim page 2 (MAP171A).

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June 24, 2021

2019 Quality Payment Program: Performance Information on Care Compare

MLN Connects newsletter for Thursday, June 24, 2021

View this edition as a: Webpage | PDF

News

- 2019 Quality Payment Program: Performance Information on Care Compare
- Orthoses Referring Providers: Comparative Billing Report in June

Compliance

- SNF 3-Day Rule: Bill Correctly

MLN Matters® Articles

- July 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.2
- July 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- National Coverage Determination (NCD) 20.9.1 Ventricular Assist Devices (VADs)
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications

- Medicare Billing for Cardiac Device Credits — Revised

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Prior authorization: Vein ablation and related services

The A/B Medicare Administrative Contractor Prior Authorization Collaboration Workgroup developed this new article on vein ablation and related services. This new article has been added to the Prior authorization (PA) program for certain hospital outpatient department (OPD) services webpage. Please ensure you carefully review this information.

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June 23, 2021

Limited Systems Availability - Friday, July 2, 2021 through Sunday, July 4, 2021

There will be Common Working File (CWF) "Dark" days from Friday, July 2, 2021, through Sunday, July 4, 2021 due to the July 2021 release upgrades. The Interactive Voice Response (IVR) will have limited availability. Additionally, the Customer Contact Center will be closed on Monday, July 5, 2021, but CWF and the IVR will be available.

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June 22, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12289 - Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2021 Update

  Change request 12289 revision deleted code J9314 from the table of new HCPCS codes for July 1, 2021, and after. CMS deleted J9314 from the table on page 4 of this article. The CR release date, transmittal number, and web address has also been revised. All other information is the same.

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June 21, 2021

Top inquiries FAQs for DE, DC, MD, NJ, & PA

The May 2021 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the general information category. Please take time to review these and other FAQs for answers to your questions.

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June 17, 2021

COVID-19: EUAs for Monoclonal Antibody Products

MLN Connects newsletter for Thursday, June 17, 2021

View this edition as a: Webpage | PDF

News

- COVID-19: EUA for Sotrovimab Monoclonal Antibody Product
- COVID-19: EUA for Regeneron Monoclonal Antibody Product Casirivimab & Imdevimab
- Men’s Health: Medicare Covers Preventive Services

Compliance

- Hospice Care: Safeguards for Medicare Patients

Events

- HCPCS Public Meeting — Begins July 7

MLN Matters® Articles

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Codes 0240U, 0241U, and 87637
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2021
- Quarterly Update to Home Health (HH) Grouper
- July 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised

Publications

- Medicare Mental Health — Revised
- Medicare Secondary Payer — Revised
- Skilled Nursing Facility 3-Day Rule Billing — Revised

Multimedia

- World of Medicare Web-Based Training — Revised

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Additional Updates to the COVID-19 Vaccine and Monoclonal Antibody (mAb) Infusions

CMS has created a new HCPCS code Q0244 effective June 3, 2021, and revised the descriptors for HCPCS code M0243 and M0244 for mAb infusions.

CMS added the fees for the recently added HCPCS codes Q0247, M0247, and M0248 to the CMS COVID-19 Vaccines and Monoclonal Antibodies webpage.

Information has been added to the CMS Medicare COVID-19 Vaccine Shot Payment webpage relating to the additional in-home payment for administering the COVID-19 vaccine M0201.

As a result of these changes, updates have been made to the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibody billing for Part B providers
- 2021 COVID-19 monoclonal antibodies reimbursement
- 2021 COVID-19 monoclonal antibodies administration (mAb) for centralized billers, Indian Health Services, and Veterans Affairs

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Modifier decision trees for hospice billing

This new article has been added to the Provider Specialty: Hospice. Please ensure you carefully review this information.

