edicare News and Web Updates for JL Part A (2020 Archive)

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* Coronavirus (COVID-19) Information

December 28, 2020

Due to extenuating circumstances, the Annual HCPCS/CPT Code Update has been delayed. The following is a preliminary list of Billing and Coding Articles that will be revised in response to the update. Due to the delay, it is anticipated that the revisions will be published to the Medicare Coverage Database (MCD) and our website in early February. Please continue to watch our website for further updates.

- Billing and Coding: Acute Care: Inpatient, Observation and Treatment Room Services (A52985)
- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Cosmetic and Reconstructive Surgery (A56587)
- Billing and Coding: eVox® System and Other Electroencephalograph Testing for Memory Loss (A56440)
- Billing and Coding: Hemophilia Factor Products (A56433)
- Billing and Coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Billing and Coding: Neurophysiology Evoked Potentials (NEPs) (A56773)
- Billing and Coding: Vestibular and Audiologic Function Studies (A57434)

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Special Edition – Monday, December 28, 2020

Provider Education Message:

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Suspended Through March

The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the payment adjustment percentage of 2% applied to all Medicare Fee-For-Service (FFS) claims from May 1 through December 31. The Consolidated Appropriations Act, 2021, signed into law on December 27, extends the suspension period to March 31, 2021.

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The following Local Coverage Determinations (LCDs) are now effective:

- Endovenous Stenting (L37893)
- Transurethral Waterjet Ablation of the Prostate (L38712)

- Treatment of Chronic Venous Insufficiency of the Lower Extremities (L34924)

The following Billing and Coding Articles are now effective:

- Billing and Coding: Transurethral Waterjet Ablation of the Prostate (A58243)
- Billing and Coding: Treatment of Chronic Venous Insufficiency of the Lower Extremities (A55229)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12070 - Instructions to Medicare Administrative Contractors (MACs) on COVID-19 Emergency Declaration Blanket Waivers for Medicare-Dependent, Small Rural Hospitals and Sole Community Hospitals

  This article informs you about actions we, CMS are taking to help health care providers contain the spread of COVID-19 with the COVID-19 emergency declaration blanket waivers for health care providers. Be sure your billing staffs are aware of these updates.

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December 23, 2020

CMS Provider Education Message:

ICD-10 Code Files for FY 2021

MLN Connects® for Wednesday, December 23, 2020

View this edition as a: Webpage | PDF

News

- Redesign of Medicare Supplier Directory Improves Beneficiary Decision-making
- Proposed Updates to Coverage Policy for Autologous Blood-Derived Products for Chronic Non-Healing Wounds
- Open Payments: Review & Dispute Data by December 31
- Hospital Price Transparency: Requirements Effective January 1
- DMEPOS Competitive Bidding Program: Round 2021 Begins January 1
- Clinics/Group Practices & Certain Other Suppliers: Revised CMS-855B Required January 4
- Acute Hospital Care at Home: Increasing Capacity through Hospital without Walls Program
- Orthoses Referring Providers: Comparative Billing Report in December
- National Correct Coding Initiative Medicare Policy Manual: Annual Update

Compliance

- Non-Physician Outpatient Services Provided Before or During Inpatient Stays: Bill Correctly

Claims, Pricers & Codes

- ICD-10 Code Files for FY 2021
- COVID-19: PC-ACE Software Vaccine Roster Billing Issue

MLN Matters® Articles

- FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients
- Calendar Year (CY) 2021 Annual Update for Clinical Laboratory Fee Schedule and Services Subject to Reasonable Charge

Publications

- Medicare Preventive Services — Revised

Multimedia

- Promoting Interoperability Call: Audio Recording & Transcript
- Physician Fee Schedule Call: Audio Recording & Transcript

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11870 – Telehealth Expansion Benefit Enhancement Under the Pennsylvania Rural Health Model (PARHM) - Implementation

  CMS revised this article due to a revised change request (CR) 11870, issued on December 22. The CR revision updated some denial edits. CMS added that information starting near the bottom of page 3 of this article. The CR release date, transmittal number, and web address of the CR were also updated. All other information remains the same.

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December 22, 2020

Special Edition – Tuesday, December 22, 2020

Provider Education Message:

COVID-19 Vaccine Codes: Updated Effective Date for Moderna

On December 18, 2020, the U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the Moderna COVID-19 Vaccine for the prevention of COVID-19 for individuals 18 years of age and older. Review Moderna's Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) regarding the limitations of authorized use.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for the administration of the vaccine (when furnished consistent with the EUA). Review our updated payment and HCPCS Level I CPT code structure for specific COVID-19 vaccine information. Only bill for the vaccine administration codes when you submit claims to Medicare; don't include the vaccine product codes when the vaccines are free.

Related links:

- CMS COVID-19 Provider Toolkit
- CMS COVID-19 FAQs
- CDC COVID-19 Vaccination Communication Toolkit for medical centers, clinics, and clinicians
- FDA COVID-19 Vaccines webpage

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Limited Systems Availability - Thursday, December 31, 2020 through Sunday, January 3, 2021

There will be Common Working File (CWF) "Dark" days from Thursday, December 31, 2020 through Sunday, January 3, 2021 due to the January 2021 release upgrades. The Interactive Voice Response (IVR) and our Customer Service Representatives will have limited availability. Customer Service Representatives will not be able to assist providers with Eligibility Inquiries, Claim Status Inquiries Relating to Eligibility or Claim Denial Inquiries Relating to Eligibility.

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Prior authorization (PA) program for certain hospital outpatient department (OPD) services

The PA program for certain hospital OPD services webpage had been updated to include announce the upcoming webinar Understanding the Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services on Wednesday, January 13, 2020. Please visit our educational event calendar to register for this event.

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December 21, 2020

Provider specialty: COVID-19 vaccine and monoclonal antibodies

We are pleased to announce the addition of COVID-19 vaccine and monoclonal antibodies to the Provider Specialties / Service page of our website. This is a central location for all COVID-19 vaccine and monoclonal antibody infusion billing information, including links to related CMS resources and references. These services include information on the COVID-19 vaccine, monoclonal antibodies, and their administration.

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COVID-19 vaccine and monoclonal antibodies billing for Part A

This billing article was created to assist Medicare Part A providers with proper billing relating to COVID-19 vaccine and monoclonal antibody infusion. When COVID-19 vaccine and monoclonal antibody doses are provided by the government without charge, only bill for the vaccine administration. Don’t include the vaccine codes on the claim when the vaccines are free.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12080 – Calendar Year (CY) 2021 Annual Update for Clinical Laboratory Fee Schedule and Services Subject to Reasonable Charge

  Related CR 12080 provides instructions for the Calendar Year (CY) 2021 Clinical Laboratory Fee Schedule (CLFS), mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

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December 18, 2020

Special Edition – Friday, December 18, 2020

Provider Education Message:

COVID-19: Add-on Payment for New Treatments

CMS issued an Interim Final Rule with Comment Period, which established the New COVID-19 Treatments Add-on Payment (NCTAP) under the Medicare Inpatient Prospective Payment System (IPPS), effective from November 2, 2020, until the end of the Public Health Emergency (PHE) for COVID-19. To mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments during the COVID-19 PHE, the Medicare program will provide an enhanced payment for eligible inpatient cases that involve use of certain new products with current Food and Drug Administration approval or emergency use authorization to treat COVID-19. Visit the NCTAP webpage for more information.

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Special Edition – Friday, December 18, 2020

Provider Education Message:

Monitoring for Hospital Price Transparency

Hospital Price Transparency requirements go into effect January 1, 2021. CMS plans to audit a sample of hospitals for compliance starting in January, in addition to investigating complaints that are submitted to CMS and reviewing analyses of non-compliance, and hospitals may face civil monetary penalties for noncompliance.

Is your institution prepared to comply with the requirements of the Hospital Price Transparency Final Rule? Effective January 1, 2021, each hospital operating in the United States is required to provide publicly accessible standard charge information online about the items and services they provide in 2 ways:

- Comprehensive machine-readable file with all items and services
- Display of 300 shoppable services in a consumer-friendly format

In the final rule, CMS outlined a monitoring and enforcement plan to ensure compliance with the requirements. We finalized a policy that CMS monitoring activities may include, but would not be limited to, the following, as appropriate:

- Evaluation of complaints made by individuals or entities to CMS
- Review of individuals' or entities' analysis of noncompliance
- Audit of hospital websites

If we conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, we may take any of the following actions, which generally, but not necessarily, will occur in the following order:

- Provide a written warning notice to the hospital of the specific violation(s)
- Request a Corrective Action Plan (CAP) if noncompliance constitutes a material violation of one or more requirements
- Impose a civil monetary penalty not in excess of $300 per day and publicize the penalty on a CMS website if the hospital fails to respond to our request to submit a CAP or comply with the requirements of a CAP

See 45 CFR part 180 Subpart C- Monitoring and Penalties for Noncompliance.

Visit the Hospital Price Transparency website for additional information and resources to help hospitals prepare for compliance, including:

- FAQs (PDF)
- 8 Steps to a Machine-Readable File (PDF)
- 10 Steps to a Consumer-Friendly Display (PDF)
- Quick Reference Checklists (PDF)

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COVID-19 vaccine and monoclonal antibody infusion fees

CMS has established new codes and fees based on the geographically-adjusted payment allowances for the COVID-19 vaccine and the monoclonal antibody infusion. Fees for 2020 and 2021 are now available on the fee schedule homepage.

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December 17, 2020

CMS Provider Education Message:

Physician Fee Schedule Final Rule Summary: Telehealth, Preventive Services & More

MLN Connects® for Thursday, December 17, 2020

View this edition as a: Webpage | PDF

News

- MLN Web-Based Training: Complete Training & Save Certificates by January 31
- IRF Quality Reporting Program: December Refresh
- LTCH Quality Reporting Program: December Refresh
- COVID-19: Stress & Resilience, Crisis Standards of Care
- COVID-19: Designated Hospitals Lessons Learned and Patient Surge Management Strategies

Compliance

- Ambulance Fee Schedule and Medicare Transports

MLN Matters® Articles

- 2021 Annual Update of Per-Beneficiary Threshold Amounts
- CY 2021 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Summary of Policies in the Calendar Year (CY) 2021 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
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021 — Revised

Publications

- Opioid Treatment Programs (OTPs) Medicare Enrollment — Revised
- Opioid Treatment Programs (OTPs) Medicare Billing and Payment — Revised

.

The following Local Coverage Determination (LCD) has been revised:

- Non-Invasive Peripheral Venous Studies (L35451)

The following Billing and Coding Article has been revised:

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

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Medicare administrative contractors (MACs) will host a Multi-Jurisdictional Contractor Advisory Committee (CAC) meeting regarding epidural interventions for chronic pain management on February 11, 2021, from 1-4 p.m. Central Time

Due to the public health crisis this meeting will be held via Teleconference/Webinar ONLY.

On February 11, 2021, seven Medicare Administrative Contractors (MACs); lead by Novitas Solutions (Jurisdictions H and L) and First Coast Service Options (Jurisdiction N), will host a multi-jurisdictional CAC meeting.

The purpose of the meeting is to obtain advice from CAC members and subject matter experts (SMEs) regarding the strength of published evidence on epidural interventions for chronic pain management. In addition to discussion, the SME panel will vote on pre-distributed questions during the meeting. CAC panels do not make coverage determinations, but MACs benefit from their advice.

All compliant CAC members will be given the opportunity to submit their answers to the voting 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, voting questions, agenda, and registration will be available on our website by January 28, 2021.

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December 14, 2020

Provider Education Message:

Special Edition – Monday, December 14, 2020

COVID-19 Vaccine Codes: Updated Effective Date for Pfizer-BioNTech

On December 11, 2020, the U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine for the prevention of COVID-19 for individuals 16 years of age and older. Review Pfizer's Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) regarding the limitations of authorized use.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for the administration of the vaccine (when furnished consistent with the EUA). Review our updated payment and HCPCS Level I CPT code structure for specific COVID-19 vaccine information. Only bill for the vaccine administration codes when you submit claims to Medicare; don't include the vaccine product codes when vaccines are free.

Related links:

- CMS COVID-19 Provider Toolkit
- CMS COVID-19 FAQs

- CDC COVID-19 Vaccination Communication Toolkit for medical centers, clinics, and clinicians
- FDA COVID-19 Vaccines webpage

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CR11642 Correction - Updates to Nursing and Allied Health Education Medicare Advantage Payment Policies

Transmittal 10486 dated November 19, 2020 is being rescinded and replaced by Transmittal 10520, dated December 14, 2020 to revise the implementation date from December 14, 2020 to December 21, 2020. All other information remains the same.

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The following local coverage determination (LCD) which was posted for notice on October 29, 2020, is now effective. The companion article for this LCD is also now effective:

- Biomarkers for Oncology (L35396)
  - Billing and Coding: Biomarkers for Oncology (A52986)

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.

- Cardiology Non-emergent Outpatient Stress Testing (DL35083)
- Facet Joint Interventions for Pain Management (DL34892)

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December 11, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM12027 – International Classification of Diseases, 10th Revision (ICD10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021

  CMS revised this article due to a revised change request (CR)12027 that they issued on December 10, 2020. The CR revision didn't impact the substance of this article. We revised the CR's release date, transmittal number, and web address. All other information remains the same.

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December 10, 2020

Special Edition – Thursday, December 10, 2020

Provider Education Message:

CMS Proposes New Rules to Address Prior Authorization and Reduce Burden on Patients and Providers

On December 10, under President Trump's leadership, CMS issued a proposed rule that would improve the electronic exchange of health care data among payers, providers, and patients and streamline processes related to prior authorization to reduce burden on providers and patients. By

both increasing data flow and reducing burden, this proposed rule would give providers more time to focus on their patients and provide better quality care.

For More Information:

- Proposed Rule: Comment period closes January 4
- Full press release
- Fact sheet
- Blog
- CMS Interoperability and Patient Access Final Rule webpage
- Register for December 16 listening session

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CMS Provider Education Message:

Flu & Pneumonia Vaccines: Protect Your Patients

MLN Connects® for Thursday, December 10, 2020

View this edition as a: Webpage | PDF

News

- Flu & Pneumonia Vaccines: Protect Your Patients
- VBID Model: Hospice Benefit Component
- Open Payments: Review and Dispute Data by December 31
- Hospital Price Transparency: Requirements Effective January 1
- Annual Participation Enrollment Period Extended to January 31
- 2020 MIPS Extreme and Uncontrollable Circumstances Exception Application: Deadline February 1
- COVID-19: Hospital Operations Toolkit

Compliance

- Telehealth Services: Bill Correctly

Claims, Pricers & Codes

- ICD-10 MS-DRG Grouper V38.1 & 2021 ICD-10-PCS Code Files
- Average Sales Price Files: January 2021

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — December 10 & January 7

MLN Matters® Articles

- Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2021
- Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2021 - Recurring File Update
- New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE — Revised

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020 — Revised
- 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) 2021 — Revised

Publications

- Medicare Provider Enrollment — Revised
- Provider Compliance Tips — Revised

.

The following local coverage determination and related billing and coding article have been revised:

- BRCA1 and BRCA2 Genetic Testing (L36715)
- Billing and coding: BRCA1 and BRCA2 Genetic Testing (A56542)

The following Billing and Coding Article has been revised:

- Billing and coding: Hydration Therapy (A56634)

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December 9, 2020

Special Edition – Wednesday, December 9, 2020

Provider Education Message:

In Case You Missed It: CMS Announces Guidance for Medicare Coverage of COVID-19 Antibody Treatment

On December 9, CMS posted updates to FAQs and an infographic about coverage and payment for monoclonal antibodies to treat COVID-19. The FAQs include general payment and billing guidance for these products, including questions on different setting types. The infographic has key facts about expected Medicare payment to providers and information about how Medicare beneficiaries can receive these innovative COVID-19 treatments with no cost-sharing during the public health emergency (PHE). CMS' November 10, 2020 announcement about coverage of monoclonal antibody therapies allows a broad range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract, to administer this treatment in accordance with the Food & Drug Administration's Emergency Use Authorization (EUA), and bill Medicare to administer these infusions. Currently, two monoclonal antibody therapies have received EUA's for treatment of COVID-19.

For More Information:

- Therapeutics Coverage Infographic
- Section BB of the FAQs: billing and payment for COVID-19 monoclonal antibody treatments
- Monoclonal toolkit and program guidance

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CR11642 Correction - Updates to Nursing and Allied Health Education Medicare Advantage Payment Policies

Transmittal 10315, dated August 21, 2020, is being rescinded and replaced by Transmittal 10486, dated November 19, 2020, to revise the implementation date from November 23, 2020, to December 14, 2020. All other information remains the same.

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December 8, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12014 – 2021 Annual Update of Per-Beneficiary Threshold Amounts

  Related change request 12014 updates the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for calendar year (CY) 2021. These amounts were previously associated with the financial limitation amounts that Medicare more commonly referred to as “therapy caps.” The Bipartisan Budget Act of 2018 repealed those caps while also retaining and adding limitations to ensure appropriate therapy. For CY 2021, the KX modifier threshold amounts are:

  a) $2,110 for physical therapy and speech-language pathology services combined, and

  b) $2,110 for occupational therapy services.

  Please make sure your billing staffs are aware of these updates.

- MM12063 – CY 2021 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  This article provides the calendar year (CY) 2021 annual update for the Medicare DMEPOS fee schedule. The article includes information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

- MM12071 – Summary of Policies in the Calendar Year (CY) 2021 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

  Change request 12071 provides a summary of the policies in the CY 2021 MPFS Final Rule and makes other policy changes that apply to Medicare Part B. These changes are effective January 1, 2021, and applicable to services you provide throughout CY 2021. Make sure your billing staffs are aware of these updates.

Revised:

- SE20016 – New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)

  CMS revised this article to provide additional guidance on telehealth services that have cost-sharing and cost-sharing waived. You’ll find substantive content updates in dark red font (see page 5).

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December 7, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12035 – Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2021

  This article provides the CY 2021 payment limit for RHCs. Effective January 1, 2021, through December 31, 2021, the RHC payment limit per visit for CY 2021 is $87.52. The CY 2021 RHC payment limit reflects a 1.4 percent increase above the CY 2020 payment limit of $86.31. Make sure your billing staffs are aware of this update.

- MM12046 – Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2021 - Recurring File Update

  This article informs you about updates to the PPS base payment rate and the geographic adjustment factors for the FQHC pricer. Make sure your billing staffs are aware of these changes.

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December 4, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20024 – FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients

  This article further explains the billing procedures and provides additional resources to avoid incorrect billing for outpatient services within 3 days before date of admission and on the date of admission. This is in response to an Office of Inspector General May 2020 report, Medicare Made $11.7 Million in Overpayments for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays. Make sure that your billing staffs are aware of this information to avoid billing errors that may lead to overpayments.

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December 3, 2020

CMS Provider Education Message:

Register for Physician Fee Schedule Call on 12/10

MLN Connects® for Thursday, December 3, 2020

View this edition as a: Webpage | PDF

News

- Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge
- CMS Updates Coverage Policies for Artificial Hearts and Ventricular Assist Devices
- PEPPERs for Short-term Acute Care Hospitals: Download December 4 through 14
- Provider Enrollment Application Fee Amount for CY 2021

Compliance

- Hospices: Create an Effective Plan of Care

Events

- Hospital Price Transparency Webcast — December 8
- Interoperability and Patient Access Final Rule Call — December 9

- Physician Fee Schedule Final Rule: Understanding 4 Key Topics Call — December 10

MLN Matters® Articles

- 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) 2021 — Revised

Publications

- Major Joint Replacement (Hip or Knee) — Revised
- Provider Compliance Tips for Tracheostomy Supplies — Revised

Multimedia

- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Procedure Coding: Using the ICD-10-PCS Web-Based Training Course — Revised

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Special Edition – Thursday, December 3, 2020

Provider Education Message:

COVID-19 Antibody Treatment and Enforcement Discretion Reminder

- CMS Takes Further Steps to Ensure Medicare Beneficiaries Have Wide Access to COVID-19 Antibody Treatment
- COVID-19 Vaccines and Monoclonal Antibody Infusion: Enforcement Discretion Relating to SNF Consolidated Billing

CMS Takes Further Steps to Ensure Medicare Beneficiaries Have Wide Access to COVID-19 Antibody Treatment

The U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the investigational monoclonal antibody therapy, casirivimab and imdevimab, administered together, for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. Casirivimab and imdevimab, administered together, may only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the Emergency Medical System (EMS), as necessary. Review the Fact Sheet for Health Care Providers EUA of Casirivimab and Imdevimab regarding the limitations of authorized use when administered together.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for these infusions the same way it covers and pays for COVID-19 vaccines (when furnished consistent with the EUA).

CMS identified specific code(s) for the monoclonal antibody product and specific administration code(s) for Medicare payment: Regeneron's Antibody Casirivimab and Imdevimab (REGN-COV2) , EUA effective November 21, 2020.

Q0243:

Long descriptor: Injection, casirivimab and imdevimab, 2400 mg

Short descriptor: casirivimab and imdevimab

M0243:

Long Descriptor: intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring

Short Descriptor: casirivi and imdevi infusion

Additional Resources:

- List COVID-19 monoclonal antibody infusion billing codes, payment allowances and effective dates
- Monoclonal Antibody COVID-19 Infusion Program Instruction
- CMS COVID-19 Vaccine Provider Toolkit

COVID-19 Vaccines and Monoclonal Antibody Infusion: Enforcement Discretion Relating to SNF Consolidated Billing

To facilitate the efficient administration of COVID-19 vaccines to Skilled Nursing Facility (SNF) residents, CMS is exercising enforcement discretion with respect to statutory provisions requiring consolidated billing by SNFs as well as any associated statutory references and implementing regulations, including as interpreted in pertinent guidance. Through the exercise of this discretion, we will allow Medicare-enrolled immunizers working within their scope of practice and subject to applicable state law, including, but not limited to, pharmacies working with the United States, as well as infusion centers, and home health agencies, to bill directly and receive direct reimbursement from the Medicare program for vaccinating Medicare Part A SNF residents. This enforcement discretion, and accordingly the ability for entities other than the SNF to submit claims for these monoclonal antibody products and their administration furnished to Medicare Part A SNF residents, is limited to the period described in the above-cited enforcement discretion notice.

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November 2020 top claim submission errors

The November 2020 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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As a reminder, the comment period for the following proposed local coverage determinations (LCDs) is currently open and will close on December 12, 2020. We encourage you to submit your comments as soon as possible.

- Cardiology Non-emergent Outpatient Stress Testing (DL35083)
- Facet Joint Interventions for Pain Management (DL34892)

Submit comments

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December 2, 2020

Special Edition – Wednesday, December 2, 2020

Provider Education Message:

Trump Administration Finalizes Policies to Give Medicare Beneficiaries More Choices around Surgery

Outpatient Prospective Payment System and Ambulatory Surgical Center final rule empowers beneficiary choices and unleashes competition to lower costs and improve innovation

On December 2, CMS finalized policy changes that will give Medicare patients and their doctors greater choices to get care at a lower cost in an outpatient setting. The Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rules will increase value for Medicare beneficiaries and reflect the agency's efforts to transform the health care delivery system through competition and innovation. These changes implement the Trump Administration's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors and will take effect on January 1, 2021.

"President Trump's term in office has been marked by an unrelenting drive to level the playing field and boost competition at every turn," said CMS Administrator Seema Verma. "Today's rule is no different. It allows doctors and patients to make decisions about the most appropriate site of care, based on what makes the most sense for the course of treatment and the patient without micromanagement from Washington."