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June 16, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12171 - Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2021

  CMS revised this article due to a revised CR12171. The CR revision didn't affect the content of this article. CMS did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

- MM12254 - National Coverage Determination (NCD) Removal

  CMS revised this article to reflect a revised CR12254. The CR revision didn't impact the substance of the article. CMS did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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Enhance your knowledge on clinical trials

Medicare covers the routine costs of qualifying clinical trials as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. Visit our new clinical trials and devices webpage for more information

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12295 - July 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.2

  This article tells you about changes to the July 2021 version of the I/OCE instructions and specifications for the I/OCE that Medicare uses:

  - In the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, and all non-OPPS providers
  - For limited services when provided in an HH Agency (HHA) not under the HH PPS
  - For a hospice patient for the treatment of a non-terminal illness.

  Make sure your billing staffs are aware of these changes.

Revised:

- MM12285 - Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

  CMS revised this article due to a revised CR12885. The CR revision modified language in the policy section of the CR. CMS revised that language in the article using red font on page 3. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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June 15, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12290 - National Coverage Determination (NCD) 20.9.1 Ventricular Assist Devices (VADs)

This article tells you that, effective December 1, 2020, CMS covers VADs under certain criteria. CR 12290 revises the relevant sections of:

- Chapter 1, Part 1, Section 20.9 of the Medicare NCD Manual
- Chapter 32, Section 320 of the Medicare Claims Processing Manual

The CR transmittals contain the revised chapters as attachments. Be sure your billing staffs are aware of these changes.

- MM12316 - July 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  This article tells you about changes to and billing instructions for various payment policies CMS is implementing in the July 2021 OPPS update. The July 2021 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions in CR 12316. Be sure your billing staffs are aware of these updates.

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Part A Open Issues Log- Update to Sequestration issue

All claims have been reprocessed to remove the sequestration reduction.

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June 14, 2021

Claim submission errors update

We've noticed over the last few years that claim submission errors do not change much across each state within the jurisdiction. As a result, beginning with the June 2021 claim submission errors, we will post a claim submission error report for the jurisdiction, not state by state.

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June 11, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12318 - Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Codes 0240U, 0241U, and 87637

  This Article tells you of the addition of the QW modifier to certain CMS HCPCS codes (0240U, 0241U, and 87637).

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June 10, 2021

Cognitive Assessment: What's in the Written Care Plan?

MLN Connects newsletter for Thursday, June 10, 2021

View this edition as a: Webpage | PDF

News

- Cognitive Assessment: What's in the Written Care Plan?

- Hospital Outpatient Departments: Prior Authorization for Additional Services Begins July 1
- PEPPERs for Short-term Acute Care Hospitals

Compliance

- Importance of Proper Documentation: Provider Minute Video

Claims, Pricers, & Codes

- ICD-10-PCS Procedure Codes: FY 2022
- Average Sales Price Files: July 2021

Events

- Physician Fee Schedule: Improving Practice Expense Data & Methods Town Hall — June 16

MLN Matters® Articles

- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2021 Update — Revised

Publications

- Medicare Modernization of Payment Software
- Medicare Quarterly Provider Compliance Newsletter

Multimedia

- Medicare Shared Savings Program Webcast: Audio Recording & Transcript

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The following Proposed Local Coverage Determinations (LCDs) have been posted for comments. The comment period will end on July 24, 2021; however, you are encouraged to submit your comments as soon as possible.

- Epidural Procedures for Pain Management (DL36920)
- Pharmacogenomics Testing (DL39063)
- Platelet Rich Plasma (DL39068)

The following Draft Billing and Coding Articles are related to the above Proposed LCDs.

- Billing and Coding: Epidural Procedures for Pain Management (DA56681)
- Billing and Coding: Pharmacogenomics Testing (DA58801)
- Billing and Coding: Platelet Rich Plasma (DA58808)

The following LCD has been revised:

- Facet Joint Interventions for Pain Management (L34892)

The following Billing and Coding Articles have been revised:

- Billing and Coding: Botulinum Toxins (A58423)
- Billing and Coding: Diagnostic Colonoscopy (A58428)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)

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Online Registration Available for June 25, 2021, Open Meeting and Proposed LCDs Now Posted

Online registration for the June 25, 2021, Open Meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, June 23, 2021. **IMPORTANT: During this unprecedented time, our Open Meeting will be held via teleconference only.** The Novitas Solutions Proposed Local Coverage Determinations (LCDs) are now posted.