In this final rule, CMS will begin eliminating the Inpatient Only (IPO) list of 1,700 procedures for which Medicare will only pay when performed in the hospital inpatient setting over a three-year transitional period, beginning with some 300 primarily musculoskeletal-related services. The IPO list will be completely phased out by CY 2024. This will make these procedures eligible to be paid by Medicare when furnished in the hospital outpatient setting when outpatient care is appropriate, as well as continuing to be payable when furnished in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician. In the short term, as hospitals face surges in patients with complications from COVID-19, being able to provide treatment in outpatient settings will allow non-COVID-19 patients to get the care they need.

In addition to putting decisions on the best site of care in the hands of physicians, allowing more procedures to be done in an outpatient setting also provides for lower-cost options that benefit the patient.

For example, thromboendarterectomy (HCPCS code 35372) is a surgical procedure that removes chronic blood clots from the arteries in the lung. If this procedure is performed in an inpatient setting, a patient who has not had other health care expenses that year would have a deductible of about $1500. In contrast, the copayment for this procedure for the same patient in the outpatient setting would be about $1150. Patient safety and quality of care will be safeguarded by the doctor's assessment of the risk of a procedure or service to the individual beneficiary and their selection of the most appropriate setting of care based on this risk. This is in addition to state and local licensure requirements, accreditation requirements, hospital conditions of participation, medical malpractice laws, and CMS quality and monitoring initiatives and programs.

Beginning January 1, 2021, we are adding eleven procedures to the ASC Covered Procedures List (CPL), including total hip arthroplasty (CPT 27130), under our standard review process. Additionally, we are revising the criteria we use to add surgical procedures to the ASC CPL, providing that certain criteria we used to add surgical procedures to the ASC CPL in the past will now be factors for physicians to consider in deciding whether a specific beneficiary should receive a covered surgical procedure in an ASC. Using our revised criteria, we are adding an additional 267 surgical procedures to the ASC CPL beginning January 1, 2021. Finally, we are adopting a notification process for surgical procedures the public believes can be added to the ASC CPL under the criteria we are retaining.

CMS is announcing that it will continue its policy of paying for 340B-acquired drugs at average sales price minus 22.5% after the July 31, 2020, decision of the Court of Appeals for the D.C. Circuit upholding the current policy. This policy lowers out-of-pocket drug costs for Medicare beneficiaries by letting them share in the discount that hospitals receive under the 340B program. Since this policy went into effect in 2018, Medicare beneficiaries have saved nearly $1 billion on drug costs, with expected Medicare beneficiary drug cost savings of over $300 million in CY 2021.

As part of the agency's Patients Over Paperwork Initiative, which is aimed at reducing burden for health care providers, CMS is establishing a simple updated methodology to calculate the Overall Hospital Quality Star Rating (Overall Star Rating). The Overall Star Rating summarizes a variety of quality measures published on the Medicare.gov Care Compare tool (the successor to Hospital Compare) for common conditions that hospitals treat, such as heart attacks or pneumonia. Along with publicly reported data on Care Compare, the Overall Star Rating helps patients make better-informed health care decisions. Veterans' Health Administration hospitals will be added to CMS' Care Compare, which will help veterans understand hospital quality within the VA system. Overall, these changes will reduce provider burden, improve the predictability of the star ratings, and make it easier for patients to compare ratings between similar hospitals.

In response to stakeholder feedback about the current methodology used to calculate the Overall Star Rating, CMS is not finalizing its proposal to stratify readmission measures under the new methodology based on dually eligible patients, but will continue to study the issue to find the best way to convey quality of care for this vulnerable population.

Finally, in order to address the ongoing public health emergency, CMS is finalizing a new requirement for the nation's 6,200 hospitals and critical access hospitals to report information about their inventory of therapeutics to treat COVID-19. This reporting will provide the information needed to track and accurately allocate therapeutics to the hospitals that need additional inventory to care for patients and meet surge needs.

For More Information:

- Final Rule
- Fact Sheet

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20025 – Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services and the Use of Condition Codes (A-04-18-04067)

  The current Office of Inspector General audit, August 2020 report no. A-04-18-04067, identifies Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). This article reminds hospitals of proper coding of the patient discharge status code and the use of condition codes 42 and 43.

Revised:

- MM12011 – 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) 2021

  CMS revised this article to add information for reporting the use of cinacalcet by ESRD facilities (on page 8). Beginning January 1, 2021, cinacalcet is an oral drug eligible for consideration as an ESRD outlier service. ESRD facilities should report revenue code 250 with the drug's NDC. All other information remains the same.

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December 1, 2020

Provider Education Message:

Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients

On December 1, CMS released the annual Physician Fee Schedule (PFS) final rule, prioritizing CMS' investment in primary care and chronic disease management by increasing payments to physicians and other practitioners for the additional time they spend with patients, especially those with chronic conditions. The rule allows non-physician practitioners to provide the care they were trained and licensed to give, cutting red tape so health care professionals can practice at the top of their license and spend more time with patients instead of on unnecessary paperwork. This final rule takes steps to further implement President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors including prioritizing the expansion of proven alternatives like telehealth.

"During the COVID-19 pandemic, actions by the Trump Administration have unleashed an explosion in telehealth innovation, and we're now moving to make many of these changes permanent," said HHS Secretary Alex Azar. "Medicare beneficiaries will now be able to receive dozens of new services via telehealth, and we'll keep exploring ways to deliver Americans access to health care in the setting that they and their doctor decide makes sense for them."

"Telehealth has long been a priority for the Trump Administration, which is why we started paying for short virtual visits in rural areas long before the pandemic struck," said CMS Administrator Seema Verma. "But the pandemic accentuated just how transformative it could be, and several months in, it's clear that the health care system has adapted seamlessly to a historic telehealth expansion that inaugurates a new era in health care delivery."

Finalizing Telehealth Expansion and Improving Rural Health

Before the COVID-19 Public Health Emergency (PHE), only 15,000 Fee-for-Service beneficiaries each week received a Medicare telemedicine service. Since the beginning of the PHE, CMS has added 144 telehealth services, such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services, that are covered by Medicare through the end of the PHE. These services were added to allow for safe access to important health care services during the PHE. As a result, preliminary data show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE.

This final rule delivers on the President's recent Executive Order on Improving Rural Health and Telehealth Access by adding more than 60 services to the Medicare telehealth list that will continue to be covered beyond the end of the PHE, and we will continue to gather more data and evaluate whether more services should be added in the future. These additions allow beneficiaries in rural areas who are in a medical facility (like a nursing home) to continue to have access to telehealth services such as certain types of emergency department visits, therapy services, and critical care services. Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home. However, this is an important step, and as a result, Medicare beneficiaries in rural areas will have more convenient access to health care.

Additionally, CMS is announcing a commissioned study of its telehealth flexibilities provided during the COVID-19 PHE. The study will explore new opportunities for services where telehealth and virtual care supervision, and remote monitoring can be used to more efficiently bring care to patients and to enhance program integrity, whether they are being treated in the hospital or at home.

Payment for Office/Outpatient Evaluation and Management (E/M) and Comparable Visits

Last year, CMS finalized a historic increase in payment rates for office/outpatient face-to-face E/M visits that goes into effect in 2021. The Medicare population is increasing, with over 10,000 beneficiaries joining the program every day. Along with this growth in enrollment is increasing complexity of beneficiary health care needs, with more than two-thirds of Medicare beneficiaries

having two or more chronic conditions. Increasing the payment rate of E/M office visits recognizes this demand and ensures clinicians are paid appropriately for the time they spend on coordinating care for patients, especially those with chronic conditions. These payment increases, informed by recommendations from the American Medical Association (AMA), support clinicians who provide crucial care for patients with dementia or manage transitions between the hospital, nursing facilities, and home.

Under this final rule, CMS continues to prioritize this investment in primary care and chronic disease management by similarly increasing the value of many services that are similar to E/M office visits, such as maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, and physical and occupational therapy evaluation services. These adjustments ensure CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients.

“This finalized policy marks the most significant updates to E/M codes in 30 years, reducing burden on doctors imposed by the coding system and rewarding time spent evaluating and managing their patients’ care,” Administrator Verma added. “In the past, the system has rewarded interventions and procedures over time spent with patients – time taken preventing disease and managing chronic illnesses.”

In addition to the increase in payment for E/M office visits, simplified coding and documentation changes for Medicare billing for these visits will go into effect beginning January 1, 2021. The changes modernize documentation and coding guidelines developed in the 1990s, and come after extensive stakeholder collaboration with the AMA and others. These changes will significantly reduce the burden of documentation for all clinicians, giving them greater discretion to choose the visit level based on either guidelines for medical decision-making (the process by which a clinician formulates a course of treatment based on a patient’s information, i.e., through performing a physical exam, reviewing history, conducting tests, etc.) or time dedicated with patients. These changes are expected to save clinicians 2.3 million hours per year in administrative burden so that clinicians can spend more time with their patients.

Professional Scope of Practice and Supervision

As part of the Patients Over Paperwork Initiative, the Trump Administration is cutting red tape so that health care professionals can practice at the top of their license and spend more time with patients instead of on unnecessary paperwork. The PFS final rule makes permanent several workforce flexibilities provided during the COVID-19 PHE that allow non-physician practitioners to provide the care they were trained and licensed to give, without imposing additional restrictions by the Medicare program.

Specifically, CMS is finalizing the following changes:

- Certain non-physician practitioners, such as nurse practitioners and physician assistants, can supervise the performance of diagnostic tests within their scope of practice and state law, as they maintain required statutory relationships with supervising or collaborating physicians.
- Physical and occupational therapists will be able to delegate “maintenance therapy” – the ongoing care after a therapy program is established – to a therapy assistant.
- Physical and occupational therapists, speech-language pathologists, and other clinicians who directly bill Medicare can review and verify, rather than re-document, information already entered by other members of the clinical team into a patient’s medical record. As a result, practitioners have the flexibility to delegate certain types of care, reduce duplicative documentation, and supervise certain services they could not before, increasing access to care for Medicare beneficiaries.

For More Information:

- Final Rule
- Physician Fee Schedule Final Rule fact sheet
- Quality Payment Program Final Rule fact sheet and FAQs
- Medicare Diabetes Prevention Program fact sheet

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11889 – Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020

  CMS revised this article to reflect the revised change request (CR) 11889 issued on August 14, 2020. The CR revision updated the codes in the CR spreadsheet for NCD 190.15. That change did not impact the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

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November 25, 2020

CMS Provider Education Message:

Hospital Price Transparency Webcast on 12/8

MLN Connects® for Wednesday, November 25, 2020

View this edition as a: Webpage | PDF

News

- CMS Announces Historic Changes to Physician Self-Referral Regulations
- Policy Will Increase Number of Lifesaving Organs by Holding OPAs Accountable through Transparency and Competition
- Prescription Drug Payment Model to Put American Patients First
- DMEPOS Competitive Bidding Program: Contract Suppliers for Round 2021
- Quality Payment Program APMs: Extended Deadline to Update Billing information — December 13
- Clinical Laboratory Fee Schedule: CY 2021 Final Payment Determinations
- Hospice Quality Reporting Program: November Refresh
- November is Home Care & Hospice Month
- World AIDS Day is December 1

Compliance

- Polysomnography Services: Bill Correctly

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Long-Term Services and Supports Open Door Forum — December 1

- Hospital Price Transparency Webcast — December 8
- Interoperability and Patient Access Final Rule Call — December 9

MLN Matters® Articles

- Changes to the End-Stage Renal Disease (ESRD) PRICER to Accept the New Outpatient Provider Specific File Supplemental Wage Index Fields, the Network Reduction Calculation and New Value Code for Time on Machine
- Claim Status Category and Claim Status Codes Update
- Implementation of Two (2) New NUBC Condition Codes. Condition Code “90”, “Service provided as Part of an Expanded Access Approval (EA)” and Condition Code “91”, “Service Provided as Part of an Emergency Use Authorization (EUA)”
- 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
- National Coverage Determination (NCD 90.3): Chimeric Antigen Receptor (CAR) T-cell Therapy
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2021
- Update to Vaccine Services Editing
- Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model — Revised
- Billing for Home Infusion Therapy Services on or After January 1, 2021 — Revised
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021 — Revised
- Update to Chapter 10 of Publication (Pub.) 100-08 - Enrollment Policies for Home Infusion Therapy (HIT) Suppliers — Revised

Publications

- DMEPOS Information for Pharmacies — Revised
- DMEPOS Quality Standards — Revised

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November 24, 2020

Appeals Corner Newsletter November 2020

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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How unsolicited/voluntary refunds are handled

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.

CMS 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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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11943 – Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  This article updates the RARC and CARC lists and instructs the Medicare's system maintainers to update MREP and PC print. Make sure billing staffs are aware of these updates. If you use the MREP or PC print software, be sure to get the updated software.

- MM11957 – Claim Status Category and Claim Status Codes Update

  This article informs you of updates, as needed, to 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 ASC X12 277 health care claim acknowledgment transactions. Make sure your billing staffs are aware of this update.

- MM12049 – Implementation of Two (2) New NUBC Condition Codes. Condition Code "90", "Service provided as Part of an Expanded Access Approval (EA)" and Condition Code "91", "Service Provided as Part of an Emergency Use Authorization (EUA)"

  This article informs you about two newly created condition codes:

  - 90" – To allow providers to report when the service is provided as part of an Expanded Access approval.
  - "91" – To allow providers to report when the service is provided as part of an Emergency Use Authorization (EUA).

  Please make sure your billing staffs are aware of these updates. These codes are effective for claims received on or after February 1, 2021.

- MM11988 – 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

  This article informs you of Medicare system updates based on CORE 360 uniform use of CARC, RARC, and CAGC rule publications. These system updates are based on the CORE code combination list to be published on or about February 1, 2021. Please make sure your billing staffs are aware of these updates.

- MM12024 – Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2021

  This article informs you of the new CY 2021 Medicare premium, coinsurance, and deductible rates.

Revised:

- MM12017 – Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021

  CMS revised this article to reflect an updated Change Request (CR) 12017 that revised the Policy section (page 4 in this article) and updated the Payment Rate Tables to include information on the cost per-unit table for outlier payments (Table 6). All references to Table 6 in the previous CR (and article) were changed to Table 7. The CR release date, transmittal number and link to the CR were also changed. All other information remains the same.

- MM12011 – 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) 2021

  CMS revised the article to reflect a revised change request (CR) 12011. The CR revision changed the CY 2021 AKI dialysis payment rate for renal dialysis services. CMS made that change in the CY 2021 ESRD PPS Updates section of the article. We also changed the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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November 19, 2020

CMS Provider Education Message:

MLN Connects® for Thursday, November 19, 2020

View this edition as a: Webpage | PDF

News

- CMS Releases Nursing Home COVID-19 Training Data with Urgent Call to Action
- Medicare FFS Estimated Improper Payments Decline by $15 Billion Since 2016
- CMS Retiring Original Compare Tools on December 1
- COVID-19: Health Care Operations Lessons and Fostering Professional Resilience
- Medicare Diabetes Prevention Program: Become a Medicare-Enrolled Supplier
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Compliance

- Hospice Care: Safeguards for Medicare Patients

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — November 19
- Hospital Price Transparency Webcast — December 8

Multimedia

- Part A Cost Report Webcast: Audio Recording and Transcript

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November 18, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11871 – Changes to the End Stage Renal Disease (ESRD) PRICER to Accept the New Outpatient Provider Specific File Supplemental Wage Index Fields, the Network Reduction Calculation and New Value Code for Time on Machine

  This article informs you about the changes to the ESRD PRICER software, the new value code required for reporting minutes of dialysis provided during the billing period. Also, the article explains the ESRD Network Reduction calculations from the Fiscal Intermediary Shared System into the PRICER and requires MACs to adjust claims for retraining treatments to correct the network reduction. Make sure your billing staffs are aware of these changes.

  Effective January 1, 2011, CMS implemented the ESRD Prospective Payment System (PPS) based on the requirements of Section 1881(b)(14) of the Social Security Act (the Act). The ESRD PPS provides a single per treatment payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

- MM11975 – Update to Vaccine Services Editing

  Related CR 11975:

  - Allows an inpatient SNF claim that contains a “From” Date of Service (DOS) that overlaps only the “Through” date of a vaccine or telehealth outpatient claim for the same beneficiary
  - Instructs MACs to pay HCPCS codes G0008, G0009, and G0010 claims with a DOS in Calendar Year (CY) 2020 based on the CY 2019 national payment amounts for immunization administration services
  - Modifies current editing to allow vaccines and their administration when they are the only services on a 12x claim where the service date is equal to the discharge date of an inpatient claim for the same provider and the service date is equal to the "From" date of another inpatient claim with condition code B4 for the same provider Please make sure your billing staffs are aware of these changes.

- MM11783 – National Coverage Determination (NCD 90.3): Chimeric Antigen Receptor (CAR) T-cell Therapy

  This article informs you that effective for claims with dates of service on or after August 7, 2019, CMS covers autologous treatment for cancer with T-cells expressing at least one CAR when administered at healthcare facilities enrolled in the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategies and meets specified FDA conditions. Make sure your billing staffs are aware of these changes.

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November 16, 2020

October 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The October 2020 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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November 12, 2020

CMS Provider Education Message:

COVID-19: Non-Physician Practitioner Billing for Audio Services

MLN Connects® for Thursday, November 12, 2020

View this edition as a: Webpage | PDF

News

- Critical Care: Comparative Billing Report in November
- Raising Awareness of Diabetes in November

Compliance

- SNF 3-Day Rule Billing

Claims, Pricers & Codes

- COVID-19: Non-Physician Practitioner Billing for CPT Codes 98966-98968

MLN Matters® Articles

- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021
- 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) 2021
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021
- Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum
- Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) Claims

Publications

- Provider Compliance Tips — Revised

Information for Medicare Patients

- 2021 Medicare Part B Premiums Remain Steady

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Special Edition – Thursday, November 12, 2020

Provider Education Message:

COVID-19 Vaccine Codes and PC-ACE Software Update

In anticipation of the availability of a vaccine(s), for the novel coronavirus (SARS-CoV-2) in response to the coronavirus disease 2019 (COVID-19), the American Medical Association (AMA), working with the Centers for Medicare & Medicaid Services (CMS), created new codes for the vaccine and the administration of the vaccine. To prepare for the vaccine administration claims, the PC-ACE software is also updated and ready for providers to download.

If you intend to administer the COVID-19 vaccines when they become available, or the new monoclonal antibody bamlanivimab, especially if you intend to roster bill these codes, please download and install the new release of PC-ACE. This release includes the coding structure, currently

comprised of both a HCPCS Level I CPT code structure issued by the American Medical Association (AMA) and a HCPCS Level II code structure issued by CMS. Together, these codes support the administration of the COVID-19 vaccines and the monoclonal antibody infusions, as they become available; this structure includes the codes for bamlanivimab. This code structure was developed to facilitate efficient claims processing for any COVID-19 vaccines and monoclonal antibody infusions that receive FDA EUA or approval. CMS and the AMA are working collaboratively regarding which codes to submit for COVID-19 vaccines and administration. Most of these codes are not currently effective and not all codes will be used. We will issue specific code descriptors in the future. Effective dates for the codes for Medicare purposes will coincide with the date of the FDA EUA or approval.

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The following local coverage determinations (LCDs) posted for comment on June 25, 2020, have been posted for notice. The LCDs and related billing and coding articles will become effective December 27, 2020:

- Transurethral Waterjet Ablation of the Prostate (L38712)
  - Billing and coding: Transurethral Waterjet Ablation of the Prostate (A58243)
- Treatment of Chronic Venous Insufficiency of the Lower Extremities (L34924)
  - Billing and coding: Treatment of Chronic Venous Insufficiency of the Lower Extremities (A55229)

The following LCD posted for comment on June 25, 2020, has been posted for notice and will become effective December 27, 2020.

- Endovenous Stenting (L37893)

The following response to comments articles contain summaries of all comments received and Novitas' responses:

- Response to comments: Endovenous Stenting (A58394)
- Response to comments: Transurethral Waterjet Ablation of the Prostate (A58377)
- Response to comments: Treatment of Chronic Venous Insufficiency of the Lower Extremities (A58378)

The following billing and coding article has been revised:

- Billing and coding: Thrombolytic Agents (A55237)

The following billing and coding article has been added:

- Billing and coding: Urodynamic Services - Non-invasive (A58541)

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November 10, 2020

Provider Education Message:

CMS Takes Steps to Ensure Medicare Beneficiaries Have Wide Access to COVID-19 Antibody Treatment

Coverage Available at No Cost to Beneficiaries Across Variety of Settings in Health Care System

CMS announced that starting November 10, Medicare beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost-sharing during the Public Health Emergency

(PHE). CMS' coverage of monoclonal antibody infusions applies to bamlanivimab, which received an Emergency Use Authorization (EUA) from the FDA on November 9.

"Today, CMS is announcing a historic, first-of-its kind policy that drastically expands access to COVID-19 monoclonal antibodies to beneficiaries without cost sharing," said CMS Administrator Seema Verma. "Our timely approach means beneficiaries can receive these potentially life-saving therapies in a range of settings – such as in a doctor's office, nursing home, infusion centers, as long as safety precautions can be met. This aggressive action and innovative approach will undoubtedly save lives."

CMS anticipates that this monoclonal antibody product will initially be given to health care providers at no charge. Medicare will not pay for the monoclonal antibody products that providers receive for free but this action provides for reimbursement for the infusion of the product. When health care providers begin to purchase monoclonal antibody products, Medicare anticipates setting the payment rate in the same way it set the payment rates for COVID-19 vaccines, such as based on 95% of the average wholesale price for COVID-19 vaccines in many provider settings. CMS will issue billing and coding instructions for health care providers in the coming days.

CMS anticipates the announcement will allow for a broad range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract, to administer this treatment in accordance with the EUA, and bill Medicare to administer these infusions.

Under section 6008 of the Families First Coronavirus Response Act (FFCRA), state and territorial Medicaid programs may receive a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), through the end of the quarter in which the COVID-19 PHE ends. A condition for receipt of this enhanced federal match is that a state or territory must cover COVID-19 testing services and treatments, including vaccines and their administration, specialized equipment, and therapies for Medicaid enrollees without cost sharing. This means that this monoclonal antibody infusion is expected to be covered when furnished to Medicaid beneficiaries, in accordance with the EUA, during this period, with limited exceptions.

View the Monoclonal Antibody COVID-19 Infusion Program Instruction.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11992 – Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) Claims

  This article informs you of an update to SNF PDPM claims processing instructions to adhere to current Medicare policy. Be sure your billing staff know of this update.

- MM12011 – 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) 2021

  This article informs you of the changes to the CY 2021 rate updates and policies for the ESRD PPS and changes to the payment for renal dialysis services provided to Medicare beneficiaries with AKI in ESRD facilities. Make sure your billing staff are aware of these changes.

- MM12017 – Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021

  This article informs you of updates of several facets related to payments made under the HH PPS. Please make sure your billing staffs are aware of these updates.

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  CMS revised the article to clarify the billing instructions in the Skilled Nursing Facility Benefit Period Waiver - Provider Information section. All other information remains the same.

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November 9, 2020

The comment period is now closed for the following proposed local coverage determinations (LCDs). Comments received will be reviewed by our contractor medical directors. The response to comments articles and finalized Billing and Coding Articles will be published and related to the final LCDs when they are posted for notice.

- Blepharoplasty and Surgical Procedures of the Brow (DL35004)
- Botulinum Toxins (DL38809)
- Diagnostic Colonoscopy (DL38812)

The comment period remains open until December 12, 2020 for the following proposed LCDs.

- Cardiology Non-emergent Outpatient Stress Testing (DL35083)
- Facet Joint Interventions for Pain Management (DL34892)

  Submit comments

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November 5, 2020

CMS Provider Education Message:

COVID-19 Vaccine: Find Out How to Prepare

MLN Connects® for Thursday, November 5, 2020

View this edition as a: Webpage | PDF

News

- COVID-19 Vaccine: Find Out How to Prepare
- Hospital Price Transparency: Requirements Effective January 1
- SNF Quality Reporting Program: October Refresh
- Flu Shots: Each Visit is an Opportunity

Compliance

- Inhalant Drugs: Bill Correctly

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — November 5

MLN Matters® Articles

- Special Provisions for Radiology Additional Documentation Requests
- Update to Chapter 10 of Publication (Pub.) 100-08 - Enrollment Policies for Home Infusion Therapy (HIT) Suppliers

- October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule — Revised
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2020 Update — Revised

Publications

- Medicare Wellness Visits

Multimedia

- SNF Quality Reporting Program: Confusion Assessment Method Video Tutorial
- SNF Quality Reporting Program: Brief Interview for Mental Status Video Tutorial

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12027 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021

  This article informs you about updated ICD-10 conversions as well as coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Any policy-related changes to NCDs continue to be implemented via the current, longstanding NCD process. There are no policy related changes with these updates. Make sure your billing staffs are aware of these updates.

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Updated: Avastin for ophthalmological use, J7999

Novitas would like to provide the following information to assist with the billing of the compounded form of Avastin for ophthalmological use to ensure the drug is reported accurately. The not otherwise classified (NOC) code, J7999, from the American Medical Association Healthcare Common Procedure Coding System (HCPCS) is to be billed for the compounded form of Avastin administered through an intravitreal injection. Find out more.

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November 4, 2020

October 2020 top claim submission errors

The October 2020 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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November 3, 2020

Special Edition – Tuesday, November 3, 2020

Provider Education Message:

ESRD & Home Health Payment Rules

- ESRD PPS: CY 2021 Payment Policies and Rates
- Home Health Agencies: CY 2021 Payment and Policy Changes and Home Infusion Therapy Benefit
- CMS' New One-Stop Nursing Home Resource Center Assists Providers, Caregivers, Residents

ESRD PPS: CY 2021 Payment Policies and Rates

On November 2, CMS issued a final rule that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries enrolled in Original Medicare on or after January 1, 2021. This rule also updates the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI and finalizes changes to the ESRD Quality Incentive Program.

The final CY 2021 ESRD PPS base rate is $253.13, which represents an increase of $13.80 to the current base rate of $239.33. This amount reflects the application of the updated wage index budget-neutrality adjustment factor (.999485), the addition to the base rate of $9.93 to include calcimimetics, and a productivity-adjusted market basket increase, as required by section 1881(b)(14)(F)(i)(I) of the Act (1.6 percent), equaling $253.13 (($239.33 x .999485) + $9.93 x 1.016 = $253.13).

CMS finalized the following:

- Update to the ESRD PPS wage index to adopt the 2018 Office of Management and Budget delineations with a transition period
- Changes to the eligibility criteria and determination process for the Transitional add-on Payment adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Expansion of the TPNIES to include new and innovative capital-related assets that are home dialysis machines
- Change to the low-volume payment adjustment eligibility criteria and attestation requirement to account for the COVID-19 public health emergency

For More Information:

- Final rule
- Press release
- Full text of fact sheet

Home Health Agencies: CY 2021 Payment and Policy Changes and Home Infusion Therapy Benefit

On October 29, CMS issued a final rule that finalizes routine updates to the home health payment rates for Calendar Year (CY) 2021 in accordance with existing statutory and regulatory requirements. This rule also finalizes the regulatory changes related to the use of telecommunications technology in providing care under the Medicare home health benefit.

CMS estimates that Medicare payments to Home Health Agencies (HHAs) in CY 2021 will increase in the aggregate by 1.9 percent, or $390 million, based on the finalized policies. This increase reflects the effects of the 2.0 percent home health payment update percentage ($410 million increase) and a 0.1 percent decrease in payments due to reductions in the rural add-on percentages mandated by the Bipartisan Budget Act of 2018 for CY 2021 ($20 million decrease). This rule also updates the home health wage index including the adoption of revised Office of Management and Budget statistical area

delineations and limiting any decreases in a geographic area's wage index value to no more than 5 percent in CY 2021.

This final rule also:

- Finalizes Medicare enrollment policies for qualified home infusion therapy suppliers
- Updates the home infusion therapy services payment rates for CY 2021
- Finalizes a policy excluding home infusion therapy services from home health services as required by law
- Finalizes policies under the Home Health Value Based Purchasing Model published in the interim final rule with comment period, as required by law

For More Information:

- Final rule
- Home Health Prospective Payment System website
- HHA Center webpage
- Home Health Patient-Driven Groupings Model webpage
- Home Infusion Therapy Services website
- Full text of Fact Sheet

CMS' New One-Stop Nursing Home Resource Center Assists Providers, Caregivers, Residents

On October 30, CMS launched a new online platform - the Nursing Home Resource Center - to serve as a centralized hub bringing together the latest information, guidance, and data on nursing homes that is important to facilities, frontline providers, residents, and their families, especially as the fight against COVID-19 continues.

The Resource Center consolidates all nursing home information, guidance, and resources into a user-friendly, one-stop-shop that is easily navigable so providers and caregivers can spend less time searching for critical answers and more time caring for residents. Moreover, the new platform contains features specific to residents and their families, ensuring they have the information needed to make empowered decisions about their health care.

With the new page, people can efficiently navigate all facility inspection reports and data – including COVID-19 pandemic and Public Health Emergency (PHE) information. This tool will remain active through and beyond the COVID-19 PHE.

Full text of News Alert.

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November 2, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11659 – Special Provisions for Radiology Additional Documentation Requests

  This article discusses a pilot process enabling MACs to request pertinent documentation from the treating/ordering provider during medical review, in an effort to support the necessity and payment for radiology service(s)/item(s) billed to Medicare. Make sure that your billing staffs are aware of these changes.

Revised:

- MM11939 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2020 Update

  CMS revised the article to reflect the revised change request (CR) 11939, issued on October 27, 2020. We added information about codes 3170F, 0599T, A4226, and the new codes 86408, 86409, 86413, and 99072. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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The Fiscal Intermediary Shared System (FISS) corrected the issue on April 6, 2020.

Novitas has identified approximately 655,000 claims that will be adjusted so the claims can process through any local edits that may have been missed due to the system error.

Depending on the coding of the claim, previously paid claim lines may now deny against LCD editing or an entire claim may be denied. Providers may also receive requests for records on previously paid claims. Claims may also be adjusted with no change to payment if the coding on the claim meets the medical necessity of any local editing that is in place.

The adjustments related to this issue can be identified with a type of bill (TOB) ending with “J” on the remittance. We will begin initiating adjustments for impacted claims 11/16/20. We will update this posting when all adjustments have been initiated.

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October 29, 2020

CMS Provider Education Message:

Quality Payment Program APMs: Update Billing Information to Get Paid

MLN Connects® for Thursday, October 29, 2020

View this edition as a: Webpage | PDF

News

- Quality Payment Program APMs: Update Billing information by November 13

Compliance

- Hospice Aide Services: Enhancing RN Supervision

MLN Matters® Articles

- Change to the Payment of Allogeneic Stem Cell Acquisition Services — Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter

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The following proposed local coverage determinations (LCDs) have been posted for comments. The comment period will end on December 12, 2020; however, you are encouraged to submit your comments as soon as possible.

- Cardiology Non-emergent Outpatient Stress Testing (DL35083)
- Facet Joint Interventions for Pain Management (DL34892)

  Submit comments

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

- Billing and coding: Cardiology Non-emergent Outpatient Stress Testing (DA56423)
- Billing and coding: Facet Joint Interventions for Pain Management (DA56670)

The following local coverage determination (LCD) posted for comment on October 31, 2019, has been posted for notice. The LCD and related billing and coding article will become effective December 13, 2020:

- Biomarkers for Oncology (L35396)
  - Billing and coding: Biomarkers for Oncology (A52986)

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

- Response to comments: Biomarkers for Oncology (A58529)

As a reminder, the comment period for the following proposed local coverage determinations (LCDs) is currently open and will close on November 7, 2020. We encourage you to submit your comments as soon as possible.

- Blepharoplasty and Surgical Procedures of the Brow (DL35004)
- Botulinum Toxins (DL38809)
- Diagnostic Colonoscopy (DL38812)

Submit comments

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11956 – October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  CMS revised this article to reflect the revised change request (CR) 11956, issued on October 27, 2020. The CR revision clarified the claims processing jurisdiction for code K1009. CMS also revised the release date, transmittal number, and the web address of the CR. All other information remains the same.

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Online registration available for November 13, 2020, Open meeting and proposed LCDs now posted

Online registration for the November 13, 2020, Open meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, November 11, 2020. **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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Special Edition – Wednesday, October 28, 2020

Provider Education Message:

Trump Administration Acts to Ensure Coverage of Life-Saving COVID-19 Vaccines & Therapeutics

Under President Trump's leadership, CMS is taking steps to ensure all Americans, including the nation's seniors, have access to the coronavirus disease 2019 (COVID-19) vaccine at no cost when it becomes available. On October 28, the agency released a comprehensive plan with proactive measures to remove regulatory barriers and ensure consistent coverage and payment for the administration of an eventual vaccine for millions of Americans. CMS released a set of toolkits for providers, states and insurers to help the health care system prepare to swiftly administer the vaccine once it is available. These resources are designed to increase the number of providers that can administer the vaccine, ensure adequate reimbursement for administering the vaccine in Medicare, while making it clear to private insurers and Medicaid programs their responsibility to cover the vaccine at no charge to beneficiaries. In addition, CMS is taking action to increase reimbursement for any new COVID-19 treatments that are approved or authorized by the FDA.

"Under President Trump's leadership, we have developed a comprehensive plan to support the swift and successful distribution of a safe and effective vaccine for COVID-19," said CMS Administrator Seema Verma. "As Operation Warp Speed nears its goal of delivering the vaccine in record time, CMS is acting now to remove bureaucratic barriers while ensuring that states, providers and health plans have the information and direction they need to ensure broad vaccine access and coverage for all Americans."

To ensure broad access to a vaccine for America's seniors, CMS released an Interim Final Rule with Comment Period (IFC) that establishes that any vaccine that receives Food and Drug Administration (FDA) authorization, either through an Emergency Use Authorization (EUA) or licensed under a Biologics License Application (BLA), will be covered under Medicare as a preventive vaccine at no cost to beneficiaries. The IFC also implements provisions of the CARES Act that ensure swift coverage of a COVID-19 vaccine by most private health insurance plans without cost sharing from both in and out-of-network providers during the course of the public health emergency (PHE).

In anticipation of the availability of new COVID-19 treatments, the IFC also establishes additional Medicare hospital payment to support Medicare patients' access to these potentially life-saving COVID-19 therapies. In Medicare, hospitals are generally reimbursed a fixed payment amount for the services they provide during an inpatient stay, even if their costs exceed that amount. Under current rules, hospitals may qualify for additional "outlier payments," but only when their costs for a particular patient exceed a certain threshold. Under this IFC, hospitals would qualify for additional payments when they treat patients with innovative new products approved or authorized to treat COVID-19 to mitigate any losses they may experience from making these therapies available, even if they do not reach the current outlier threshold. The IFC also makes changes to reimbursement for outpatient hospital services to ensure payment for certain innovative treatments for COVID-19 that occur outside of bundled arrangements and are paid separately. In addition, CMS released information to prepare hospitals to bill for the outpatient administration of a monoclonal antibody product in the event one is approved under an emergency use authorization (EUA).

This rule also allows states to employ a broad range of strategies - based on local needs - to appropriately manage their Medicaid program costs. The guidance and flexibility provided to states in the IFC will help them maintain Medicaid beneficiary enrollment while receiving the temporary increase in federal funding in the Families First Coronavirus Response Act (FFCRA).

CMS is also taking continued steps to ensure that price transparency extends to COVID-19 testing during the PHE. Provisions in the IFC require that any provider who performs a COVID-19 diagnostic test post their cash prices online. Providers that are non-compliant may face civil monetary penalties.

In addition to these provisions, the IFC:

- Provides an extension of Performance Year 5 for the Comprehensive Care for Joint Replacement (CJR) model; and
- Creates flexibilities in the public notice requirements and post-award public participation requirements for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act during the COVID-19 PHE.

Along with these regulatory changes, CMS is issuing three toolkits aimed at state Medicaid agencies, providers who will administer the vaccine, and health insurance plans. Together, these toolkits will help ensure the health care system is prepared to successfully administer a safe and effective vaccine by addressing issues related to access, billing and payment, and coverage.

Increasing Access to Vaccines for Medicare & Medicaid Beneficiaries

The toolkits issued today give health care providers not currently enrolled in Medicare the information needed to administer and bill vaccines to Medicare patients. CMS is working to increase the number of providers that will administer a COVID-19 vaccine to Medicare beneficiaries when it becomes available, to make it as convenient as possible for America's seniors. New providers are now able to enroll as a "Medicare mass immunizers" through an expedited 24-hour process. The ability to easily enroll as a mass immunizer is important for some pharmacies, schools, and other entities that may be non-traditional providers or otherwise not eligible for Medicare enrollment. To further increase the number of providers who can administer the COVID -19 vaccine, CMS will continue to share approved Medicare provider information with states to assist with Medicaid provider enrollment efforts. CMS is also making it easier for newly enrolled Medicare providers to also enroll in state Medicaid programs to support state administration of vaccines for Medicaid recipients.

Coverage

As a condition of receiving free COVID-19 vaccines from the federal government, providers will be prohibited from charging consumers for administration of the vaccine. To ensure broad and consistent coverage across programs and payers, the toolkits have specific information for several programs, including:

Medicare: Beneficiaries with Medicare pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.

Medicare Advantage (MA): For calendar years 2020 and 2021, Medicare will pay directly for the COVID-19 vaccine and its administration for beneficiaries enrolled in MA plans. MA plans would not be responsible for reimbursing providers to administer the vaccine during this time. Medicare Advantage beneficiaries also pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.

Medicaid: State Medicaid and CHIP agencies must provide vaccine administration with no cost sharing for most beneficiaries during the public health emergency. Following the public health emergency, depending on the population, states may have to evaluate cost sharing policies and may have to submit state plan amendments if updates are needed.

Private Plans: CMS, along with the Departments of Labor and the Treasury, is requiring that most private health plans and issuers cover a recommended COVID-19 vaccine and its administration, both in-network and out-of-network, with no cost sharing. The rule also provides that out-of-network rates cannot be unreasonably low, and references CMS's reimbursement rates as a potential guideline for insurance companies.

Uninsured: For individuals who are uninsured, providers will be able to be reimbursed for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by the Health Resources and Services Administration (HRSA).

Billing and Payment

The toolkits also address issues related to billing and payment. After the FDA either approves or authorizes a vaccine for COVID-19, CMS will identify the specific vaccine codes, by dose if necessary, and specific vaccine administration codes for each dose for Medicare payment. CMS and the American Medical Association (AMA) are working collaboratively on finalizing a new approach to report use of COVID-19 vaccines, which include separate vaccine-specific codes. Providers and insurance companies will be able to use these to bill for and track vaccinations for the different vaccines that are provided to their enrollees.

Medicare Payment

CMS also released new Medicare payment rates for COVID-19 vaccine administration. The Medicare payment rates will be $28.39 to administer single-dose vaccines. For a COVID-19 vaccine requiring a series of two or more doses, the initial dose(s) administration payment rate will be $16.94, and $28.39 for the administration of the final dose in the series. These rates will be geographically adjusted and recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. Medicare beneficiaries, those in Original Medicare or enrolled in Medicare Advantage, will be able to get the vaccine at no cost.

CMS is encouraging state policymakers and other private insurance agencies to utilize the information on the Medicare reimbursement strategy to develop their vaccine administration payment plan in the Medicaid program, CHIP, the Basic Health Program (BHP), and private plans. Using the Medicare strategy as a model would allow states to match federal efforts in successfully administering the full vaccine to the most vulnerable populations.

The IFC (CMS-9912-IFC) is scheduled to display at the Federal Register as soon as possible with an immediate effective date and a 30-day comment period.

For More Information:

- Fact Sheet
- COVID-19 vaccine resources for providers, health plans and State Medicaid programs
- FAQs on billing for therapeutics

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October 27, 2020

Special Edition – Tuesday, October 27, 2020

Provider Education Message:

New CMS Proposals Streamline Medicare Coverage, Payment, and Coding for Innovative New Technologies and Provide Beneficiaries with Diabetes Access to More Therapy Choices

Durable Medical Equipment (DME) proposed rule would reduce administrative burden for new innovative technologies

On October 27, under the leadership of President Trump, CMS proposed new changes to Medicare Durable Medical Equipment, Prosthetics, Orthotic Devices, and Supplies (DMEPOS) coverage and payment policies. This rule would provide more choices for beneficiaries with diabetes, while streamlining the process for innovators in getting their technologies approved for coverage, payment, and coding by Medicare.

The proposed rule would expand the interpretation regarding when external infusion pumps are appropriate for use in the home and can be covered as DME under Medicare Part B, increasing access to drug infusion therapy services in the home. The proposed rule also drastically reduces administrative burdens – such as complicated government coverage, payment, and coding processes – that block innovators from getting their products to Medicare beneficiaries in a timely manner. This action aligns with President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors.

"With the policies outlined in this proposed rule, innovators have a much more predictable path to understanding the kinds of products that Medicare will pay for," said CMS Administrator Seema Verma. "For manufacturers, bringing a new product to market will mean they can get a Medicare payment amount and billing code right off the bat, resulting in quicker access for Medicare beneficiaries to the latest technological advances and the most, cutting-edge devices available. It's clearly a win-win for patients and innovators alike."

Due to administrative constraints, the process for making Medicare benefit classifications, pricing determinations, and creating billing codes for DMEPOS used to routinely take up to 18 months to complete. Last year, CMS changed this process through sub-regulatory guidance to reduce that timeframe to six months in many cases and is now proposing to establish a streamlined process for coding, coverage, and payment in regulation. Under this accelerated process, benefit classification and pricing decisions could happen on the same day the billing codes used for payment of new items take effect, which would facilitate seamless coverage and payment for new DMEPOS and services. If finalized, this proposed rule would allow innovators to bring their products to Medicare beneficiaries quicker giving them more choices and increased access to the latest, cutting-edge devices.

If finalized, this proposed rule will also expand Medicare coverage and payment for Continuous Glucose Monitors (CGMs) that provide critical information on blood glucose levels to help patients with diabetes manage their disease. Currently, CMS only covers therapeutic CGMs or those approved by the FDA for use in making diabetes treatment decisions, such as changing one's diet or insulin dosage based solely on the readings of the CGM.

CMS is proposing to classify all CGMs (not just limited to therapeutic CGMs) as DME and establish payment amounts for these items and related supplies and accessories. CGMs that are not approved for use in making diabetes treatment decisions can be used to alert beneficiaries about potentially dangerous glucose levels while they sleep and that they should further test their glucose levels using a blood glucose monitor. With one in every three Medicare beneficiaries having diabetes, this proposal would give Medicare beneficiaries and their physicians a wider range of technology and devices to choose from in managing diabetes. This proposal will improve access to these medical technologies and empower patients to make the best health care decisions for themselves.

In addition, the proposed rule would expand classification of external infusion pumps under the DME benefit making home infusion of more drugs possible for beneficiaries. An external infusion pump is a medical device used to deliver fluids such as nutrients or medications into a patient's body in a controlled manner. The proposal would expand classification of external infusion pumps as DME in cases where assistance from a skilled home infusion therapy supplier is necessary for safe infusion in the home, allowing beneficiaries more choices to get therapies at home instead of traveling to a health care facility.

Lastly, in the proposed rule, CMS proposes to continue to pay higher amounts to suppliers for DMEPOS items and services furnished in rural and non-contiguous areas to encourage suppliers to provide access and choices for beneficiaries living in those areas. CMS is making this proposal based on previous stakeholder feedback that indicate unique challenges and higher costs for providing for DMEPOS items for beneficiaries in rural and remote areas.

For More Information:

- Proposed Rule
- Fact Sheet

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October 26, 2020

Billing outpatient observation services

Billing clarification added for non-OPPS providers when the total hours of observation exceed 72 hours.

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October 22, 2020

CMS Provider Education Message:

Medicare Coverage for Opioid Use Disorder Treatment

MLN Connects® for Thursday, October 22, 2020

View this edition as a: Webpage | PDF

News

- Opioid Use Disorder Treatment: Medicare Coverage
- Clinical Diagnostic Laboratory Tests Advisory Panel: Request for Nominations
- Medicare Diabetes Prevention Program: Become a Medicare-Enrolled Supplier

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — October 22
- Medicare Part A Cost Report: New Bulk e-Filing Feature Webcast — October 29

MLN Matters® Articles

- Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2021 and Productivity Adjustment
- Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) — Revised
- New Waived Tests — Revised

Multimedia

- Nursing Home COVID-19 Preparedness for Fall & Winter Web-Based Training

Information for Medicare Patients

- Diabetes Management Resources

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September 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The September 2020 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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Appeals Corner Newsletter October 2020

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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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11729 – Change to the Payment of Allogeneic Stem Cell Acquisition Services

  CMS revised this article to reflect the revised change request (CR) 11729 issued on October 20, 2020. The CR revision did not impact the substance of the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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Qualified Independent Contractor (QIC) Appeals Demonstration October 2020 Newsletter

C2C Innovative Solutions has added their October 2020 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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October 20, 2020

Retroactive prior authorization for certain outpatient department (OPD) services in the emergency department (ED)

CMS will allow exclusions for certain PARs to be submitted retroactively when those services were rendered in the Emergency Department (ED) and obtaining a prior authorization was not possible given the timing of the emergency and conditions when service(s) cannot be delayed. Such a PAR must be submitted no more than two business days (excluding federal holidays and weekends) after the service was rendered in the ED using the expedited PAR cover sheet.

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October 19, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12031 – Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2021 and Productivity Adjustment

  This article gives you the CY 2021 AIF for determining the payment limit for ambulance services. The AIF for CY 2021 is 0.2 percent. Make sure that your billing staffs are aware of this change.

Revised:

- SE20011 – Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  CMS revised the article to clarify the HCPCS codes that critical access hospitals (CAHs) should use in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. Also, we clarified the skilled nursing facility (SNF) benefit period waiver - provider information section to show the SNF waiver applies to swing-bed services in rural hospitals and CAHs. All other information remains the same.

October 16, 2020

Special Edition – Friday, October 16, 2020

Provider Education Message:

Enforcement Discretion Relating to Certain Pharmacy Billing

The Centers for Medicare & Medicaid Services ("CMS") appreciates its long-standing partnership with immunizers, including pharmacies, to facilitate the efficient administration of vaccinations, particularly for vulnerable populations in long-term care facilities and other congregate care settings across America. Leveraging immunizers' capabilities and expertise will play an important role in the Department's ability to broadly distribute and administer COVID-19 vaccinations, including Medicare beneficiaries.

America is facing an unprecedented challenge. Quickly, safely, and effectively vaccinating our most vulnerable citizens in settings that have accounted for about 30 percent of U.S. COVID-19 deaths is a top-priority mission for the Trump Administration. Unfortunately, many long-term care facilities may not have sufficient capacity to receive, store, and administer vaccines. And some long-term care facility residents cannot safely leave the facility to receive vaccinations.

Outside immunizers can help fill that urgent need and provide onsite vaccinations at skilled nursing facilities ("SNFs"). But to do so during this global emergency, Medicare-enrolled vaccinators must be able to bill directly and receive direct reimbursement from the Medicare program. However, the Social Security Act requires SNFs to bill for certain services, including vaccine administration, even when SNFs rely on an outside vendor to perform the service. See Social Security Act §§ 1862(a)(18), 1842(b)(6)(E).