Open Meetings are to allow interested parties the opportunity to make presentations of information and offer comments related to new Proposed LCDs and/or the revised portion of a Proposed LCD that are in the 45-day open comment period. Interested parties may also request to attend as an observer. If you are interested in attending as a presenter or observer, please view our Proposed Local Coverage Determination Open Meetings page for specific guidelines and other helpful information.

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June 9, 2021

Special Edition – Wednesday, June 9, 2021

Biden Administration Continues Efforts to Increase Vaccinations by Bolstering Payments for At-Home COVID-19 Vaccinations for Medicare Beneficiaries

As part of President Biden's commitment to increasing access to vaccinations, CMS announced an additional payment amount for administering in-home COVID-19 vaccinations to Medicare beneficiaries who have difficulty leaving their homes or are otherwise hard-to-reach. This announcement further demonstrates continued efforts of the Biden-Harris Administration to meet people where they are and make it as easy as possible for all Americans to get vaccinated. There are approximately 1.6 million adults 65 or older who may have trouble accessing COVID-19 vaccinations because they have difficulty leaving home.

While many Medicare beneficiaries can receive a COVID-19 vaccine at a retail pharmacy, their physician's office, or a mass vaccination site, some beneficiaries have great difficulty leaving their homes or face a taxing effort getting around their communities easily to access vaccination in these settings. To better serve this group, Medicare is incentivizing providers and will pay an additional $35 per dose for COVID-19 vaccine administration in a beneficiary's home, increasing the total payment amount for at-home vaccination from approximately $40 to approximately $75 per vaccine dose. For a two-dose vaccine, this results in a total payment of approximately $150 for the administration of both doses, or approximately $70 more than the current rate.

"CMS is committed to meeting the unique needs of Medicare consumers and their communities – particularly those who are home bound or who have trouble getting to a vaccination site. That's why we're acting today to expand the availability of the COVID-19 vaccine to people with Medicare at home," said CMS Administrator Chiquita Brooks-Lasure. "We're committed to taking action wherever barriers exist and bringing the fight against the COVID-19 pandemic to the door of older adults and other individuals covered by Medicare who still need protection."

Delivering COVID-19 vaccination to access-challenged and hard-to-reach individuals poses some unique challenges, such as ensuring appropriate vaccine storage temperatures, handling, and administration. The CDC has outlined guidance to assist vaccinators in overcoming these challenges. This announcement now helps to address the financial burden associated with accommodating these complications.

The additional payment amount also accounts for the clinical time needed to monitor a beneficiary after the vaccine is administered, as well as the upfront costs associated with administering the vaccine safely and appropriately in a beneficiary's home. The payment rate for administering each dose of a COVID-19 vaccine, as well as the additional in-home payment amount, will be geographically adjusted based on where the service is furnished.

How to Find a COVID-19 Vaccine:

As this action demonstrates, a person's ability to leave their home should not be an obstacle to getting the COVID-19 vaccine. As states and the federal government continue to break down barriers – like where vaccines can be administered – resources for connecting communities to vaccination options remain key. Unvaccinated individuals and those looking to assist friends and family can:

1. Visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby
2. Text GETVAX (438829) for English or VACUNA (822862) for Spanish for near-instant access to details on three vaccine sites in the local area
3. Call the National COVID-19 Vaccination Assistance Hotline at 1-800-232-0233 (TTY: 1-888-720-7489) for assistance in English and Spanish

Coverage of COVID-19 Vaccines:

The federal government is providing the COVID-19 vaccine free of charge or with no cost-sharing for all people living in the United States. As a condition of receiving free COVID-19 vaccines from the federal government, vaccine providers cannot charge patients any amount for administering the vaccine.