Therefore, in order to facilitate the efficient administration of COVID-19 vaccines to SNF residents, CMS will exercise enforcement discretion with respect to these statutory provisions as well as any associated statutory references and implementing regulations, including as interpreted in pertinent guidance (collectively, "SNF Consolidated Billing Provisions"). Through the exercise of that discretion, CMS will allow Medicare-enrolled immunizers, including but not limited to pharmacies working with the United States, to bill directly and receive direct reimbursement from the Medicare program for vaccinating Medicare SNF residents.

CMS will exercise such discretion (1) during the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. § 1320b-5(g)) and ending on the last day of the calendar quarter in which the last day of such emergency period occurs; or (2) so long as CMS determines that there is a public health need for mass COVID-19 vaccinations in congregate care settings—whichever is later. While CMS exercises this enforcement discretion, compliance with SNF Consolidated Billing Provisions is not material to CMS' decision to reimburse for COVID-19 vaccine administration. If CMS decides in the future to cease exercising this enforcement discretion, CMS will provide public notice in advance and allow at least 60 days for affected outside immunizers to modify their business practices.

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October 15, 2020

Special Edition – Thursday, October 15, 2020

Provider Education Message:

Trump Administration Drives Telehealth Services in Medicaid and Medicare

On October 14, CMS expanded the list of telehealth services that Medicare Fee-for-Service will pay for during the COVID-19 Public Health Emergency (PHE). CMS is also providing additional support to state Medicaid and Children's Health Insurance Program (CHIP) agencies in their efforts to expand access to telehealth. The actions reinforce President Trump's Executive Order on Improving Rural Health and Telehealth Access to improve the health of all Americans by increasing access to better care.

"Responding to President Trump's Executive Order, CMS is taking action to increase telehealth adoption across the country," said CMS Administrator Seema Verma. "Medicaid patients should not be forgotten, and today's announcement promotes telehealth for them as well. This revolutionary method of improving access to care is transforming health care delivery in America. President Trump will not let the genie go back into the bottle."

Expanding Medicare Telehealth Services:

For the first time using a new expedited process, CMS added 11 new services to the Medicare telehealth services list since the publication of the May 1 COVID-19 Interim Final Rule with comment period (IFC). Medicare will begin paying eligible practitioners who furnish these newly added telehealth services effective immediately and for the duration of the PHE. These new telehealth services include certain neurostimulator analysis and programming services, and cardiac and pulmonary rehabilitation services. The list of these newly added services is available on the List of telehealth services webpage.

In the May 1 COVID-19 IFC, CMS modified the process for adding or deleting services from the Medicare telehealth services list to allow for expedited consideration of additional telehealth services during the PHE outside of rulemaking. This update to the Medicare telehealth services list builds on the efforts CMS has already taken to increase Medicare beneficiaries' access to telehealth services during the COVID-19 PHE.

Since the beginning of the PHE, CMS added over 135 services to the Medicare telehealth services list – such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services. With this action, Medicare will pay for 144 services performed via telehealth. Between mid-March and mid-August, over 12.1 million Medicare beneficiaries – over 36% – of people with Medicare Fee-for-Service received a telemedicine service.

Preliminary Medicaid and CHIP Data Snapshot on Telehealth Utilization and Medicaid & CHIP Telehealth Toolkit Supplement:

In an effort to provide greater transparency on telehealth access in Medicaid and CHIP, CMS released, for the first time, a preliminary Medicaid and CHIP data snapshot on telehealth utilization during the PHE. This snapshot shows, among other things, that there have been more than 34.5 million services delivered via telehealth to Medicaid and CHIP beneficiaries between March and June of this year, representing an increase of more than 2,600% when compared to the same period from the prior year. The data also shows that adults ages 19-64 received the most services delivered via telehealth, although there was substantial variance across both age groups and states.

To further drive telehealth, CMS released a new supplement to its State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version that

provides numerous new examples and insights into lessons learned from states that implemented telehealth changes. The updated supplemental information is intended to help states strategically think through how they explain and clarify to providers and other stakeholders which policies are temporary or permanent. It also helps states identify services that can be accessed through telehealth, which providers may deliver those services, the ways providers may use in order to deliver services through telehealth, as well as the circumstances under which telehealth can be reimbursed once the PHE expires.

The toolkit includes approaches and tools states can use to communicate with providers on utilizing telehealth for patient care. It updates and consolidates in one place the FAQs and resources for states to consider as they begin planning beyond the temporary flexibilities provided in response to the pandemic.

View the Medicaid and CHIP data snapshot on telehealth utilization during the PHE.

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CMS Provider Education Message:

COVID-19 Testing: Protecting Integrity

MLN Connects® for Thursday, October 15, 2020

View this edition as a: Webpage | PDF

News

- CMS Takes Action to Protect Integrity of COVID-19 Testing
- Protect Your Patients: Give Them a Flu Shot

Events

- Medicare Part A Cost Report: New Bulk e-Filing Feature Webcast — October 29

MLN Matters® Articles

- New Waived Tests
- January 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3 — Revised
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2021 — Revised

Publications

- Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies — Revised

Multimedia

- Coverage of an Annual Wellness Visit Video

Information for Medicare Patients

- Medicare Health and Drug Plans Receive Star Ratings

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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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The following billing and coding article has been revised:

- Billing and coding: Psychiatric codes (A57130)

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Avastin for ophthalmological use, J7999

Novitas would like to provide the following information to assist with the billing of the compounded form of Avastin for ophthalmological use to ensure the drug administration is reported accurately. The not otherwise classified (NOC) code, J7999, from the American Medical Association Healthcare Common Procedure Coding System (HCPCS) is to be billed for the intravitreal administration of the compounded form of Avastin.

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October 12, 2020

The following local coverage determination (LCD) which was posted for notice on August 27, 2020, is now effective. The companion article for this LCD is also now effective:

- Implantable Continuous Glucose Monitors (I-CGM) (L38617)
  - Billing and coding: Implantable Continuous Glucose Monitors (I-CGM) (A58110)

The comment period is now closed for the following proposed local coverage determination. 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.

- Colon Capsule Endoscopy (CCE) (DL38807)
  - Billing and coding: Colon Capsule Endoscopy (CCE) (DA58414)

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Accelerated and advance repayments

CMS expedited payments to increase cash flow to providers/suppliers due to a disruption in claim submission and/or claims processing. As these funds were temporary, they will need to be refunded to Medicare through the recoupment process. If you are a provider or supplier who had received these payments, we encourage you to review our article Learn about CMS' amended repayment process for accelerated and advance repayments to learn how to prepare for the recoupment of these funds.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM12020 – January 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  This article informs you of updates to the quarterly ASP Medicare Part B pricing files and informs providers of revisions, if needed, to prior quarterly pricing files. Please make sure your billing staffs are aware of these updates and revisions.

October 8, 2020

Special Edition – Thursday, October 8, 2020

Provider Education Message:

CMS Announces New Repayment Terms for Medicare Loans Made to Providers During COVID-19

New recoupment terms allow providers and suppliers one additional year to start loan payments

CMS announced amended terms for payments issued under the Accelerated and Advance Payment (AAP) Program as required by recent action by President Trump and Congress. This Medicare loan program allows CMS to make advance payments to providers, which are typically used in emergency situations. Under the Continuing Appropriations Act, 2021 and Other Extensions Act, repayment will now begin one year from the issuance date of each provider or supplier's accelerated or advance payment. CMS issued $106 billion in payments to providers and suppliers in order to alleviate the financial burden health care providers faced while experiencing cash flow issues in the early stages of combating the Coronavirus Disease 2019 (COVID-19) public health emergency.

"In the throes of an unprecedented pandemic, providers and suppliers on the frontlines needed a lifeline to help keep them afloat," said CMS Administrator Seema Verma. "CMS' advanced payments were loans given to providers and suppliers to avoid having to close their doors and potentially causing a disruption in service for seniors. While we are seeing patients return to hospitals and doctors providing care we are not yet back to normal," she added.

CMS expanded the AAP Program on March 28, 2020, and gave these loans to health care providers and suppliers in order to combat the financial burden of the pandemic. CMS successfully paid more than 22,000 Part A providers, totaling more than $98 billion in accelerated payments. This included payments to Part A providers for Part B items and services they furnished. In addition, more than 28,000 Part B suppliers, including doctors, non-physician practitioners, and durable medical equipment suppliers received advance payments totaling more than $8.5 billion.

Providers were required to make payments starting in August of this year, but with this action, repayment will be delayed until one year after payment was issued. After that first year, Medicare will automatically recoup 25% of Medicare payments otherwise owed to the provider or supplier for 11 months. At the end of the 11-month period, recoupment will increase to 50% for another 6 months. If the provider or supplier is unable to repay the total amount of the AAP during this time-period (a total of 29 months), CMS will issue letters requiring repayment of any outstanding balance, subject to an interest rate of 4%.

The letter also provides guidance on how to request an Extended Repayment Schedule (ERS) for providers and suppliers who are experiencing financial hardships. An ERS is a debt installment payment plan that allows a provider or supplier to pay debts over the course of 3 years, or, up to 5 years in the case of extreme hardship. Providers and suppliers are encouraged to contact their MAC for information on how to request an ERS. To allow even more flexibility in paying back the loans, the $175 billion issued in Provider Relief funds can be used towards repayment of these Medicare loans. CMS will be communicating with each provider and supplier in the coming weeks as to the repayment terms and amounts owed as applicable for any accelerated or advance payment issued.

For More Information:

- Fact Sheet
- FAQs

CMS Provider Education Message:

17 Provider Compliance Tips Fact Sheets

MLN Connects® for Thursday, October 8, 2020

View this edition as a: Webpage | PDF

News

- Hospice Quality Reporting Program: Successful Facilities for FY 2021
- Laboratories: Pay Your CLIA Certification Fees Online
- Institutional Providers: Give Us Your Feedback on the Provider Specific File by November 1
- Submit Medicare GME Affiliation Agreements during COVID-19 PHE by January 1
- COVID-19: Optimizing PPEand Child Health and Wellness
- Ostomies are Life-Savers

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — October 8

Publications

- Laboratory Quick Start Guide for CLIA Certification
- Provider Compliance Tips — Revised
- ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets — Revised
- DMEPOS Accreditation — Revised
- SNF and LTCH Quality Reporting Programs: COVID-19 Public Reporting — Revised

Multimedia

- Dementia Care Call: Audio Recording and Transcript

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October 7, 2020

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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October 6, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11944 – October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3

The Centers for Medicare & Medicaid Services revised this article to reflect the revised change request (CR) 11944, issued on October 2, 2020. The CR revision added several items to the Summary of Quarterly Release Modifications table, and we made those same changes in the article. Also, we revised 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 2021

The Centers for Medicare & Medicaid Services has announced the dollar amount that must remain in controversy to sustain appeal rights beginning January 1, 2021. Please read this article for details.

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October 5, 2020

September 2020 top claim submission errors

The September 2020 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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October 1, 2020

CMS Provider Education Message:

Hospital Price Transparency: Requirements Effective January 1

MLN Connects® for Thursday, October 1, 2020

View this edition as a: Webpage | PDF

News

- Hospital Price Transparency: Requirements Effective January 1
- IRF Provider Preview Reports: Review Your Data by October 26
- LTCH Provider Preview Reports: Review Your Data by October 26
- Therapeutic Injections and Infusions: Comparative Billing Report
- SNF Healthcare-Associated Infections Confidential Dry Run Report
- COVID-19: Optimizing Health Care PPE and Supplies
- Hospice Quality Reporting Program News
- October is National Breast Cancer Awareness Month

MLN Matters® Articles

- Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 27.0, Effective January 1, 2021
- Change to the Payment of Allogeneic Stem Cell Acquisition Services — Revised

- New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services — Revised
- October 2020 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
  Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Multimedia

- ICD-10 Coordination and Maintenance Committee Meeting Materials
- SNF Consolidated Billing Web-Based Training Course — Revised

Information for Medicare Patients

- Making Insulin More Affordable for Medicare Patients Beginning January 1

.

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, 2020.

- Billing and coding: Allergen Immunotherapy (A56538)
- Billing and coding: Allergy Testing (A56558)
- 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: Biomarkers for Oncology (A52986)
- Billing and coding: Controlled Substance Monitoring and Drugs of Abuse Testing (A56645)
- Billing and coding: Epidural Injections for Pain Management (A56681)
- Billing and coding: Flow Cytometry (A56676)
- Billing and coding: Hydration Therapy (A56634)
- Billing and coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (A56938)
- Billing and coding: Intravenous Immune Globulin (IVIG) (A56786)
- Billing and coding: Magnetic Resonance Angiography (MRA) (A56805)
- Billing and coding: Monitored Anesthesia Care (A57361)
- Billing and coding: Nerve Conduction Studies and Electromyography (A54095)
- Billing and coding: Neurophysiology Evoked Potentials (NEPs) (A56773)
- 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: Scanning Computerized Ophthalmic Diagnostic Imaging (A57600)
- Billing and coding: Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) (A57414)

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

- Chiropractic services (L35424)
  - Billing and coding: Chiropractic services (A52987)

The following billing and coding article that was published on August 27, 2020, is now effective:

- Billing and coding: Chiropractic services (A58345)

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Prior authorization (PA) for hospital outpatient department (OPD) tips and reminders

We have been processing prior authorization requests (PARs) since the implementation of the program and have found errors and omissions in these requests. These errors and omissions can result in delays or dismissals of the PAR. This article provides tips and reminders that will assist you in avoiding a delay or dismissal of a PAR.

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September 30, 2020

Fiscal Intermediary Shared System (FISS) Manual update

The FISS manual has been updated to reflect the addition of the Medicare Beneficiary Identifier (MBI) 'eligibility from date' and 'eligibility thru date' fields to the Eligibility Detail Screen (MAP1751). Once the MBI eligibility from and thru dates are entered, the following will occur:

- If the MBI used is active for the dates entered, the beneficiary information will be displayed.
- If the MBI is inactive for the dates entered, the following message will be displayed: "MBI being used in the query is not active and is end dated."

.

September 29, 2020

Increased payments for COVID-19 discharges under the Inpatient Prospective Payment System (IPPS)

Effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the Medicare Severity-Diagnosis Related Group (MS-DRG) weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient's medical record. To notify us when there is no evidence of a positive laboratory test documented in the patient's medical record, enter a Billing Note NTE02 "No Pos Test" on the electronic claim 837I or a remark "No Pos Test" on a paper claim or report "No Pos Test" in position one in the remarks field in the Fiscal Intermediary Shared System exactly as listed with no punctuation. Please review this article for billing guidance.

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Part A open issues 37096 update

The issue has been identified and corrected. Claims received between September 10, 2020, through September 23, 2020, were returned in error. Please resubmit or F9 any claims that were RTP with reason code 37096 for processing.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11960 – October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  CMS revised this article to reflect an updated change request (CR) 11960 that made several changes including:

  - Added a new COVID-19 CPT code, 86413, to Table 1
  - Added new Section 2: "New Category I CPT code 99072 for Reporting of Additional Practice Expenses Incurred During a Public Health Emergency (PHE), Including Supplies and Additional Clinical Staff Time."
  - Added new Table 2, with the new 99072 CPT code.
  - Re-numbered all sections after Section 2 and all the tables following Table 2.
  - Added a new Sub-section e. to Section 8: "Drugs, Biologicals, and Radiopharmaceuticals."
  - Added New Table 12 to describe these changes. All sub-sections following new Sub-section e. were re-numbered.
  - Updated Sub-section g. and Table 14 to reflect the change to the long descriptor for HCPCS, C9066.
  - Updated Tables 8 and 13 to reflect the correct long descriptor for C9066. The CR release date, transmittal number and link to the transmittal was also changed. All other information remains the same.

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September 28, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11729 – Change to the Payment of Allogeneic Stem Cell Acquisition Services

  CMS revised this article to reflect the revised change request (CR) 11729 issued on September 24, 2020. CMS also revised the CR release date, transmittal number, and web address. All other information remains the same.

- MM11750 – New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services

  CMS revised this article to reflect the revised change request (CR) 11750, issued on September 25, 2020. CMS also revised the CR release date, transmittal number, and web address. All other information remains the same.

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September 25, 2020

Reporting Bevacizumab for ophthalmological use

Novitas revised Local Coverage Article A53121 Information Regarding Uses, Including Off-Label Uses, of Anti-Vascular Endothelial Growth Factor (anti-VEGF), for The Treatment of Ophthalmological Diseases on February 13, 2020 to provide clarification to the billing instruction for Bevacizumab. Physicians providing Bevacizumab for ophthalmological use should report HCPCS code J7999 (Compounded drug, not otherwise classified). Each 1.25mg dose administered is considered one unit. The total dosage administered should be noted in the "Remarks" section of the claim.

.

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11937 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  CMS revised the article to add a new COVID 19 code (86413) and advanced diagnostic laboratory test code (0090U). CMS also revised the change request (CR) release date, transmittal number, and web address of the CR. All other information remains the same.

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September 24, 2020

CMS Provider Education Message:

Need Help Checking Medicare Eligibility?

MLN Connects® for Thursday, September 24, 2020

View this edition as a PDF

News

- CMS to Expand Successful Ambulance Program Integrity Payment Model Nationwide
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- COVID-19: Maintaining Safety, Critical Care Load-Balancing, & Behavioral Health
- National Cholesterol Education Month & World Heart Day

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — September 24

MLN Matters® Articles

- 2021 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update
- National Coverage Determination (NCD 90.2): Next Generation Sequencing (NGS) for Medicare Beneficiaries with Germline (Inherited) Cancer
- Update to the Medicare Claims Processing Manual

- Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries — Revised

Publications

- Checking Medicare Eligibility

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The following proposed local coverage determinations (LCDs) have been posted for comments. The comment period will end on November 7, 2020; however you are encouraged to submit your comments as soon as possible.

- Blepharoplasty and Surgical Procedures of the Brow (DL35004)
- Botulinum Toxins (DL38809)
- Diagnostic Colonoscopy (DL38812)

Submit comments

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

- Billing and coding: Blepharoplasty and Surgical Procedures of the Brow (DA57618)
- Billing and coding: Botulinum Toxins (DA58423)
- Billing and coding: Diagnostic Colonoscopy (DA58428)

The following billing and coding article has been revised:

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

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

- Corus® CAD Test (L36713)
  - Billing and coding: Corus® CAD Test (A56608)

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Online registration available for October 9, 2020, open meeting and proposed LCD now posted

Online registration for the October 9, 2020, open meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, October 7, 2020. **Important:** During this unprecedented time, our Open Meeting will be held via teleconference only. The Novitas Solutions proposed local coverage determination (LCD) is 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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September 23, 2020

Appeals Corner Newsletter September 2020

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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Upcoming direct data entry (DDE) screen change

Effective October 1, the Fiscal Intermediary Shared System (FISS) maintainer is adding the Medicare Beneficiary Identifier ‘eligibility from date’ and ‘eligibility thru date’ to the Eligibility Detail Screen (MAP1751) in DDE. The FISS Manual will be updated to reflect this change by the effective date.

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Limited systems availability - Friday, October 2, 2020, through Sunday, October 4, 2020

There will be Common Working File (CWF) "Dark" days from Friday, October 2, 2020, through Sunday, October 4, 2020, due to the October 2020 release upgrades. The interactive voice response (IVR) unit and our Customer Service representatives will have limited availability. Customer service representatives will not be able to assist providers with eligibility Inquiries, Claim status inquiries relating to eligibility or claim denial inquiries relating to eligibility.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11879 – Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

  This article provides the FY 2021 update to the IPPS and LTCH prospective payment system. Please make sure your billing staffs are aware of these updates.

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September 21, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11958 – Update to the Medicare Claims Processing Manual

  Change request 11958 updates the Medicare Claims Processing Manual, Chapters 12 and 23. The list of non-facility place of service (POS) codes in the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, is updated to reflect previous updates to the POS list in Chapter 26, Section 10.5. Therefore, the Non-Residential Opioid Treatment Facility (POS code 58) setting is now included in Chapter 12, Section 20.4.2. Also, the Medicare Physician Fee Schedule Database (MPFSDB) file layout in the Chapter 23 Addendum is updated to show the procedure code series that are not included on the MPFSDB file. There are no policy changes, and no changes to the function of the MPFSDB file.

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September 17, 2020

Provider Education Message:

Nursing Home COVID-19 Commission Findings, Oregon Wildfires, & Flu

- Independent Nursing Home COVID-19 Commission Findings Validate Unprecedented Federal Response
- CMS Offers Comprehensive Support for Oregon due to Wildfires
- Protect Yourself & Your Patients from Flu this Season

Independent Nursing Home COVID-19 Commission Findings Validate Unprecedented Federal Response

On September 16, CMS received the final report from the independent Coronavirus Commission for Safety and Quality in Nursing Homes (Commission), which was facilitated by MITRE. CMS also released an overview of the robust public health actions the agency has taken to date to combat the spread of the Coronavirus Disease 2019 (COVID-19) in nursing homes. The Commission's findings align with the actions the Trump Administration and CMS have taken to contain the spread of the virus and to safeguard nursing home residents from the ongoing threat of the COVID-19 pandemic. This announcement delivers on the Administration's commitments to keeping nursing home residents safe and to transparency for the American people in the face of this unprecedented pandemic.

"The Trump Administration's effort to protect the uniquely vulnerable residents of nursing homes from COVID-19 is nothing short of unprecedented," said CMS Administrator Seema Verma. "In tasking a contractor to convene this independent Commission comprised of a broad range of experts and stakeholders, President Trump sought to refine our approach still further as we continue to battle the virus in the months to come. Its findings represent both an invaluable action plan for the future and a resounding vindication of our overall approach to date. We are grateful for the Commission's important contribution."

As the capstone to the Commission's extensive report, on September 17, Administrator Verma will join Vice President Mike Pence and CDC Director Dr. Robert R. Redfield, some members of the Commission, and other public health and elder care experts at the White House. The Vice President, Dr. Redfield, and Administrator Verma will lead the group in a discussion regarding the Commission's findings and general issues facing the nation's elder care system.

Nursing homes and other shared or congregate living facilities have been severely affected by COVID-19, as these facilities often house older individuals who suffer from multiple medical conditions, making them particularly susceptible to complications from the virus. To help CMS inform immediate and future actions as well as identify opportunities for improvement, the Commission was created to conduct an independent review and comprehensive assessments of confronting COVID-19. The Commission's report contains best practices that emphasize and reinforce CMS strategies and initiatives to ensure nursing home residents are protected from COVID-19.

As outlined in the overview released on September 16, the Trump Administration has already taken significant steps to implement many of the Commission's findings. The Administration has worked to support nursing homes financially during this challenging time, distributing over $21 billion to America's nursing homes – more than $1.5 million each on average. To ensure nursing homes had access to supplies, the Trump Administration shipped a 14-day supply of personal protective equipment to more than 15,000 nursing homes across the Nation in May.

The Administration has also required facilities to report data about COVID-19 cases, deaths, and supply levels, with 99.3 percent of facilities currently reporting. CMS took action to keep COVID-19 out of nursing homes by requiring them to test staff, a requirement that was paired with the Administration's distribution of 13,850 point-of-care testing devices to America's nursing homes. The Administration has also deployed federal Task Force Strike Teams in six waves, in 18 states so far, to 61 facilities particularly affected by COVID-19 to share best practices and gain a deeper understanding of how the virus spreads. CMS also required states to conduct focused infection

control inspections at their nursing homes; between June and July, states completed these inspections at 99.8 percent of Medicare and Medicaid certified nursing homes.

Additionally, since March, CMS has conducted weekly calls with nursing homes, issued over 22 guidance documents and established a National Nursing Home COVID-19 Training program focused on infection control and best practices. CMS is also using COVID-19 data to target support to the highest risk nursing homes. In May, CMS released a new toolkit developed to aid nursing homes, Governors, states, departments of health, and other agencies who provide oversight and assistance to nursing homes. The toolkit is a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19. CMS updates the toolkit on a biweekly basis.

For More Information:

Coronavirus Commission for Safety and Quality in Nursing Homes Report

Trump Administration Response to Commission findings

COVID-19 Guidance and Updates for Nursing Homes during COVID-19

See the full text of this excerpted CMS Press Release (issued September 16), including a list of CMS public health actions for nursing homes on COVID-19 to date..

CMS Offers Comprehensive Support for Oregon due to Wildfires

On September 17, CMS announced efforts underway to support Oregon in response to wildfires across the state. On September 16, HHS Secretary Alex Azar declared a Public Health Emergency (PHE) in Oregon, retroactive to September 8. CMS is working to ensure hospitals and other facilities can continue operations and provide access to care despite the effects of the wildfires. CMS provided numerous waivers to health care providers during the current Coronavirus Disease 2019 (COVID-19) pandemic to meet the needs of beneficiaries and providers. These waivers will continue be available to health care providers to use for the duration of the COVID-19 PHE and for the wildfires PHEs. CMS will be waiving certain Medicare, Medicaid, and Children's Health Insurance Program requirements; creating special enrollment opportunities for individuals to access health care quickly; and taking steps to ensure dialysis patients obtain critical life-saving services.

For More Information, visit www.cms.gov/emergency. See the full text of this excerpted CMS Press Release (issued September
17).

Protect Yourself & Your Patients from Flu this Season

Do your part to prevent the spread of seasonal flu. The CDC published flu vaccine recommendations for the 2020-2021 season. Because of the COVID-19 pandemic, reducing the spread of respiratory illness, like flu, this fall and winter is more important than ever.

Frequency and Coverage:

- Medicare Part B covers one flu shot per flu season and additional flu shots if medically necessary
- Flu shots are free for your Medicare patients if you accept assignment

You can give pneumonia and flu shots during the same office visit; see CDC recommendations.

The CDC, the Advisory Committee on Immunization Practices, and the Healthcare Infection Control Practices Advisory Committee recommend that all U.S. health care workers get annual flu shots.

For More Information:

- CMS Flu Shot webpage
- CDC Flu website

- CDC Information for Health Professionals webpage
- CDC Fight Flu Toolkit webpage
- Vaccines.gov

CMS Provider Education Message:

Participate in Medical Documentation Interoperability Pilot

MLN Connects® for Thursday, September 17, 2020

View this edition as a PDF

News

- SNF Healthcare-Associated Infections Measure: Submit Comments by October 14
- Participate in Medical Documentation Interoperability Pilot
- COVID-19 Lessons Learned & Infectious Disease Surge Annex Template
- Healthy Aging® Month: Discuss Preventive Services with Your Patients
- Prostate Cancer Awareness Month

Events

- Dementia Care Call — September 22

MLN Matters® Articles

- October 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act — Revised
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2021 — Revised

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11968 – 2021 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

  CR 11968 makes changes to HCPCS codes and Medicare Physician Fee Schedule (MPFS) designations that Medicare uses to revise its Common Working File (CWF) edits to allow MACs to make appropriate payments in accordance with policy for SNF CB in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

Revised:

- MM11945 – Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries

  CMS revised this article to reflect an updated change request (CR) 11945. The CR revision added part of a sentence that had been left out of manual Section 20.2.2 of the Medicare Secondary Payer Manual, which is part of the CR. The correction of the CR had no impact on

the substance of the article. In the article, the CR release date, transmittal number, and the web address of the CR were revised. All other information remains the same.

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August 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The August 2020 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the claim denials, claim status, and general information categories. Please take time to review these and other FAQs for answers to your questions.

.

September 16, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11837– National Coverage Determination (NCD 90.2): Next Generation Sequencing (NGS) for Medicare Beneficiaries with Germline (Inherited) Cancer

  Effective for dates of service on and after January 27, 2020, CMS has determined that NGS, as a diagnostic laboratory test, is reasonable and necessary and covered nationally for patients with germline (inherited) cancer when performed in a CLIA-certified laboratory, when ordered by a treating physician, and when specific requirements are met. Make sure that your billing staffs are aware of these changes.

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September 15, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20015 – New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act

  CMS revised this article to add guidance on how providers notify their MAC when there is no evidence of a positive laboratory test documented in the patient's medical record. All other information is unchanged.

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September 11, 2020

Special Edition – Friday, September 11, 2020

Provider Education Message:

Community Health Access and Rural Transformation Model

The CMS Innovation Center announced the Community Health Access and Rural Transformation (CHART) Model.

The approximately 57 million Americans living in rural communities, including millions of Medicare and Medicaid beneficiaries, face unique challenges when seeking health care services, such as limited

transportation options, shortages of health care services, and an inability to fully benefit from technological and care-delivery innovations.

Current regulations and volume-based payment structures perpetuate these challenges, with unsustainable financial models leading to over 130 rural hospitals closing since 2010. The constellation of reduced access to care and patients not seeking or delaying care leads to rural Americans facing worse health outcomes and having higher rates of preventable diseases than those living in urban areas.

CMS remains focused on the transformation of rural health care delivery and enabling local community collaboration to redesign their systems of care and align across providers and payers based on their unique needs. As part of that rural transformation, including transforming a system built on fee-for-service and volume to one based on value, CMS is testing the CHART Model.

Through the Model, CMS is directly providing a pool of $75M in upfront, seed funding, with 15 rural communities applying for up to $5M to develop local transformation plans. With this upfront seed funding, CMS is also providing regulatory and operational flexibility for updated service delivery models as well as changing how participating hospitals in these communities are paid, from a system based on volume to stable, monthly payments. In additional to supporting these 15 rural communities, CMS is also looking for 20 rural Accountable Care Organizations (ACOs) to participate in the model, paying shared savings upfront so that ACOs have infrastructure funding to be successful on the move towards achieving better outcomes. Taken together, these are substantial and tangible actions to support health care in our rural communities.

Specifically, the CHART Model will:

- Increase financial stability for rural health care providers through multiple new funding approaches, including the use of up-front investments and predictable, capitated payments that pay for quality and patient outcomes over volume
- Provide the necessary operational and regulatory flexibilities to allow health care providers and CMS to test the Model in their local communities and successfully transform themselves
- Support local rural communities' transformation efforts by being directly engaged at CMS, offering real-time technical expertise and other learning when needed to foster success

If successful, beneficiaries' access to health care services should be improved, rural provider's financial sustainability should increase for years to come, and communities can align with payers and other stakeholders to address both their health care service delivery ecosystem and the necessary social support structures, such as food and housing, to deliver improved health. Ultimately, the CHART Model aims to improve quality and health, while reducing Medicare and Medicaid expenditures, in rural communities over the long-term.

CMS is providing funding, regulatory and operational flexibilities, and technical assistance for rural communities to transform their systems of care through a Community Transformation Track. Further, CMS is enabling providers to participate in value-based payment models where they are paid for quality and outcomes, instead of volume, through an ACO Transformation Track.

CMS anticipates the Notice of Funding Opportunity for the Community Transformation Track will be available in September on the Model website. The Request for Application for the ACO Transformation Track will be available in early 2021 on the CHART Model website.

See the full text of this excerpted CMS Fact Sheet (issued August 11).

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September 10, 2020

CMS Provider Education Message:

CMS Care Compare Empowers Patients

MLN Connects® for Thursday, September 10, 2020

View this edition as a PDF

News

- CMS Care Compare Empowers Patients When Making Important Health Care Decisions
- Open Payments: Adding 5 Provider Types in 2021
- Breast Re-Excision: Comparative Billing Report in September

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — September 10
- Dementia Care Call — September 22

MLN Matters® Articles

- October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2021
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2021
- Internet Only Manual Update to Pub. 100-04, Chapter 16, Section 60.1.2 and Pub. 100-04, Chapter 26, Section 10.4, Item 19
- Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries
- National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP) — Revised

Publications

- Understanding Your Remittance Advice Reports
- Home Health, Hospice, IRF, LTCH, & SNF Quality Reporting Programs: COVID-19 Public Reporting

Multimedia

- Pain Management Listening Session: Audio Recording & Transcript
- Introduction to the LTCH Quality Reporting Program Web-Based Training
- Introduction to the Home Health Quality Reporting Program Web-Based Training

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September 8, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11945 – Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries

  This article informs you that the Centers for Medicare & Medicaid Services is modifying and streamlining the model admission questions for providers to ask Medicare beneficiaries or

authorized representatives upon admission or start of care. No other updates have been made to the hospital admissions or billing process.

September 4, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11858 – Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2021

  This article notifies IRFs that Medicare will release a new IRF pricer software package prior to October 1, 2020. It will contain updated rates that are effective for IRF claims with discharges that fall within October 1, 2020, through September 30, 2021. Make sure your billing staffs are aware of these changes.

September 3, 2020

CMS Provider Education Message:

CMS Acts to Spur Innovation for America's Seniors

MLN Connects® for Thursday, September 3, 2020

View this edition as a PDF

News

- CMS Acts to Spur Innovation for America's Seniors
- Hospital Opioid Toolkit
- CMS Offers Comprehensive Support for California due to Wildfires
- PEPPERs for Short-term Acute Care Hospitals
- Office Visits by Nurse Practitioners: Comparative Billing Report

Events

- Dementia Care Call — September 22

MLN Matters® Articles

- 2021 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Annual Clotting Factor Furnishing Fee Update 2021
- Claim Status Category and Claim Status Codes Update
- 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
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2021

- The Intravenous Immune Globulin (IVIG) Demonstration: Demonstration is ending on December 31, 2020
- October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3
- October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised
- Update to the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for Vaping Related Disorder and Diagnosis and Procedure Codes for the 2019 Novel Coronavirus (COVID-19) — Revised

Publications

- Medicare Preventive Services — Revised
- Medicare Preventive Services Poster — Revised

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August 2020 top claim submission errors

The August 2020 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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September 2, 2020

Special Edition – Wednesday, September 2, 2020

Provider Education Message:

CMS Advancing Seniors' Access to Cutting-edge Therapies and Technology in Medicare Hospital Rule

Finalized policy changes expand new technology add-on payment pathway for certain antimicrobials

On September 2, CMS issued the FY 2021 Medicare Hospital Inpatient Prospective Payment System and Long Term Acute Care Hospital (LTCH) final rule, which includes important provisions designed to ensure access to potentially life-saving diagnostics and therapies for hospitalized Medicare beneficiaries. The changes will affect approximately 3,200 acute care hospitals and approximately 360 LTCHs. CMS estimates that total Medicare spending on acute care inpatient hospital services will increase by about $3.5 billion in FY 2021, or 2.7 percent.

"President Trump is committed to ensuring that seniors on Medicare have access to the latest life-saving diagnostics and therapies," said CMS Administrator Seema Verma. "This rule is another critical step in our effort to modernize the program and strip away bureaucratic barriers between our seniors and the latest innovative treatments."

CMS' rule creates a new Medicare Severity Diagnostic Related Group (MS-DRG) that provides a predictable payment to help adequately compensate hospitals for administering Chimeric Antigen Receptor (CAR) T-cell therapies. The current FDA-approved CAR-T-cell cancer therapies use a patient's genetically modified immune cells to treat specific types of cancer.

Also in the final rule, CMS approved a record number of 24 New Technology Add-on Payments (NTAPs), which is an additional payment to hospitals for cases involving eligible new and relatively

high cost technologies. Last year, to remove barriers to innovation, CMS established alternative streamlined pathways for FDA Breakthrough Devices and FDA Qualified Infectious Disease Products (QIDPs) to qualify for NTAPs. Among CMS' approval of these 24 additional NTAPs are two technologies for new medical devices that are part of the FDA's Breakthrough Devices Program and six technologies that received FDA QIDP designation. This will provide additional Medicare payment for these technologies while real-world evidence is emerging, giving Medicare beneficiaries timely access to the latest innovations.

CMS is also expanding the add-on payment alternative pathway for antimicrobial products approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD pathway), which encourages the development of safe and effective drug products that address unmet needs of patients with serious bacterial and fungal infections. Specifically, an antibacterial or antifungal drug approved under the LPAD pathway is used to treat a serious or life-threatening infection in a limited population of patients with unmet needs.

CMS is also taking steps to ensure that the Medicare Fee-for-Service (FFS) program adopts pricing strategies based on real world market forces. Medicare generally pays hospitals a rate that is weighted by the relative cost of providing certain services based on a patient's diagnosis. These weights are currently based in large part on the charges that hospitals report to the federal government, which often have little relevancy to the actual rates paid by insurance companies. Hospitals are already required to report these negotiated rates as part of the Trump Administration's efforts to promote price transparency, and CMS is now finalizing a requirement for hospitals to report to CMS the median rate negotiated with Medicare Advantage Organizations for inpatient services to use instead of the charge based data. CMS will begin to collect this data in 2021 and will use it in the methodology for calculating inpatient hospital payments beginning in 2024. These provisions will introduce the influences of market competition into hospital payment and help advance CMS's goal of utilizing market- based pricing strategies in the Medicare FFS program.

For More Information:

- Final Rule
- Fact Sheet

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11755 – National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)

  The Centers for Medicare & Medicaid Services revised this article on August 28, 2020, to reflect an updated change request 11755 that provides revised messaging (page 3 in this article). It also revised the Claims Processing Manual at Section 410.4. All other information remains the same.

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September 1, 2020

Appeals Corner Newsletter August 2020

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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Prior authorization (PA) for certain hospital outpatient department (OPD) services upcoming webinars

Join us for our upcoming webinars to learn more about the PA for certain hospital OPD services program and to review common issues that have contributed to dismissal or nonaffirmation of PA requests. In addition, each webinar will focus on one of the five categories below requiring the PA as a condition of payment for dates of service (DOS) on or after July 1, 2020, by reviewing documentation and medical necessity guidelines.

- Blepharoplasty, eyelid surgery, brow lift, and related services
- Botulinum toxin injections
- Panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy), and related services
- Rhinoplasty and related services
- Vein ablation and related services

To register for the upcoming webinars, visit our Educational Event Calendar (JH) (JL).

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11796 – Claim Status Category and Claim Status Codes Updates

  This article informs you of updates to 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 ASC X12 277 health care claim acknowledgement transactions. Please make sure your billing staffs are aware of these updates.

- MM11852 – 2021 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

  This article informs you that the Centers for Medicare & Medicaid Services will provide Medicare administrative contractors with files for the automated payments of HPSA bonuses for dates of service January 1, 2021, through December 31, 2021. Make sure that your billing staffs are aware of these changes.

- MM11881 – 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

  This article informs you that Medicare will update its claims processing systems based on the CORE 360 Uniform use of CARC, RARC, and CAGC rule publication. These system updates are based on the CORE code combination list, which will be published on or about October 1, 2020. Make sure that your billing staffs are aware of these updates.

- MM11932 – Annual Clotting Factor Furnishing Fee Update 2021

  This article informs you that the clotting factor furnishing fee for 2021 is $0.238 per unit. Make sure your billing staffs are aware of the update to the annual clotting factor furnishing fee for 2021, which pertains to Chapter 17, Section 80.4.1 of the Medicare Claims Processing Manual.

- MM11944 – October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3

  This article discusses changes to the October 2020 version of the I/OCE instructions and specifications for the Integrated OCE that Medicare uses:

  - Under 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 a home health agency not under the home health prospective payment system.
  - For a hospice patient for the treatment of a non-terminal illness.

  Make sure your billing staffs are aware of these changes.

- MM11956 – October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  CR 11956 informs Durable Medical Equipment MACs about the changes to the DMEPOS fee schedules that Medicare updates quarterly, when necessary, to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

- MM11960 – October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  This article informs you about the changes to and billing instructions for various payment policies implemented in the October 2020 OPPS update. The October 2020 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification, HCPCS modifier, and revenue code additions, changes, and deletions identified in change request 11960. The October 2020 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming October 2020 I/OCE CR. Make sure that your billing staffs are aware of these changes.

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August 28, 2020

Special Edition – Friday, August 28, 2020

Provider Education Message:

CMS Offers Comprehensive Support for Louisiana and Texas with Hurricane Laura

On August 27, CMS announced efforts underway to support Louisiana and Texas in response to Hurricane Laura. On August 26, 2020, Department of Health and Human Services (HHS) Secretary Alex Azar declared public health emergencies (PHEs) in these states, retroactive to August 22, 2020 for the state of Louisiana and to August 23, 2020 for the state of Texas. CMS is working to ensure hospitals and other facilities can continue operations and provide access to care despite the effects of Hurricane Laura.

CMS provided numerous waivers to health care providers during the current coronavirus disease 2019 (COVID-19) pandemic to meet the needs of beneficiaries and providers. The waivers already in place will be available to health care providers to use during the duration of the COVID-19 PHE determination timeframe and for the Hurricane Laura PHE. CMS may waive certain additional Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements, create special enrollment opportunities for individuals to access healthcare quickly, and take steps to ensure dialysis patients obtain critical life-saving services.

“Our thoughts are with everyone who is in the path of this powerful and dangerous hurricane and CMS is doing everything within its authority to provide assistance and relief to all who are affected,” said CMS Administrator Seema Verma. “We will partner and coordinate with state, federal, and local officials to make sure that in the midst of all of the uncertainty a natural disaster can bring, our beneficiaries will not have to worry about access to healthcare and other crucial life-saving and sustaining services they may need.”

Below are key administrative actions CMS will be taking in response to the PHEs declared in Louisiana and Texas:

Waivers and Flexibilities for Hospitals and Other Healthcare Facilities: CMS has already waived many Medicare, Medicaid, and CHIP requirements for facilities. The CMS Dallas Survey & Enforcement Division, under the Survey Operations Group, will grant other provider-specific requests for specific types of hospitals and other facilities in Louisiana and Texas. These waivers, once issued, will help provide continued access to care for beneficiaries. For more information on the waivers CMS has granted, visit www.cms.gov/emergency.

Special Enrollment Opportunities for Hurricane Victims: CMS will make available special enrollment periods for certain Medicare beneficiaries and certain individuals seeking health plans offered through the Federal Health Insurance Exchange. This gives people impacted by the hurricane the opportunity to change their Medicare health and prescription drug plans and gain access to health coverage on the Exchange if eligible for the special enrollment period. For more information, please visit:

- https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf
- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html

Disaster Preparedness Toolkit for State Medicaid Agencies: CMS developed an inventory of Medicaid and CHIP flexibilities and authorities available to states in the event of a disaster. For more information and to access the toolkit, visit: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html.

Dialysis Care: CMS is helping patients obtain access to critical life-saving services. The Kidney Community Emergency Response (KCER) program has been activated and is working with the End Stage Renal Disease (ESRD) Network, Network 13 – Louisiana, and Network 14 - Texas, to assess the status of dialysis facilities in the potentially impacted areas related to generators, alternate water supplies, education and materials for patients and more.

The KCER is also assisting patients who evacuated ahead of the storm to receive dialysis services in the location to which they evacuated. Patients have been educated to have an emergency supply kit on hand including important personal, medical, and insurance information; contact information for their facility, the ESRD Network hotline number, and contact information of those with whom they may stay or for out-of-state contacts in a waterproof bag. They have also been instructed to have supplies on hand to follow a three-day emergency diet. The ESRD Network 8 – Mississippi hotline is 1-800-638-8299, Network 13 – Louisiana hotline is 800-472-7139, the ESRD Network 14 - Texas hotline is 877-886-4435, and the KCER hotline is 866-901-3773. Additional information is available on the KCER website https://www.kcercoalition.com/.

During the 2017 and 2018 hurricane seasons, CMS approved special purpose renal dialysis facilities in several states to furnish dialysis on a short-term basis at designated locations to serve ESRD patients under emergency circumstances in which there were limited dialysis resources or access-to-care problems due to the emergency circumstances.

Medical equipment and supplies replacements: Under the COVD-19 waivers, CMS suspended certain requirements necessary for Medicare beneficiaries who have lost or realized damage to their durable

medical equipment, prosthetics, orthotics, and supplies as a result of the PHE. This will help to make sure that beneficiaries can continue to access the needed medical equipment and supplies they rely on each day. Medicare beneficiaries can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

Ensuring Access to Care in Medicare Advantage and Part D: During a public health emergency, Medicare Advantage Organizations and Part D Plan sponsors must take steps to maintain access to covered benefits for beneficiaries in affected areas. These steps include allowing Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities and waiving, in full, requirements for gatekeeper referrals where applicable.

Emergency Preparedness Requirements: Providers and suppliers are expected to have emergency preparedness programs based on an all-hazards approach. To assist in the understanding of the emergency preparedness requirements, CMS Central Office and the Regional Offices hosted two webinars in 2018 regarding Emergency Preparedness requirements and provider expectations. One was an all provider training on June 19, 2018 with more than 3,000 provider participants and the other an all-surveyor training on August 8, 2018. Both presentations covered the emergency preparedness final rule which included emergency power supply; 1135 waiver process; best practices and lessons learned from past disasters; and helpful resources and more. Both webinars are available at https://qsep.cms.gov/welcome.aspx.

CMS also compiled a list of Frequently Asked Questions (FAQs) and useful national emergency preparedness resources to assist state Survey Agencies (SAs), their state, tribal, regional, local emergency management partners and health care providers to develop effective and robust emergency plans and tool kits to assure compliance with the emergency preparedness rules. The tools can be located at:

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Templates-Checklists.html

CMS Regional Offices have provided specific emergency preparedness information to Medicare providers and suppliers through meetings, dialogue, and presentations. The regional offices also provide regular technical assistance in emergency preparedness to state agencies and staff, who, since November 2017, have been regularly surveying providers and suppliers for compliance with emergency preparedness regulations.

Additional information on the emergency preparedness requirements can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf

CMS will continue to work with all geographic areas impacted by Hurricane Laura. We encourage beneficiaries and providers of healthcare services that have been impacted to seek help by visiting CMS' emergency webpage (www.cms.gov/emergency).

For more information about the HHS PHE, please visit:

https://www.hhs.gov/about/news/2020/08/26/hhs-secretary-azar-declares-public-health-emergencies-in-louisiana-and-texas-due-to-hurricane-laura.html.

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Updated Financial & overpayment / Refund forms

Novitas has updated Financial & overpayment / Refund forms to help stream line the process. Please review the new forms as well as instructions provided.

- Return of Monies to Medicare form (8322-1) (Part A)

- Extended Repayment Plan (ERP) Form - Not a Sole Proprietor
- Extended Repayment Plan (ERP) Form - Sole Proprietor

If you have any questions on the overpayment processes, please visit our web page Medicare Overpayments.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised the article to add information about the HCPCS codes for outpatient prospective payment system, rural health clinic, federally qualified health center, and critical access hospital billers in the Families First Coronavirus Response Act waives coinsurance and deductibles for additional COVID-19 related services section. All other information remains the same.

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August 27, 2020

CMS Provider Education Message:

COVID-19: Training to Strengthen Nursing Home Infection Control Practices

MLN Connects® for Thursday, August 27, 2020

View this edition as a PDF

News

- Trump Administration Launches National Training Program to Strengthen Nursing Home Infection Control Practices
- SNF Provider Preview Reports: Review Your Data by August 30
- COVID: Nursing Home Toolkit
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- COVID-19: Waive Cost Sharing for These HCPCS Codes

MLN Matters® Articles

- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021 — Revised
- October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised

Publications

Creating an Effective Hospice Plan of Care

Multimedia

- Physician Fee Schedule Listening Session: Audio Recording and Transcript

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The following proposed local coverage determination (LCD) has been posted for comments. The comment period will end on October 10, 2020; however you are encouraged to submit your comments as soon as possible.

- Colon Capsule Endoscopy (CCE) (DL38807)

  Submit comments

The following draft billing and coding article is related to the above Proposed LCD.