Because no patient can be billed for COVID-19 vaccinations, CMS and its partners have provided a variety of information online for providers vaccinating all Americans regardless of their insurance status:

- Original Medicare and Medicare Advantage:Beneficiaries with Medicare pay nothing for COVID-19 vaccines or their administration, and there is no applicable copayment, coinsurance or deductible.
- Medicaid and the Children's Health Insurance Program (CHIP):State Medicaid and CHIP agencies must cover COVID-19 vaccine administration with no cost sharing for nearly all beneficiaries during the COVID-19 Public Health Emergency (PHE) and for over a year after it ends. For the very limited number of Medicaid beneficiaries who are not eligible for this coverage (and do not receive it through other coverage they might have), providers may submit claims for reimbursement for administering the COVID-19 vaccine to underinsured individuals through the COVID-19 Coverage Assistance Fund, administered by the Health Resources and Services Administration (HRSA), as discussed below. Under the American Rescue Plan Act of 2021 (ARP), signed by President Biden on March 11, 2021, the federal matching percentage for state Medicaid and CHIP expenditures on COVID-19 vaccine administration is currently 100% (as of April 1, 2021), and will remain 100% for more than a year after the COVID-19 PHE ends. The ARP also expands coverage of COVID-19 vaccine administration under Medicaid and CHIP to additional eligibility groups. CMS recently updated the Medicaid vaccine toolkit to reflect the enactment of the ARP at https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf.
- Private Plans: The vaccine is free for people enrolled in private health plans and issuers COVID-19 vaccine and its administration is covered without cost sharing for most enrollees, and such coverage must be provided both in-network and out-of-network during the PHE. Current regulations provide that out-of-network rates must be reasonable as compared to prevailing market rates, and the rules reference using the Medicare payment rates as a potential guideline for insurance companies. In light of CMS's increased Medicare payment

rates, CMS will expect health insurance issuers and group health plans to continue to ensure their rates are reasonable when compared to prevailing market rates. Under the conditions of participation in the CDC COVID-19 Vaccination Program, providers cannot charge plan enrollees any administration fee or cost sharing, regardless of whether the COVID-19 vaccine is administered in-network or out-of-network.

The Biden-Harris Administration is providing free access to COVID-19 vaccines for every adult living in the United States. For individuals who are underinsured, providers may submit claims for reimbursement for administering the COVID-19 vaccine through the COVID-19 Coverage Assistance Fund administered by HRSA after the claim to the individual's health plan for payment has been denied or only partially paid. Information is available at https://www.hrsa.gov/covid19-coverage-assistance.

For individuals who are uninsured, providers may submit claims for reimbursement for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by HRSA. Information on the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program is available at https://www.hrsa.gov/CovidUninsuredClaim.

More information on Medicare payment for COVID-19 vaccine administration – including a list of billing codes, payment allowances and effective dates – is available at https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment.

More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12244 - July 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- CMS added language, in red font on page 2, regarding Section 405 of the Consolidated Appropriations Act, 2021. The CR release date, transmittal number, and the web address of the CR were also revised. All other information is the same.

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Important Updates to the COVID-19 Vaccine and Monoclonal Antibody (mAb) Infusions

Effective with claims received on and after June 8, 2021, a new add-on payment code M0201 (COVID-19 vaccine home administration code) has been developed and can be added to COVID-19 vaccine administration codes: 0001A, 0002A, 0011A, 0012A, and 0031A.

New mAb infusion codes M0247 (Intravenous infusion, sotrovimab, includes infusion and post administration monitoring) M0248 (Sotrovimab infusion home administration and Q0247 (Injection, sotrovimab, 500 mg) have been developed effective with dates of service on and after May 26, 2021. Refer to the reimbursement articles below for the updated rates.

Additionally, an update has been made to the diagnosis reporting for the mAb infusion therapy administration.