- Billing and coding: Colon Capsule Endoscopy (CCE) (DA58414)

The following local coverage determination (LCD) posted for comment on April 30, 2020 has been posted for notice. The LCD and related billing and coding article will become effective October 11, 2020:

- Implantable Continuous Glucose Monitors (I-CGM) (L38617)
  - Billing and coding: Implantable Continuous Glucose Monitors (I-CGM) (A58110)

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

- Response to comments: Implantable Continuous Glucose Monitors (I-CGM) (A58415)

The following future billing and coding article, which will replace the current billing and coding article: Chiropractic services (A52987), has been published and will become effective October 01, 2020:

- Billing and coding: Chiropractic services (A58345)

The following LCDs and related billing and coding articles have been retired:

- Hyperbaric Oxygen (HBO) Therapy (L35021)
  - Billing and coding: Hyperbaric Oxygen (HBO) Therapy (A56714)
- Reflectance Confocal Microscopy (L37375)
  - Billing and coding: Reflectance Confocal Microscopy (A56969)

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Online Registration Available for September 11, 2020, Open Meeting and Proposed LCD Now Posted

Online registration for the September 11, 2020, Open Meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, September 9, 2020. **Important:** During this unprecedented time, our Open Meeting will be held via teleconference only. The Novitas Solutions proposed local coverage determination (LCD) is 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 26, 2020

Practitioners! Are you ordering oxygen for your patients?

This is your opportunity to hear directly from the Medicare administrative contractors (MACs). This session will focus on:

- Practitioner role in documenting clinical need for oxygen
- Testing requirements
- Effects from COVID-19 public health emergency

Representatives from the four durable medical equipment (DME) MACs will join your regular A/B education staff to bring you this webinar with the objective of increasing practitioner understanding for required clinical documentation. It is our hope that this information will ease practitioner burden and assist in making it a smoother process for your patients to obtain the oxygen that is prescribed.

Register here

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August 25, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11949 – Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2021

  This article is based on change request (CR) 11949 and identifies changes that are required as part of the annual IPF PPS update established in IPF final rule entitled “Medicare Program; FY 2021 Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) and Special Requirements for Psychiatric Hospitals for Fiscal Year Beginning October 1, 2020 (FY 2021).” These changes are applicable to discharges occurring from October 1, 2020, through September 30, 2021 (FY 2021). CR 11949 applies to the Medicare Claims Processing Manual (CLM), Chapter 3, Section 190.4.3.

  Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Revised:

- MM11623 – Update to the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for Vaping Related Disorder and Diagnosis and Procedure Codes for the 2019 Novel Coronavirus (COVID-19)

  CMS revised this article on August 21, 2020, to reflect an updated change request (CR) 11623. The CR revision updated the title, background section and includes new procedure codes in version 37.2 of the ICD-10 Medicare Severity - Diagnosis Related Groups (MS-DRG) Grouper and ICD-10 Medicare Code Editor (MCE). The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

- MM11937 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  CMS revised this article on August 24, 2020, to reflect an updated change request (CR) 11937 that includes additional COVID-19 codes 86408, 86409, 0225U, 0226U, effective August 10, 2020. CR 11937 also added codes 0015M and 0016M, effective October 1, 2020. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

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August 24, 2020

CR11642 - Updates to Nursing and Allied Health Education Medicare Advantage Payment Policies

Section 541 of the Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113), and section 512 of the Benefits Improvement and Protection Act (BIPA), (P.L. 106-554), instituted Medicare+Choice nursing and allied health payments for portions of cost reporting periods occurring on or after January 1, 2000. CMS issued this change request (CR) to provide MACs with instructions on how to compute and/or reconcile these payments for calendar years 2002 through 2018, as applicable.

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August 21, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11859 – Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021

  The Centers for Medicare & Medicaid Services (CMS) revised this article to reflect a revised change request (CR) 11859, issued on August 19, 2020. The CR revision shows that effective for fiscal year (FY) 2021, a 5 percent cap will be adopted and applied to all skilled nursing facility providers on any decrease to a provider's FY 2021 final wage index from that provider's final wage index of the prior fiscal year (FY 2020). CMS added that language to the article. CMS also revised the CR release date, transmittal number, and the web address. All other information remains the same.

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August 20, 2020

CMS Provider Education Message:

Routine Provider Inspections Resume

MLN Connects® for Thursday, August 20, 2020

View this edition as a PDF

News

- CMS Announces Resumption of Routine Inspections of All Provider and Suppliers, Issues Updated Enforcement Guidance to States, and Posts Toolkit to Assist Nursing Homes
- Reduce Provider Burden: Electronic Medical Documentation Interoperability Pilot Program

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Homes: New Format

MLN Matters® Articles

- New COVID-19 Policies for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act— Revised

Publications

- Enhancing RN Supervision of Hospice Aide Services

Multimedia

- Medicare Secondary Payer (MSP) Provision (June 2020)

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August 19, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11854 – October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  The Centers for Medicare & Medicaid Services (CMS) revised this article to reflect a revised change request (CR) 11854 issued on August 14, 2020. The revised CR did not change the substance of the article. 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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August 18, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20015 – New COVID-19 Policies for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act

  The Centers for Medicare & Medicaid Services revised this article on August 17, 2020, to add an update regarding the implementation of Section 3710 of the CARES Act for IPPS hospitals to address potential Medicare program integrity risks. All other information is unchanged.

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August 17, 2020

July 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The July 2020 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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Appeals Corner Newsletter July 2020

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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August 14, 2020

POE A/B MAC Medicare Secondary Payer (MSP) series question and answer document

Novitas, in collaboration with the A/B Medicare administrative contractor (MAC) Provider Outreach & Education (POE) Collaboration Team, developed a question and answer document based on questions received during the MSP series event.

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August 13, 2020

CMS Provider Education Message:

COVID-19: CMS/CDC Nursing Home Training Series Webcast – August 13

MLN Connects® for Thursday, August 13, 2020

View this edition as a PDF

News

- Trump Administration Announces Initiative to Transform Rural Health
- Physician Compare Preview Period Open through August 20
- Management of Acute and Chronic Pain – Stakeholder Engagement Opportunity: Reply by August 21
- SNF Provider Preview Reports: Review Your Data by August 30
- PEPPERs for HHAs and PHPs
- Hospitals: Three Year Geographic Reclassification Data for FY 2022 MGCRB Applications
- Opioids: Co-Prescribing Naloxone

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — August 13
- Dr. Todd Graham Pain Management Study Listening Session — August 27

MLN Matters® Articles

- Billing for Home Infusion Therapy Services On or After January 1, 2021
- Correction to Editing Update for Vaccine Services
- International Classification of Diseases, 10th Revision (ICD10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2021 Update
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2020 Update
- Update to Osteoporosis Drug Codes Billable on Home Health Claims
- Influenza Vaccine Payment Allowances – Annual Update for 2020-2021 Season — Revised

Multimedia

- HQRP Training Resources Web-Based Training Course

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The following billing and coding article has been revised, consistent with CPT guidelines, to clarify that non-graft wound dressings (e.g., gel, powder, ointment, foam, liquid) or injected skin substitutes should not be reported with skin replacement surgery application codes. Claims received on and after August 13, 2020, reporting non-graft wound dressings with a surgery application code will be rejected.

- Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)

The following local coverage determinations (LCDs) have been revised:

- Cardiac Rhythm Device Evaluation (L34833)
- Speech-Language Pathology (SLP) Services: Communication Disorders (L35070)

The following billing and coding articles have been revised:

- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (A56642)
- Non-Invasive Peripheral Venous Studies (A52993)

The following LCDs and their related billing and coding articles have been retired:

- Molecular Diagnostics: Genitourinary Infectious Disease Testing (L35015)
  - Billing and coding: Molecular Diagnostics: Genitourinary Infectious Disease Testing (A56791)
- Sacral Nerve Stimulation (L35449)
  - Billing and coding: Sacral Nerve Stimulation (A57617)

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August 12, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11870 – Telehealth Expansion Benefit Enhancement Under the Pennsylvania Rural Health Model (PARHM) - Implementation

  This article informs you about information related to the PARHM and the “Transformation Plans” for participating hospitals. Change request (CR) 11870 expands the allowable telehealth services for Model participant hospitals. Without this CR, some hospitals may fail to meet healthcare transformation goals set by the model. Make sure your billing staffs are aware of these changes.

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August 11, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11937 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  This article informs laboratories of changes resulting from the quarterly update to the clinical laboratory fee schedule. Please be sure your billing staff is aware of these updates.

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August 10, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11939 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2020 Update

  This article informs you about the issuance of updated payment files in the October update of the 2020 MPFS. Make sure your billing staffs are aware of these updates.

- MM11867 – Correction to Editing Update for Vaccine Services

  This article informs you that Medicare is changing the common working file to bypass line-item dates of service for vaccines reported on inpatient Part B claims with type of bill (TOB) 12X and 22X when the dates of service equal a posted outpatient TOB 73X or 77X service dates, or if present, occurrence span code visit date, regardless of the date of service. Please make sure your billing staffs are aware of these corrections.

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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 articles and finalized billing and coding articles will be related to the final LCDs when they are posted for notice.

- Endovenous Stenting (DL37893)
- Transurethral Waterjet Ablation of the Prostate (DL38712)
- Treatment of Chronic Venous Insufficiency of the Lower Extremities (DL34924)

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August 6, 2020

CMS Provider Education Message:

Physician Fee Schedule Proposed Rule Listening Session: Register Now

MLN Connects® for Thursday, August 6, 2020

View this edition as a PDF

News

- Electronic Prescribing of Controlled Substances in Medicare Part D: Request for Information
- Release of the IRF Web Pricer
- Subsequent Nursing Facility E/M Services: Comparative Billing Report
- Nursing Home Compare Refresh
- Medicare Ground Ambulance Data Collection System: Updated Documents
- MACs Resume Medical Review on a Post-Payment Basis
- Renewed ABN: Deadline Extended to January 1
- COVID-19: Telemedicine, Clinical Experiences, Resources for Hospitals and Urgent Care Centers

- Protect Your Patients Against Vaccine-Preventable Diseases

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — August 6
- COVID-19: Lessons from the Front Lines Call — August 7
- Physician Fee Schedule Proposed Rule: Understanding 4 Key Topics Listening Session — August 13
- Dr. Todd Graham Pain Management Study Listening Session — August 27

MLN Matters® Articles

- New Waived Tests
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation

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August 5, 2020

Special Edition – Tuesday, August 04, 2020

Provider Education Message:

PFS, OPPS, and IRF: FY 2021 Payment Rules

- Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas
- Trump Administration Proposes Policies to Provide Seniors with More Choices and Lower Costs for Surgeries
- CMS Updates Medicare Payment Policies for IRFs

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Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas

CMS is proposing changes to expand telehealth permanently, consistent with the Executive Order on Improving Rural and Telehealth Access that President Trump signed. The Executive Order and proposed rule advance our efforts to improve access and convenience of care for Medicare beneficiaries, particularly those living in rural areas. Additionally, the proposed rule implements a multi-year effort to reduce clinician burden under our Patients Over Paperwork initiative and to ensure appropriate reimbursement for time spent with patients. This proposed rule also takes steps to implement President Trump's Executive Order on Protecting and Improving Medicare for our Nation's Seniors and continues our commitment to ensure that the Medicare program is sustainable for future generations.

Expanding Beneficiary Access to Care through Telehealth:

Over the last three years, as part of the Fostering Innovation and Rethinking Rural Health strategic initiatives, CMS has been working to modernize Medicare by unleashing private sector innovations and improve beneficiary access to services furnished via telecommunications technology. Starting in 2019, Medicare began paying for virtual check-ins, meaning patients across the country can briefly connect with doctors by phone or video chat to see whether they need to come in for a visit. In response to the COVID-19 pandemic, CMS moved swiftly to significantly expand payment for

telehealth services and implement other flexibilities so that Medicare beneficiaries living in all areas of the country can get convenient and high-quality care from the comfort of their home while avoiding unnecessary exposure to the virus. Before the Public Health Emergency (PHE), only 14,000 beneficiaries received a Medicare telehealth service in a week, while over 10.1 million beneficiaries have received a Medicare telehealth service during the PHE from mid-March through early-July. For more information on Medicare's unprecedented increases in telemedicine and its impact on the health care delivery system, visit the CMS Health Affairs blog.

As directed by President Trump's Executive Order on Improving Rural and Telehealth Access, through this rule, CMS is taking steps to extend the availability of certain telemedicine services after the PHE ends, giving Medicare beneficiaries more convenient ways to access health care particularly in rural areas where access to health care providers may otherwise be limited.

"Telemedicine can never fully replace in-person care, but it can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for Americas seniors," said CMS Administrator Seema Verma. "The Trump Administration's unprecedented expansion of telemedicine during the pandemic represents a revolution in health care delivery, one to which the health care system has adapted quickly and effectively. Never one merely to tinker around the edges when it comes to patient-centered care, President Trump will not let this opportunity slip through our fingers."

During the PHE, CMS added 135 services such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services that could be paid when delivered by telehealth. CMS is proposing to permanently allow some of those services to be done by telehealth, including home visits for the evaluation and management of a patient (in the case where the law allows telehealth services in the patient's home) and certain types of visits for patients with cognitive impairments. CMS is seeking public input on other services to permanently add to the telehealth list beyond the PHE in order to give clinicians and patients time as they get ready to provide in-person care again. CMS is also proposing to temporarily extend payment for other telehealth services, such as emergency department visits for a specific time period, through the calendar year in which the PHE ends. This will also give the community time to consider whether these services should be delivered permanently through telehealth outside of the PHE.

Prioritizing Investment in Preventive Care and Chronic Disease Management:

Under our Patients Over Paperwork initiative, the Trump Administration has taken steps to eliminate burdensome billing and coding requirements for Evaluation and Management (E/M) (for office/outpatient visits) that make up 20 percent of the spending under the Physician Fee Schedule. These billing and documentation requirements for E/M codes were established 20 years ago and have been subject to longstanding criticism from clinicians that they do not reflect current care practices and needs. After extensive stakeholder collaboration with the American Medical Association and others, simplified coding and billing requirements for E/M visits will go into effect January 1, 2021, saving clinicians 2.3 million hours per year in burden reduction. As a result of this change, clinicians will be able to make better use of their time and restore the doctor-patient relationship by spending less time on documenting visits and more time on treating their patients.

Additionally, last year, the Trump Administration finalized historic changes to increase payment rates for office/outpatient E/M visits beginning in 2021. The higher payment for E/M visits takes into account the changes in the practice of medicine, recognizing that additional resources are required of clinicians to take care of their Medicare patients, of which two-thirds have multiple chronic conditions. The prevalence of certain chronic conditions in the Medicare population is growing. For example, as of 2018, 68.9% of beneficiaries have 2 or more chronic conditions. In addition, between 2014 and 2018, the percent of beneficiaries with 6 or more chronic conditions has grown from 14.3% to 17.7%.

In this rule, CMS is proposing to similarly increase the value of many services that are comparable to or include office/outpatient E/M visits, such as maternity care bundles, emergency department visits,

end-stage renal disease capitated payment bundles, physical and occupational therapy evaluation services, and others. The proposed adjustments, which implement recommendations from the American Medical Association, help to ensure that CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients, like primary care and complex or chronic disease management.

Bolstering the Health Care Workforce/Patients Over Paperwork:

CMS is also taking steps to ensure that health care professionals can practice at the top of their professional training. During the COVID-19 public health emergency, CMS announced several temporary changes to expand workforce capacity and reduce clinician burden so that staffing levels remain high in response to the pandemic. As part of its Patients over Paperwork initiative to reduce regulatory burden for providers, CMS is proposing to make some of these temporary changes permanent following the PHE. Such proposed changes include:

- Nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives (instead of only physicians) to supervise others performing diagnostic tests consistent with state law and licensure, providing that they maintain the required relationships with supervising/collaborating physicians as required by state law
- Clarifying that pharmacists can provide services as part of the professional services of a practitioner who bills Medicare
- Allowing physical and occupational therapy assistants (instead of only physical and occupational therapists) to provide maintenance therapy in outpatient settings
- Allowing physical or occupational therapists, speech-language pathologists, and other clinicians who directly bill Medicare to review and verify (sign and date), rather than re-document, information already entered by other members of the clinical team into a patient's medical record

For More Information:

- CY 2021 Physician Fee Schedule and Quality Payment Program Proposed Rule: Public comments are due by October 5, 2020.
- CY 2021 Physician Fee Schedule Proposed Rule Fact Sheet
- CY 2021 Quality Payment Program Proposed Rule Fact Sheet
- Medicare Diabetes Prevention Program Fact Sheet

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Trump Administration Proposes Policies to Provide Seniors with More Choices and Lower Costs for Surgeries

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS' commitment to increasing competition

As directed by President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors, CMS is proposing several policies that would give Medicare beneficiaries more choices in where they seek care and lower their out-of-pocket costs for surgeries. The proposed rule takes steps that would allow hospitals and ambulatory surgical centers to operate with better flexibility and patients to have what they need to make informed decisions on where they receive care.

"President Trump's mandate is to put patients and doctors back in charge of health care," said CMS Administrator Seema Verma. "Following through on that mandate entails loosening the stranglehold of government control that has accumulated over decades. Surgeries can be expensive. Patients should have as many options as possible for lowering their costs while getting quality care. These

proposed changes, if finalized, would do exactly that, help put patients and doctors back in the driver's seat and in a position to make decisions about their own care."

For patients having surgery, hospital outpatient departments are subject to the same quality and safety standards as inpatient settings under Medicare rules. With this in mind, for 2021, CMS proposes to expand the number of procedures that Medicare would pay for in the hospital outpatient setting by eliminating the "Inpatient Only list," which includes procedures for which Medicare will only make payment when performed in the hospital inpatient setting. This proposed change would remove regulatory barriers to give beneficiaries the choice to receive these services in a lower cost setting and convenience to go home as early as the same day after a procedure, when their clinician decides such a setting is appropriate. CMS would phase-in this proposal over three years and would gradually allow over 1,700 additional services to be paid when furnished in the hospital outpatient setting. In 2021, approximately 300 musculoskeletal services (such as certain joint replacement procedures) would be newly payable in the hospital outpatient setting. The proposed change would be the largest one-time reduction to the Inpatient Only list by far; from 2017 through 2020, approximately 30 services total were removed from the Inpatient Only list.

Medicare pays for most services furnished in ASCs at a lower rate than hospital outpatient departments. As a result, when receiving care in an ASC rather than a hospital outpatient department, patients can potentially lower their out-of-pocket costs for certain services. For example, for one of the most common cataract surgeries, currently, on average, a Medicare beneficiary pays $101 if the procedure is done in a hospital outpatient department compared to $51 if done in a surgery center.

CMS proposes to expand the number of procedures that Medicare would pay for when performed in an ASC, which would give patients more choices in where they receive care and ensure CMS does not favor one type of care setting over another. For CY 2021, we propose to add eleven procedures that Medicare would pay for when provided in an ASC, including total hip arthroplasty. Since 2018, CMS has added 28 procedures to the list of surgical services that can be paid under Medicare when performed in ASCs.

Additionally, we propose two alternatives that would further expand our goals of increasing access to care at a lower cost. Under the first alternative, CMS would establish a process where the public could nominate additional services that could be performed in ASCs based on certain quality and safety parameters. Under the other proposed alternative, we would revise the criteria used to determine the procedures that Medicare would pay for in an ASC, potentially adding approximately 270 procedures that are already payable when performed in the hospital outpatient setting to the ASC list. Under this alternative, we solicit comment on whether the ASC conditions for coverage (the baseline health and safety requirements for Medicare-participating ASCs) should be revised given the potential for a significant expansion in the nature of services that would be added under this alternative proposal.

As part of the Trump Administration's commitment to lowering drug prices, CMS is proposing a change that would lower beneficiaries' out-of-pocket drug costs for certain hospital outpatient drugs. In 2018 and 2019, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments and acquired through the 340B program, which allows certain hospitals to buy outpatient drugs at lower costs. Due to CMS' policy change, which was recently upheld by the United States Court of Appeals for the D.C Circuit, Medicare beneficiaries now benefit from the steep discounts that 340B-enrolled hospitals receive when they purchase drugs through the 340B program.

For 2021, CMS would provide even larger discounts for beneficiaries by proposing to further reduce the payment rate for drugs purchased through the 340B Program based on hospital survey data on drug acquisition costs. CMS is proposing to pay for 340B acquired drugs at average sales price minus 28.7 percent. With this proposed change, CMS estimates that, in 2021, Medicare beneficiaries would save an additional $85 million on out-of-pocket payments for these drugs and that OPPS payments

for 340B drugs would be reduced by approximately $427 million. The savings from this change would be reallocated on an equal percentage basis to all hospitals paid under the OPPS. We propose that children's hospitals, certain cancer hospitals, and rural sole community hospitals would continue be excepted from these drug payment reductions. In the alternative, and in light of the court's recent decision, we propose to continue our current policy of paying ASP minus 22.5% for 340B drugs.

In continuing the agency's Patients Over Paperwork Initiative to reduce burden for health care providers, CMS is proposing to establish, update, and simplify the methodology to calculate the Overall Hospital Quality Star Rating (Overall Star Rating) beginning with CY 2021. The Overall Star Rating summarizes a variety of quality measures published on the Medicare.gov Hospital Compare tool for common conditions that hospitals treat, such as heart attacks or pneumonia. Along with publicly reported data on Hospital Compare, the Overall Star Rating helps patients make better informed health care decisions.

Responding to stakeholder feedback about the current methodology used to calculate the Overall Star Rating, CMS is proposing revisions on how to calculate the ratings and grouping hospitals in the Readmission measure group by the hospital's percentage of patients who are dually enrolled in Medicare and Medicaid, which would help provide better insight on health disparities. These and other proposed changes are intended to reduce provider burden, improve the predictability of the star ratings, and make it easier to compare ratings between similar hospitals.

As part of the agency's Rethinking Rural Health Initiative, in the FY 2020 Inpatient Prospective Payment System (IPPS) final rule, CMS increased the wage index for certain low wage index hospitals for at least four years, beginning in FY 2020. In the CY 2020 OPPS/ASC Payment System final rule, CMS adopted changes to the wage index for outpatient hospitals as were finalized in the FY 2020 IPPS final rule, including the increase in wage index for certain low wage index hospitals. The OPPS wage index adjusts hospital outpatient payment rates to account for local differences in wages that hospitals face in their respective labor markets. For 2021, under the OPPS, CMS proposes to continue to adopt the IPPS post-reclassified wage index, including the wage index increase for certain low wage index hospitals. The increase would address a common concern that the current wage index system contributes to disparities between high and low wage index hospitals. Overall, CMS estimates that payment for outpatient services in rural hospitals across the country would increase by 3 percent, which is 0.5 percent higher than the national average increase of 2.5 percent.

For More Information:

- Proposed Rule
- Fact Sheet

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CMS Updates Medicare Payment Policies for IRFs

On August 4, CMS finalized a Medicare payment rule that further advances our efforts to strengthen the Medicare program by better aligning payments for Inpatient Rehabilitation Facilities (IRFs). The final rule updates Medicare payment policies and rates for facilities under the IRF Prospective Payment System (PPS) for FY 2021. This final rule also includes making permanent the regulatory change to eliminate the requirement for physicians to conduct a post admission visit since much of the information is included in the pre-admission visit. This flexibility was offered during the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE), and the rule would make this flexibility permanent beyond the expiration of the PHE. In recognition of the interdisciplinary role that non-physician practitioners are currently performing with patients in the IRF, CMS is also finalizing that a non-physician practitioner may perform one of the three required visits in lieu of the physician in the second and later weeks of a patient's care when consistent with the non-physician

practitioner's state scope of practice. Additionally, for FY 2021, CMS is updating the IRF PPS payment rates by 2.4 percent.

For More Information:

- Final Rule
- Fact Sheet

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11905 – International Classification of Diseases, 10th Revision (ICD10) and Other Coding Revisions to National Coverage Determination (NCDs)--January 2021 Update

  This article informs providers about updated ICD-10 conversions as well as coding updates specific to NCDs. Please make sure your billing staffs are aware of these updates.

Revised:

- MM11882 – Influenza Vaccine Payment Allowances – Annual Update for 2020-2021 Season

  The Centers for Medicare & Medicaid Services revised this article on July 31, 2020, to reflect an updated change request 11882 that extended the implementation date. All other information remains the same.

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July 2020 top claim submission errors

The July 2020 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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August 3, 2020

Provider Education Message:

FY 2021 Medicare Payment Policies for IPFs, SNFs, and Hospices

- CMS Updates Medicare Payment Policies for IPFs, SNFs, and Hospices
- COVID-19: Coverage of Physician Telehealth Services Provided to SNF Residents

CMS Updates Medicare Payment Policies for IPFs, SNFs, and Hospices

On July 31, CMS finalized three Medicare payment rules that further advance our efforts to strengthen the Medicare program by better aligning payments for Inpatient Psychiatric Facilities (IPFs), Skilled Nursing Facilities (SNFs), and hospices.

Inpatient Psychiatric Facilities:

The final rule updates Medicare payment policies and rates for the IPF Prospective Payment System (PPS) for FY 2021. In this final rule, CMS is finalizing a 2.2 percent payment rate update and finalizing its proposal to adopt revised Office of Management and Budget (OMB) statistical area delineations resulting in wage index values being more representative of the actual costs of labor in a given area. CMS is finalizing updates to allow advanced practice providers, including physician assistants, nurse practitioners, psychologists, and clinical nurse specialists to operate within the

scope of practice allowed by state law by documenting progress notes in the medical record of patients for whom they are responsible, receiving services in psychiatric hospitals.

Skilled Nursing Facilities:

The final rule updates the Medicare payment rates and the quality programs for SNFs. These updates include routine technical rate-setting updates to the SNF PPS payment rates, as well as finalizes adoption of the most recent OMB statistical area delineations and applies a 5 percent cap on wage index decreases from FY 2020 to FY 2021. CMS is also finalizing changes to the ICD-10 code mappings that would be effective beginning in FY 2021 in response to stakeholder feedback. CMS projects aggregate payments to SNFs will increase by $750 million, or 2.2 percent, for FY 2021, compared to FY 2020.

Hospices:

For FY 2021, hospice payment rates are updated by the market basket percentage increase of 2.4 percent ($540 million). Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual market basket percentage increase for the year. The hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments made to a hospice annually. The final hospice cap amount for the FY 2021 cap year is $30,683.93, which is equal to the FY 2020 cap amount ($29,964.78) updated by the final FY 2021 hospice payment update percentage of 2.4 percent.

For More Information:

- PF Final Rule and Fact Sheet
- SNF Final Rule and Fact Sheet
- Hospice Final Rule and Fact Sheet

COVID-19: Coverage of Physician Telehealth Services Provided to SNF Residents

The current COVID-19 Public Health Emergency (PHE) does not waive any requirements related to Skilled Nursing Facility (SNF) Consolidated Billing (CB); however, CMS added CPT codes 99441, 99442, and 99443, to the list of telehealth codes coverable under the waiver during the COVID-19 PHE. These codes designate three different time increments of telephone evaluation and management service provided by a physician. You can bill for these physician services separately under Part B when furnished to a SNF's Part A resident.

Medicare Administrative Contractors (MACs) will reprocess claims for CPT codes 99441, 99442, and 99443 with dates of service on or after March 1, 2020, that were denied due to SNF CB edits. You do not have to do anything. If you already received payment from the SNF for these physician services, return that payment to the SNF once the MAC reprocesses your claim.

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July 31, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised the article on July 30, 2020, to add the section "Counseling and COVID-19 Testing." All other information remains the same.

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July 30, 2020

Special Edition – Thursday, July 30, 2020

Provider Education Message:

Payment for COVID-19 Counseling, Reporting Hospital Therapeutics, Out-of-Pocket Drug Costs

- CMS and CDC Announce Provider Reimbursement Available for Counseling Patients to Self-Isolate at Time of COVID-19 Testing
- CMS Announces New Hospital Procedure Codes for Therapeutics in Response to the COVID-19 Public Health Emergency
- Trump Administration Continues to Keep Out-of-Pocket Drug Costs Low for Seniors

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CMS and CDC Announce Provider Reimbursement Available for Counseling Patients to Self-Isolate at Time of COVID-19 Testing

On July 30, CMS and the Centers for Disease Control and Prevention (CDC) are announcing that payment is available to physicians and health care providers to counsel patients, at the time of Coronavirus Disease 2019 (COVID-19) testing, about the importance of self-isolation after they are tested and prior to the onset of symptoms.

The transmission of COVID-19 occurs from both symptomatic, pre-symptomatic, and asymptomatic individuals emphasizing the importance of education on self-isolation as the spread of the virus can be reduced significantly by having patients isolated earlier, while waiting for test results or symptom onset. The CDC models show that when individuals who are tested for the virus are separated from others and placed in quarantine, there can be up to an 86 percent reduction in the transmission of the virus compared to a 40 percent decrease in viral transmission if the person isolates after symptoms arise.

Provider counseling to patients, at the time of their COVID-19 testing, will include the discussion of immediate need for isolation, even before results are available, the importance to inform their immediate household that they too should be tested for COVID-19, and the review of signs and symptoms and services available to them to aid in isolating at home. In addition, they will be counseled that if they test positive, to wear a mask at all times, and they will be contacted by public health authorities and asked to provide information for contact tracing and to tell their immediate household and recent contacts in case it is appropriate for these individuals to be tested for the virus and to self-isolate as well.

CMS will use existing evaluation and management payment codes to reimburse providers who are eligible to bill CMS for counseling services no matter where a test is administered, including doctor's offices, urgent care clinics, hospitals, and community drive-thru or pharmacy testing sites.

For More Information:

- Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) MLN Matters Special Edition Article SE20011
- Counseling Check List, including resource links

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CMS Announces New Hospital Procedure Codes for Therapeutics in Response to the COVID-19 Public Health Emergency

With the emergence of Coronavirus Disease 2019 (COVID-19) and the new treatments that have followed, it is critical to be able to track the use of these treatments and their effectiveness in real-time. CMS responded to this need, and in record time is implementing new procedure codes to allow Medicare and other insurers to identify the use of the therapeutics remdesivir and convalescent plasma for treating hospital in-patients with COVID-19. These new codes, which go into effect August 1, will enable CMS to conduct real-time surveillance and obtain real-world evidence in how these drugs are working and provide critical information on their effectiveness and how they can protect patients. These codes can be reported to Medicare and other insurers may also use the codes to identify the use of COVID-19 therapies and help facilitate monitoring and data collection on their use.

These new codes are being implemented into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). ICD-10-PCS is the Health Insurance Portability and Accountability Act (HIPAA) designated code set for reporting hospital inpatient procedures, which is developed and maintained by CMS and can be used by other health insurers.

The implementation of these new procedure codes is part of the Trump Administration's ongoing efforts to protect the health and safety of COVID-19 patients across the country during the public health emergency.

For more information, see ICD-10 MS-DRGs Version 37.2 Effective August 1.

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Trump Administration Continues to Keep Out-of-Pocket Drug Costs Low for Seniors

On July 29, CMS announced the average basic premium for Medicare Part D prescription drug plans, which cover prescription drugs that beneficiaries pick up at a pharmacy. Under the leadership of President Trump, for the first time seniors that use insulin will be able to choose a prescription drug plan in their area that offers a broad set of insulins for no more than $35 per month per prescription.

The average basic Part D premium will be $30.50 in 2021. The 2021 and 2020 average basic premiums are the second lowest and lowest, respectively, average basic premiums in Part D since 2013. This trend of lower Part D premiums, which have decreased by 12 percent since 2017, means that beneficiaries have saved nearly $1.9 billion in premium costs over that time. Further, Part D continues to be an extremely popular program, with enrollment increasing by 16.7 percent since 2017.

"At every turn, the Trump Administration has prioritized policies that introduce choice and competition in Part D," said CMS Administrator Seema Verma. "The result is lower prices for life-saving drugs like insulin, which will be available to Medicare beneficiaries at this fall's Open Enrollment for no more than $35 a month. In short, Part D premiums continue to stay at their lowest levels in years even as beneficiaries enjoy a more robust set of options from which to choose a plan that meets their needs."

In addition to the $1.9 billion in premium savings for beneficiaries since 2017, the Trump Administration has produced substantial Part D program savings for taxpayers. With about 200 additional standalone prescription drug plans and 1,500 additional Medicare Advantage plans with prescription drug coverage joining the program between 2017 and 2020, and that trend expected to continue in 2021, increased market competition has led to lower costs and lower Medicare premium subsidies, which has saved taxpayers approximately $8.5 billion over the past four years.

Earlier this year, CMS launched the Part D Senior Savings Model, which will allow Medicare beneficiaries to choose a plan that provides access to a broad set of insulins at a maximum $35 copay for a month's supply. Starting January 1, 2021, beneficiaries who select these plans will save, on average, $446 per year, or 66 percent, on their out-of-pocket costs for insulin. Beneficiaries will be able to choose from more than 1,600 participating standalone Medicare Part D prescription drug plans and Medicare Advantage plans with prescription drug coverage, all across the country this open enrollment period, which runs from October 15 through December 7. And because the majority of

participating Medicare Advantage plans with prescription drug coverage do not charge a Part D premium, beneficiaries who enroll in those plans will save on insulin and not pay any extra premiums.

In January 2020, CMS, through the Part D Payment Modernization Model, offered an innovative new opportunity for Part D plan sponsors to lower costs for beneficiaries, while improving care quality. Under this model, Part D sponsors can better manage prescription drug costs through all phases of the Part D benefit, including the catastrophic phase. Through the use of better tools and program flexibilities, sponsors are better able to negotiate on high cost drugs and design plans that increase access and lower out-of-pocket costs for beneficiaries. For CY 2021, there will be nine plan options in Utah, New Mexico, Idaho and Pennsylvania that participate in this model.

In Medicare Part D, beneficiaries choose the prescription drug plan that best meets their needs, and plans have to improve quality and lower costs to attract beneficiaries. This competitive dynamic sets up clear incentives that drive towards value. CMS has taken steps to modernize the Part D program by providing beneficiaries the opportunity to choose among plans with greater negotiating tools that have been developed in the private market and by providing patients with more transparency on drug prices. Improvements to the Medicare Part D program that CMS has made to date include:

- Beginning in 2021, providing more information on out-of-pocket costs for prescription drugs to beneficiaries by requiring Part D plans to provide a real time benefit tool to clinicians with information that they can discuss with patients on out-of-pocket drug costs at the time a prescription is written
- Implementing Part D legislation signed by President Trump to prohibit “gag clauses,” which keep pharmacists from telling patients about lower-cost ways to obtain prescription drugs
- Beginning in 2021, requiring the Explanation of Benefits document that Part D beneficiaries receive each month to include information on drug price increases and lower-cost therapeutic alternatives
- Providing beneficiaries with more drug choices and empowering beneficiaries to select a plan that meets their needs by allowing plans to cover different prescription drugs for different indications, an approach used in the private sector
- Reducing the maximum amount that low-income beneficiaries pay for certain innovative medicines known as “biosimilars,” which will lower the out-of-pocket cost of these innovative medicines for these beneficiaries
- Empowering Medicare Advantage to negotiate lower costs for physician-administered prescription drugs for seniors for the first time, as well allowing Part D plans to substitute certain generic drugs on plan formularies more quickly during the year, so beneficiaries immediately have access to the generic, which typically has lower cost sharing than the brand
- Increasing competition among plans by removing the requirement that certain Part D plans have to “meaningfully differ” from each other, making more plan options available for beneficiaries

For More Information:

- Part D Senior Savings Model webpage
- Ratebooks & Supporting Data webpage: View the 2021 Part D base beneficiary premium, the Part D national average monthly bid amount, the Part D regional low-income premium subsidy amounts, the de minimis amount, the Medicare Advantage employer group waiver plan regional payment rates, and the Medicare Advantage regional PPO benchmarks

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CMS Provider Education Message:

COVID-19 Impacts on Medicare Beneficiaries – Updated Data

MLN Connects® for Thursday, July 30, 2020

View this edition as a PDF

News

- CMS Updates Data on COVID-19 Impacts on Medicare Beneficiaries
- Short-Term Acute Care Hospitals: Submit Occupational Mix Surveys by September 3
- PEPPERs for SNFs, Hospices, IRFs, IPFs, CAHs, and LTCHs
- Hospice Quality Reporting Program: HART v1.6.0
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- COVID-19: Laboratory Claims Requiring the NPI of the Ordering/Referring Professional — Update
- Medicare Diabetes Prevention Program: Valid Claims

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — July 30

MLN Matters® Articles

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 87426
- Overview of the Repetitive, Scheduled Non-Emergent Ambulance Prior Authorization Model — Revised
- Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan — Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 4
- Home Health, IRF, LTCH, and SNF Quality Reporting Programs: COVID-19 PHE

.

The following billing and coding articles have been revised to reflect the July 2020 CPT/HCPCS code quarterly updates effective for dates of service on and after July 1, 2020:

- Billing and coding: Allergy Testing (A56558)
- Billing and coding: Hemophilia Factor Products (A56433)
- Billing and coding: Hyaluronan Acid Therapies for Osteoarthritis of the Knee (A55036)
- Billing and coding: Independent Diagnostic Testing Facility (IDTF) (A53252)

As a reminder, the comment period for the following proposed local coverage determinations (LCDs) is currently open and will close on August 8, 2020. We encourage you to submit your comments as soon as possible to allow ample time for us to review them thoroughly.

- Endovenous Stenting (DL37893)
- Transurethral Waterjet Ablation of the Prostate (DL38712)
- Treatment of Chronic Venous Insufficiency of the Lower Extremities (DL34924)

Submit comments

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July 27, 2020

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised the article on July 24, 2020, to add clarifying language to the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section to show it applies to lab tests regardless of the HCPCS codes used to report those tests. All other information remains the same.

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July 23, 2020

Special Edition – Thursday, July 23, 2020

Provider Education Message:

Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19

As part of the unprecedented efforts taken by the Trump Administration, President Trump announced several new CMS initiatives designed to protect nursing home residents from Coronavirus Disease 2019 (COVID-19).

“From the moment the threat of this virus materialized, the Trump Administration has placed a priority on protecting nursing home residents,” said CMS Administrator Seema Verma. “Today’s multi-pronged intervention represents the latest efforts in fulfilling that unwavering commitment. As caseloads continue to increase in areas around the country, it has never been more important that nursing homes have what they need to maintain a sturdy defense against the virus. These measures will help them do exactly that.”

New Funding:

HHS will devote $5 billion of the Provider Relief Fund authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act to Medicare-certified long term care facilities and state veterans’ homes (“nursing homes”), to build nursing home skills and enhance nursing homes’ response to COVID-19, including enhanced infection control. This funding could be used to address critical needs in nursing homes including hiring additional staff, implementing infection control “mentorship” programs with subject matter experts, increasing testing, and providing additional services, such as technology so residents can connect with their families if they are not able to visit. Nursing homes must participate in the Nursing Home COVID-19 Training (described below) to be qualified to receive this funding. This new funding is in addition to the $4.9 billion previously announced to offset revenue losses and assist nursing homes with additional costs related to responding to the COVID-19 public health emergency and the shipments of personal protective equipment provided to nursing homes by the Federal Emergency Management Agency.

Enhanced Testing:

Building on the initiative HHS announced last week, in which rapid point-of-care diagnostic testing devices will be distributed to nursing homes, and the new funding from the Provider Relief Fund, CMS will begin requiring, rather than recommending, that all nursing homes in states with a 5% positivity

rate or greater test all nursing home staff each week. This new staff testing requirement will enhance efforts to keep the virus from entering and spreading through nursing homes by identifying asymptomatic carriers.

More than 15,000 testing devices will be deployed over the next few months to help support this mandate, with over 600 devices shipping this week. Funds from the Provider Relief Fund can also be used to pay for additional testing of visitors.

Additional Technical Assistance & Support:

The Trump administration recently deployed federal Task Force Strike Teams to provide onsite technical assistance and education to nursing homes experiencing outbreaks in an effort to help reduce transmission and the risk of COVID-19 spread among residents. The first deployments took place in 18 nursing homes in Illinois, Florida, Louisiana, Ohio, Pennsylvania and Texas between July 18 and July 20. The Task Force Strike Teams are composed of clinicians and public health service officials from CMS, the Centers for Disease Control & Prevention (CDC), and the Office of the Assistant Secretary for Health.

The Task Force Strike Teams went into nursing homes based on data they reported to the CDC that indicated an increase in COVID-19 cases. The teams focused on the four key areas of support, including keeping COVID-19 out of facilities, detecting COVID-19 cases quickly, preventing virus transmission, and managing staff. The goal was to determine what immediate actions nursing homes needed to take to help reduce the spread and risk of COVID-19 among residents, and to better understand what federal, state, and local resources nursing homes need to ensure the health and safety of their residents. CMS and its partners plan to use what is learned on the ground to determine remote education and other critical needs to support nursing homes and mitigate future outbreaks.

In addition, CMS, in partnership with the CDC, is rolling out an online, self-paced, on-demand Nursing Home COVID-19 Training focused on infection control and best practices. The training being offered has 23 educational modules and a scenario-based learning modules that include materials on cohorting strategies and using telehealth in nursing homes to assist facilities as they continue to work to mitigate the virus spread in their facilities. This program supplements training already underway to better equip nursing homes to contain and stop the spread of COVID-19. The training is a requirement for nursing homes to receive the additional funding from the Provider Relief Fund Program.

The training will be available to all 15,400 nursing homes nationwide along with specialized technical assistance to nursing homes who have been found to have infection prevention deficiencies in their most recent CMS inspection and had recent COVID-19 cases based upon their data submissions to CDC. A certificate of completion is offered and recognition badges can be downloaded for nursing homes to display on their website.

Weekly Data on High Risk Nursing Homes:

Early on during this pandemic, CMS required nursing homes to inform residents, their families and representatives of COVID-19 cases in their nursing homes. Starting in May, CMS and CDC began collecting weekly data on each nursing home including their number of COVID-19 cases. Now that this data collection process has matured, the White House and CMS will release a list of nursing homes with an increase in cases that will be sent to states each week as part of the weekly Governor’s report to ensure states have the information needed to target their support to the highest risk nursing homes.

This announcement builds on the unprecedented and aggressive actions CMS has taken to address the impact of COVID-19 in nursing homes.

See the full text of this excerpted CMS Press Release (issued July 22), including a list of actions CMS took to address the impact of COVID-19 in nursing homes.

.

CMS Provider Education Message:

Telemedicine Hack: 10-Week Learning Community for Ambulatory Providers

MLN Connects® for Thursday, July 23, 2020

View this edition as a PDF

News

- Peripheral Vascular Intervention for Claudication: Comparative Billing Report
- Physician Compare Preview Period Open through August 20

Claims, Pricers & Codes

- SNF Patient Driven Payment Model Interrupted Stay Issue

Events

- Telemedicine Hack: A 10-Week Learning Community to Accelerate Telemedicine Implementation for Ambulatory Providers: July 22–September 23
- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — July 23

MLN Matters® Articles

- Change to the Payment of Allogeneic Stem Cell Acquisition Services
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised

Multimedia

- Part A Cost Report Call: Audio Recording and Transcript

.

The following local coverage determination (LCD) and its related billing and coding article has been revised:

- Trigger Point Injections (L35010)
  - Billing and coding: Trigger Point Injections (A57751)

The following LCD has been revised:

- Wound Care (L35125)

The following billing and coding article has been revised:

- Billing and coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device) (A55240)

The following LCDs and related billing and coding articles have been retired:

- Nusinersen (Spinraza) (L37682)
  - Billing and coding: Nusinersen (Spinraza) (A56860)
- Strapping (L36423)
  - Billing and coding: Strapping (A56804)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11580 – Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan

  The Centers for Medicare & Medicaid Services (CMS) revised this article to reflect a revised change request (CR) 11850, issued on July 21, 2020. In the article, CMS revised the CR release date, transmittal number, and web address. All other information remains the same.

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July 22, 2020

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 21, 2020

Part A Open Issues Log Update: W7020 adjustments update

All impacted claims have been reprocessed.

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July 20, 2020

CMS Provider Education Message:

Provider Education Message:

COVID-19: Nursing Home Testing, SNF Benefit Period Waiver

MLN Matters Special Edition Article SE20011 Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) is updated. Learn about:

- Updated Centers for Disease Control and Prevention guidelines for testing nursing home residents and patients
- Update on applying the Skilled Nursing Facility (SNF) benefit period waiver

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June 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The June 2020 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.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services (CMS) revised the article to add a row at the end of the waiver/flexibility table (page seven) to address services provided by the hospital in

the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient. CMS also added the section on Teaching physicians and residents: Expansion of current procedure terminology codes that may be billed with the GE modifier. All other information remains the same.

- MM11814 – July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  The Centers for Medicare & Medicaid Services (CMS) revised this article on July 16, 2020, to reflect a revised CR11814. In the article CMS updated the section on "Covid-19 Laboratory Tests and Services and Other Laboratory Tests Coding Update". Table 1 has also been updated to add 3 new COVID-19 codes: 87426, 0223U, and 0224U. CMS is also changing payment status indicator for HCPCS code Q5112 from SI=E2 to SI=K, effective April 15, 2020 through September 30, 2020, and updating section 9 "Drugs, Biologicals, and Radiopharmaceuticals" by adding new subsections j and k to reflect this change. CMS renumbered all other subsequent sub-sections, and Tables 19 and 20 added to reflect payment status indicator change for Q5112. All other tables have been re-numbered. CMS also revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

.

July 16, 2020

CMS Provider Education Message:

Nursing Homes & COVID: Five Things to Know, Additional Resources, Training

MLN Connects® for Thursday, July 16, 2020

View this edition as a PDF

News

- CMS Directs Additional Resources to Nursing Homes in COVID-19 Hotspot Areas
- Five Things About Nursing Homes During COVID-19
- PEPPER for Short-term Acute Care Hospitals
- Lower Extremity Joint Replacement: Comparative Billing Report

Events

- Nursing Home Training Series Webcasts: New Topic for July 16
- COVID-19: Lessons from the Front Lines Call — July 17

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020
- Influenza Vaccine Payment Allowances - Annual Update for 2020-2021 Season
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021
- October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2020 Update

- July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised
- Claim Status Category Codes and Claim Status Codes Update — Rescinded

.

Prior authorization request (PAR) cover sheet instructions

Instructions on how to complete the PAR cover sheet have been added to our PA for certain hospital outpatient department (OPD) webpage. Failure to complete the PAR cover sheet in its entirety could result in delays in processing your PAR request, a non-affirmed decision, or a determination that the request is incomplete and cannot be processed.

.

As a reminder, the comment period for the following proposed local coverage determinations is currently open and will close on August 8, 2020. We encourage you to submit your comments as soon as possible to allow ample time for us to review them thoroughly.

- Endovenous Stenting (DL37893)
- Transurethral Waterjet Ablation of the Prostate (DL38712)
- Treatment of Chronic Venous Insufficiency of the Lower Extremities (DL34924)

  Submit comments

.

July 14, 2020

The following Local Coverage Determinations (LCDs) which were posted for notice on May 28, 2020 are now effective. The related Billing and Coding articles for these LCDs are also now effective:

- Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (L38495)
  - Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (A57839)
- Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (L35130)
  - Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (A57752)

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11882 – Influenza Vaccine Payment Allowances - Annual Update for 2020-2021 Season

  This article informs you of the availability of payment allowances for the seasonal influenza virus vaccines as updated on an annual basis, effective August 1 of each year. Please make sure your billing staffs are aware of these updates.