Based on the above changes, the following articles on our COVID-19 vaccine and monoclonal antibodies specialty page have been updated:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibody billing for Part B providers
- Roster billing for Part A providers
- Roster billing for Part B providers
- 2021 COVID-19 vaccine reimbursement
- 2021 COVID-19 vaccine administration fees for centralized billers, Indian Health Services, and Veterans Affairs
- 2021 COVID-19 monoclonal antibodies reimbursement
- 2021 COVID-19 monoclonal antibodies administration (mAb) for centralized billers, Indian Health Services, and Veterans Affairs
- COVID-19 vaccine and monoclonal antibody (mAb) infusion questions and answers

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June 8, 2021

Redetermination submissions for claim corrections

Did you know that submitting a request with medical documentation attached for claim corrections is less efficient and can create extra cost and time for your organization? If a claim is billed with an incorrect or missing diagnosis and denies for medical necessity a redetermination with medical records is not required if your patient's medical records support a change or addition to the diagnosis code(s) originally billed.

We have listed your options below with reference articles to correct your denied claim or denied line item:

- You can cancel and rebill your claim with the updated/additional diagnosis code(s):
- Knowing how and when to cancel a claim
- The Redetermination and Clerical Error Reopening Form can be sent with the updated/additional diagnosis code(s). There is no need to include medical documentation if the corrected billing information is documented on the form (e.g., the corrected diagnosis code):
- Submit Claim Corrections & Reopenings
- How to correct claim errors by clerical error reopening or requesting a redetermination

Please share this valuable information with your staff or billing agency to help reduce extra time and cost for your organization.

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June 7, 2021

May 2021 top claim submission errors

The May 2021 Part A top claim submission errors and resolutions for Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania are now available. Please take time to review these errors and avoid them on future claims.

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Monoclonal antibodies (mAb) billing for Part A

CMS has provided clarification when billing mAb infusion HCPCS for Part A providers. Providers are instructed not to report condition code A6 and diagnosis code Z23 on mAb infusion claims. Please take time to review updates in the following articles:

- COVID-19 vaccine and monoclonal antibodies billing for Part A
- COVID-19 vaccine and monoclonal antibody (mAb) infusion questions and answers
- COVID-19 vaccine and monoclonal antibody (mAb) infusion billing alerts

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June 4, 2021

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12124 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) July 2021

  CMS revised this article to reflect a revised CR12124. The CR revision changed a business requirement for NCD 90.2, Next Generation Sequencing. This results in a new spreadsheet for that NCD. Also, CMS deleted the NCD 230.9, Cryosurgery of Prostate, business requirement and its spreadsheet. In this article, CMS deleted the reference to NCD 230.9 and changed the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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June 3, 2021

MACs Resume Medical Review

MLN Connects newsletter for Thursday, June 3, 2021

View this edition as a: Webpage | PDF

News

- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 7
- Clinical Diagnostic Laboratories: Key Dates for New & Reconsidered Test Codes
- Clinical Diagnostic Laboratories: Private Payor Rate-Based CLFS Resources
- MACs Resume Medical Review on a Post-payment Basis
- CMS Celebrates Pride Month

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

MLN Matters® Articles

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – October 2021
- National Coverage Determination (NCD) 110.24: Chimeric Antigen Receptor (CAR) T-cell Therapy

- National Coverage Determination (NCD) 210.3: Screening for Colorectal Cancer (CRC) - Blood-Based Biomarker Tests
- National Coverage Determination (NCD) Removal
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

Publications

- Medicare Disproportionate Share Hospital — Revised

Multimedia

- Hospice Quality Reporting Program: May Forum Materials

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12131 - Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

  CMS revised this article to reflect a revised CR12131. The CR revision added important information about the use of the QW modifier. CMS added that information in red print on page 10. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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Centers for Medicare & Medicaid Services (CMS) Education

New information has been added relating to Home Health in efforts to educate Home Health providers on how to properly bill for services slightly above the Low Utilization Payment Adjustment (LUPA) threshold.

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