- MM11729 – Change to the Payment of Allogeneic Stem Cell Acquisition Services

  This change request provides instructions to pay inpatient hospital allogeneic stem cell acquisition services on a reasonable cost basis. Please make sure your billing staffs are aware of these changes.

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July 13, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11889 – Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020

  This article announces the changes that will be included in the October 2020 quarterly release of the edit module for clinical diagnostic laboratory services. Please be sure your billing staffs are aware of these updates.

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July 10, 2020

Part A June 2020 Newsletter

The June 2020 Part A Newsletter is now available. Please take a moment to review.

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Modifiers used during the COVID-19 Public Health Emergency (PHE)

Novitas in collaboration with the the A/B Medicare Administrative Contractor (MAC) Provider Outreach & Education (POE) Collaboration Team created a chart detailing the modifiers to be used during the COVID-19 PHE.

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Medicare Learning Network® MLN Matters® Articles from CMS

Rescinded:

- MM11699 – Claim Status Category Codes and Claim Status Codes Update

  This article was rescinded on July 9, 2020, as the related change request (CR) 11699, transmittal R10148CP, dated May 22, 2020, was rescinded and will not be replaced.

Revised:

- MM11815 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  The Centers for Medicare & Medicaid Services (CMS) revised this article to add information on COVID-19 codes 87426, 0223U and 0224U. CMS also revised the CR release date, transmittal number and the web address of the CR. All other information remains the same.

.

July 9, 2020

CMS Provider Education Message:

ICD-10-CM Diagnosis Codes: FY 2021

MLN Connects® for Thursday, July 9, 2020

View this edition as a PDF

News

- Open Payments: Program Year 2019 Data
- LTCH Provider Preview Reports: Review Your Data by July 18
- IRF Provider Preview Reports: Review Your Data by July 21
- Reduce Provider Burden: Participate in Medical Documentation Interoperability Pilot
- COVID-19: Alternate Care Site Toolkit, Third Edition

Claims, Pricers & Codes

- ICD-10-CM Diagnosis Codes: FY 2021
- Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier

Events

- Nursing Home Training Series Webcasts — July 9 and 16

MLN Matters® Articles

- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Revising Chapters 3 and 5 of Publication (Pub.) 100-08, to Reflect the Recent Final Rule CMS-1713-F
- New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site — Revised

Publications

- Hospice Quality Reporting Program: COVID-19 PHE

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June 2020 top claim submission errors

The June 2020 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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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised the article to add a row at the end of the waiver/flexibility table (page seven) to address services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient. Also, we added the section on Teaching physicians and residents:

Expansion of current procedure terminology codes that may be billed with the GE modifier. All other information remains the same.

.

July 7, 2020

MLN Connects Special Edition for Monday, July 6, 2020

Provider Education Message:

ESRD PPS CY 2021 Proposed Rule; COVID-19: New and Expanded Flexibilities for RHCs & FQHCs

- ESRD PPS CY 2021 Proposed Rule
- COVID-19: New and Expanded Flexibilities for RHCs & FQHCs during the Public Health Emergency

ESRD PPS CY 2021 Proposed Rule

On July 6, CMS issued a proposed rule that proposes to update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2021. This rule also proposes updates to the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI and proposes changes to the ESRD Quality Incentive Program (QIP).

In addition to the annual technical updates for the ESRD PPS, the proposed rule proposes the following:

- An addition to the ESRD PPS base rate to include calcimimetics in the ESRD PPS bundled payment
- Changes to the eligibility criteria and determination process for the Transitional add-on Payment adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Expansion of the TPNIES to include new and innovative capital-related assets that are home dialysis machines
- A change to the low-volume adjustment eligibility criteria and attestation requirement to account for the COVID-19 public health emergency
- An update to the ESRD PPS wage index to adopt the new Office of Management and Budget delineations with a transition period
- Information received from two manufacturers whose products, a dialyzer and a cartridge for a home dialysis machine, are being considered for TPNIES in CY 2021

Additionally, the proposed rule proposes the following updates to the ESRD QIP:

- Scoring methodology changes to the ultrafiltration rate reporting measure
- Updates to the National Healthcare Safety Network validation study

The proposed CY 2021 ESRD PPS base rate is $255.59, an increase of $16.26 to the current base rate of $239.33. This proposed amount reflects the application of the proposed wage index budget-neutrality adjustment factor (.998652), the proposed addition to the base rate of $12.06 to include calcimimetics, and a proposed productivity-adjusted market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.8 percent), equaling $255.59 (($239.33 x .998652) + $12.06) x 1.018 = $255.59).

The proposed rule also includes:

- Annual update to the wage index
- Update to the outlier policy
- Low-volume eligibility criteria and attestation requirement
- Impact analysis

For More Information:

- Proposed Rule
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued July 6).

COVID-19: New and Expanded Flexibilities for RHCs & FQHCs during the Public Health Emergency

On July 6, CMS updated MLN Matters Article SE20016 to clarify how Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can apply the Cost Sharing (CS) modifier to preventive services furnished via telehealth. This update includes:

- Additional claim examples
- New section on the RHC Productivity Standard

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Appeals Corner Newsletter June 2020

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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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11769 – Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2020 Update

  Change request 11769 updates the HCPCS code set for codes related to drugs and biologicals. Please alert your billing staffs of these updates.

- MM11854 – October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  This article updates the quarterly ASP Medicare Part B pricing files and informs providers of revisions to prior quarterly pricing files. Please make sure your billing staffs are aware of these updates and revisions.

- MM11859 – Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021

  This article provides information on the fiscal year 2021 updates to the SNF PPS payment rates, as required by statute. Make sure your billing staffs are aware of these updates.

Revised:

- SE20016 – New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)

  The Centers for Medicare & Medicaid Services revised this article to provide additional guidance on telehealth services that have cost-sharing waived and additional claim examples, and an additional section on the RHC productivity standard. All other information remains the same.

- MM11814 – July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  The Centers for Medicare & Medicaid Services (CMS) revised this article due to an updated change request (CR). CMS also changed the CR release date, transmittal number and link to the transmittal. All other information is unchanged.

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July 6, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11836 – New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site

  The Centers for Medicare & Medicaid Services revised this article on July 2, 2020, to reflect an updated change request (CR) that changed the implementation date to August 3, 2020. The transmittal number, release date of the CR and link to the transmittal also changed. All other information is unchanged.

.

July 2, 2020

CMS Provider Education Message:

Attend Nursing Home Training Series Webcasts

MLN Connects® for Thursday, July 2, 2020

View this edition as a PDF

News

- CMS Proposes to Expand Coverage Policy for Transcatheter Edge-to-Edge Repair for Patients with Mitral Valve Regurgitation
- Physician Compare Preview Period Open through August 20
- ABN Form Renewal
- Medicare Enrollment Application Fee Refunds through EFT

Claims, Pricers & Codes

- SNF Benefit Waiver Period: Billing Update

Events

- Nursing Home Training Series Webcasts — July 2, 9, and 16

- Medicare Part A Cost Report: New Online Status Tracking Feature Call — July 9

MLN Matters® Articles

- July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.3, Effective October 1, 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – July 2020 Update — Revised
- National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS) — Revised
- Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer — Revised

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The following LCDs and related billing and coding articles have been revised:

- Allergy Testing (L36241)
  - Billing and coding: Allergy Testing (A56558)
- Assays for Vitamins and Metabolic Function (L34914)
  - Billing and coding: Assays for Vitamins and Metabolic Function (A56416)
- Biomarkers for Oncology (L35396)
  - Billing and coding: Biomarkers for Oncology (A52986)
- Biomarkers Overview (L35062)
  - Billing and coding: Biomarkers Overview (A56541)
- Magnetic Resonance Angiography (MRA) (L34865)
  - Billing and coding: Magnetic Resonance Angiography (MRA) (A56805)
- Pulmonary Function Testing (L35360)
  - Billing and coding: Pulmonary Function Testing (A57320)

The following LCDs have been revised:

- Epidural Injections for Pain Management (L36920)
- Psychiatric Codes (L35101)

The following billing and coding article has been revised:

- Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)

The following LCDs and the related billing and coding articles have been retired effective for dates of service on and after July 1, 2020:

- In Vitro Chemosensitivity & Chemoresistance Assays (L36634)
  - Billing and coding: In Vitro Chemosensitivity & Chemoresistance Assays (A56710)
- Microvascular Therapy (L36434)
  - Billing and coding: Microvascular Therapy (A54343)
- Outpatient Wireless Pulmonary Artery Pressure Monitoring for Heart Failure (L36419)

    - Billing and coding: Outpatient Wireless Pulmonary Artery Pressure Monitoring for Heart Failure (A56856)
- Services That Are Not Reasonable and Necessary (L35094)
    - Billing and coding: Services That Are Not Reasonable and Necessary (A56967)
- Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy (L34891)
    - Billing and coding: Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy (A57656)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised the billing instructions on page 12 of this article. Changes include instructions to readmit the beneficiary on day 101 to start the skilled nursing facility benefit period waiver. All other information remains the same.

.

July 1, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11835 – Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)

  Change request 11835 informs providers about new diagnosis codes eligible for the ESRD PPS comorbidity payment adjustment effective October 1, 2020. Make your billing staff aware of these additions.

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June 29, 2020

Advance Beneficiary Notice (ABN) Form Renewal

Providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service - FFS) issue the ABN Form CMS-R-131 to beneficiaries in situations where Medicare payment is expected to be denied

The ABN form and instructions have been approved by the Office of Management and Budget (OMB) has been renewed.

The new ABN form is effective for current use with an expiration date of June 30, 2023.

Please update any old forms, use of the old ABN form (version 03/2020) will be considered invalid after August 31, 2020.

ABN form and instructions:

- Advance Beneficiary Notice of non-coverage

- ABN Form Instructions
- ABN Forms
- Medicare Claims Processing Manual, 100-4, Chapter 30

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  On June 26, 2020, the Centers for Medicare & Medicaid Services revised the article to add the section, “Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information” and related billing instructions. All other information remains the same.

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June 26, 2020

Provider Education Message:

Special Edition – Friday, June 26, 2020

COVID-19: SNF Benefit Period Waiver, HHAs Proposed Rule, Ending Nursing Home Blanket Waiver

- COVID-19: SNF Benefit Period Waiver
- HHAs: Proposed Payment and Policy Changes and Home Infusion Therapy Benefit for CY 2021
- CMS Announces Plans to End the Blanket Waiver Requiring Nursing Homes to Submit Staffing Data

COVID-19: SNF Benefit Period Waiver

Disruptions during a Public Health Emergency can affect the Skilled Nursing Facility (SNF) benefit:

- Prevent a beneficiary from having the Qualifying Hospital Stay (QHS)
- Disrupt the process of ending the beneficiary’s current benefit period and renewing their benefits

Emergency waivers of QHS and benefit period requirements under §1812(f) of the Social Security Act help restore SNF coverage that beneficiaries affected by the emergency would be entitled to under normal circumstances.

Learn more about the waiver and how to bill in MLN Matters Article SE20011.

HHAs: Proposed Payment and Policy Changes and Home Infusion Therapy Benefit for CY 2021

On June 25, CMS issued a proposed rule [CMS-1730-P] for FY 2021 that updates the Medicare payment rates for Home Health Agencies (HHAs). This proposed rule also includes a proposal to make permanent the regulatory changes related to telecommunications technologies in providing care under the Medicare home health benefit beyond the expiration of the Public Health Emergency for the COVID-19 pandemic.

For More Information:

- Fact Sheet
- Proposed Rule

CMS Announces Plans to End the Blanket Waiver Requiring Nursing Homes to Submit Staffing Data

On June 25, CMS announced plans to end the emergency blanket waiver requiring all nursing homes to resume submitting staffing data through the Payroll-Based Journal (PBJ) system by August 14, 2020. The PBJ system allows CMS to collect nursing home staffing information which impacts the quality of care residents receive. The blanket waiver was intended to temporarily allow the agency to concentrate efforts on combating COVID-19 and reduce administrative burden on nursing homes so they could focus on patient health and safety during this Public Health Emergency.

The memorandum also provides updates related to staffing and quality measures used on the Nursing Home Compare website and the Five Star Rating System.

To view the memorandum to states and nursing home stakeholders, visit: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/changes-staffing-information-and-quality-measures-posted-nursing-home-compare-website-and-five-star.

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Hospital outpatient department (HOPD) services prior authorization (PA) calculator

Novitas has developed a HOPD PA calculator to help you determine the time you have remaining to perform the approved procedure before the PA expires. The service listed on the prior authorization request (PAR) must be performed within 120 days of the date of the decision letter. The 120 days begins with the date on the decision letter. By entering the date of the decision in the tool, it will tell you the last date your authorization will be valid. For more information on the HOPD PA program refer to Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services.

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June 25, 2020

CMS Provider Education Message:

COVID-19: New Data Details Impacts on Medicare Beneficiaries

MLN Connects® for Thursday, June 25, 2020

View this edition as a PDF

News

- Trump Administration Issues Call to Action Based on New Data Detailing COVID-19 Impacts on Medicare Beneficiaries
- Hospital Outpatient Departments: Prior Authorization Begins July 1
- IRF Provider Preview Reports: Review Your Data by July 18
- LTCH Provider Preview Reports: Review Your Data by July 18
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Personal Protective Equipment Strategies for COVID Care Webcast — June 25
- Medicare Part A Cost Report: New Online Status Tracking Feature Call — July 9

Publications

- Clinical Laboratory Fee Schedule Annual Payment Determination Process

.

The following proposed local coverage determinations (LCDs) have been posted for comments. The comment period will end on August 8, 2020; however you are encouraged to submit your comments as soon as possible to allow ample time for us to review them thoroughly.

- Endovenous Stenting (DL37893)
- Transurethral Waterjet Ablation of the Prostate (DL38712)
- Treatment of Chronic Venous Insufficiency of the Lower Extremities (DL34924)

  Submit comments

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

- Billing and coding: Treatment of Chronic Insufficiency of the Lower Extremities (DA55229)
- Billing and coding: Transurethral Waterjet Ablation of the Prostate (DA58243)

The following billing and coding article has been revised:

- Billing and coding: Endovenous Stenting (A56414)

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

- Lacrimal Punctum Plugs (L35095)
  - Billing and coding: Lacrimal Punctum Plugs (A56780)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11461 – National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS)

  The Centers for Medicare & Medicaid Services (CMS) revised this article to reflect the revised change request (CR)11461, issued on June 23, 2020. The CR revision clarified instructions for the Medicare administrative contractors and changed the implementation date to July 22, 2020. In the article, CMS changed the implementation date, the CR release date, transmittal number, and the web address. All other information remains the same.

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Upcoming direct data entry (DDE) screen changes

Effective July 1, 2020, the Fiscal Intermediary Standard System (FISS) maintainer will be making changes to the DDE screens listed below. The FISS User Guide has been updated to reflect these changes.

- MAP1716 – Integrated code editor claim processed flag (I/OCE CLM PR FL) field added
- MAP171E – Line level ordering provider field added for advanced diagnostic imaging

- MAP171G – New screen to display the Outcome and Assessment Information Set (OASIS) data returned by the Quality Improvement and Evaluation System (QIES)

.

Online registration available for July 10, 2020, open meeting and proposed LCDs now posted

Online registration for the July 10, 2020, open meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, July 8, 2020. **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 24, 2020

A/B MAC and DME MAC collaborative webinar on therapeutic shoes for persons with diabetes

Do you order therapeutic shoes for your patients that are enrolled in Medicare? Do you wonder why you are asked for specific documentation? These questions and many more will be addressed during the “Therapeutic shoes for persons with diabetes” webinar on June 30, 2020. Register today!

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June 23, 2020

Limited systems availability - Friday, July 3, 2020, through Sunday, July 5, 2020

There will be Common Working File (CWF) "Dark" days from Friday, July 3, 2020, through Sunday, July 5, 2020, due to the July 2020 release upgrades. The interactive voice response (IVR) unit and our customer service representatives will have limited availability. Customer service representatives will not be able to assist providers with eligibility inquiries, claim status inquiries relating to eligibility or claim denial inquiries relating to eligibility.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  On June 19, 2020, the Centers for Medicare & Medicaid Services revised the article to add the section, “Medicare coverage of COVID-19 testing for nursing home residents and patients.” All other information remains the same.

- MM11742 – Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer

The Centers for Medicare & Medicaid Services (CMS) revised this article to reflect a revised change request (CR) 11742, issued on June 19, 2020. CMS revised the CR to revise the COVID19 blanket waiver for the LTCH average length of stay policy, to include revising the effective date and policy section. We updated that portion of this article. Also, CMS revised the CR release date, transmittal number, and the web address. All other information remains the same.

- MM11655 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) -- July 2020 Update

  The Centers for Medicare & Medicaid Services revised this article to reflect a revised change request (CR) 11655. The CR was revised to remove Current Procedural Technology (CPT) code 0048U from the business requirement for national coverage determinations (NCD) 90.2 Next generation sequencing (NGS) and corresponding removals of CPT 0048U and its associated diagnosis codes from the NCD 90.2 NGS spreadsheet. This revision is necessary because the CPT code does not meet the policy criteria in NCD 90.2 for NGS. In this article, we revised the CR release date, transmittal number, and the web address. All other information remains the same

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June 22, 2020

Provider Education Message:

Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients

Today, the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare Administrative Contactors and notified Medicare Advantage plans to cover coronavirus disease 2019 (COVID-19) laboratory tests for nursing home residents and patients. This instruction follows the Centers for Disease Control and Prevention's (CDC) recent update of COVID-19 testing guidelines for nursing homes that provides recommendations for testing of nursing home residents and patients with symptoms consistent with COVID-19 as well as for asymptomatic residents and patients who have been exposed to COVID like in an outbreak. Original Medicare and Medicare Advantage plans will cover COVID-19 lab tests consistent with CDC guidance.

Medicare Advantage plans must continue not to charge cost sharing (including deductibles, copayments, and coinsurance) or apply prior authorization or other utilization management requirements for COVID-19 tests and testing-related services.

Read the Medicare Learning Network article: https://www.cms.gov/files/document/se20011.pdf.

Read the memo to Medicare Advantage plans: https://cms.gov/files/document/hpms-memo-diagnostic-testing-nursing-home-residents-and-patients-coronavirus-disease-2019.pdf.

More information about Medicare coverage of COVID-19 tests is available at: https://www.medicare.gov/coverage/coronavirus-disease-2019-covid-19-tests.

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June 18, 2020

CMS Provider Education Message:

COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services

MLN Connects® for Thursday, June 18, 2020

View this edition as a PDF

News

- Hospitals: Submit Medicare GME Affiliation Agreements by October 1 During the COVID-19 PHE

Claims, Pricers & Codes

- COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services

Events

- COVID-19: Lessons from the Front Lines Call — June 19
- Medicare Part A Cost Report: New Online Status Tracking Feature Call — July 9

MLN Matters® Articles

- New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to Home Health (HH) Grouper
- NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR) — Revised
- Value-Based Insurance Design (VBID) Model – Implementation of the Hospice Benefit Component — Revised

Publications

- CLIA Program and Medicare Laboratory Services — Revised
- Medicare Preventive Services — Revised

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Part A: Open issues log

Adjustments and cancels for period interim payment providers are currently suspended in status location SM95HG and cannot be processed. The Centers for Medicare & Medicaid Services (CMS) is working with the Fiscal Intermediary Shared System and the Healthcare Integrated General Ledger Accounting System on a correction. We will post additional information once a correction date is scheduled.

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June 17, 2020

May 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The May 2020 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 claim status categories. Please take time to review these and other FAQs for answers to your questions.

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June 16, 2020

Prior authorization request (PAR) hospital outpatient procedures Medicare Part A fax/mail cover sheet

The PAR fax/mail cover sheet is now available. The hospital outpatient department (OPD), or provider on behalf of the hospital OPD, must submit the PAR to us before the service is provided to the beneficiary and before the claim is submitted for processing. For more information on PAR submission, review the guidelines for submitting the PAR. The expedited PAR cover sheet is available when the normal timeframe for a decision notification could jeopardize the life or health of the beneficiary.

Refer to Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services webpage for more details on the PA program. Questions can be directed to the PA customer service at 855-340-5975.

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June 15, 2020

The comment period is now closed for the following proposed local coverage determination. 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.

- Implantable Continuous Glucose Monitors (I-CGM) (DL38617)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11815 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  This article informs laboratories of changes in the quarterly update to the clinical laboratory fee schedule. Please be sure your billing staff is aware of these updates.

- MM11836 – New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site

  Change request 11836 announces a new point of origin code “G” to indicate a “transfer from a designated disaster alternative care site,” due to changes relative to the COVID-19 public health emergency. Make sure your billing staffs are aware of these changes

Revised:

- MM11660 – NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR)

  The Centers for Medicare & Medicaid Services revised this article to reflect a revised change request (CR) 11660 issued on June 10, 2020. The CR revisions were for formatting purposes only and did not alter the substance of the article. In the article, CMS revised the CR release date, transmittal numbers, and web addresses. All other information remains the same.

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June 12, 2020

May 2020 Part A Newsletter

The May 2020 Part A Newsletter is now available. Please take a moment to review.

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

The PA hospital OPD FAQ document has been developed to include questions and answers posed during our webinars on the PA program for certain hospital OPD services.

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June 11, 2020

CMS Provider Education Message:

COVID-19: Reopening Health Care Facilities

MLN Connects® for Thursday, June 11, 2020

View this edition as a PDF

News

- Nursing Home COVID-19 Data and Inspections Results Available on Nursing Home Compare
- Trump Administration Encourages Reopening of Health Care Facilities
- HHS Announces New Laboratory Data Reporting Guidance for COVID-19 Testing
- Prior Authorization Process and Requirements for Certain Hospital OPD Services: Payment for Related Services

Events

- Medicare Documentation Requirement Lookup Service Special Open Door Forum — June 25

MLN Matters® Articles

- July 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.2
- July Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS)
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2020

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11754 – Value-Based Insurance Design (VBID) Model – Implementation of the Hospice Benefit Component

  The Centers for Medicare & Medicaid Services (CMS) revised this article on June 10, 2020, to reflect a revised change request (CR) 11754 issued on June 9. CMS revised the article to add a note to the effective date, the CR release date, transmittal number, and the web address. All other information remains the same.

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June 9, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11814 – July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  This article informs you about the changes to and billing instructions for various payment policies implemented in the July 2020 OPPS update. The July 2020 Integrated Outpatient Code Editor (I/OCE) will reflect the healthcare common procedure coding system (HCPCS), ambulatory payment classification, HCPCS modifier, and revenue code additions, changes and deletions identified in change request (CR) 11814. The July 2020 revisions to I/OCE data files, instructions, and specifications are provided in CR 11792. The article related to that CR, MM11792, is available on the Centers for Medicare & Medicaid Services website. Make sure that your billing staffs are aware of these changes.

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June 8, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11792 – July 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.2

  This article provides the I/OCE instructions and specifications for the I/OCE employed under the Outpatient Prospective Payment System (OPPS) and non-OPPS. The specifications are for:

  - Hospital outpatient departments.
  - Community mental health centers.
  - All non-OPPS hospital providers.
  - For limited services when provided in a home health agency not under the home health prospective payment system or to a hospice patient for the treatment of a nonterminal illness. The I/OCE specifications will be posted on the Centers for Medicare & Medicaid Services website.

  Make sure your billing staffs are aware of these changes.

- MM11810 – July Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

  This article informs durable medical equipment Medicare administrative contractors about the changes to the DMEPOS fees schedules that are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

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June 4, 2020

CMS Provider Education Message:

ICD-10-PCS Procedure Codes: FY 2021

MLN Connects® for Thursday, June 4, 2020

View this edition as a PDF

News

- Trump Administration Unveils Enhanced Enforcement Actions Based on Nursing Home COVID-19 Data and Inspection Results
- Hospice Provider Preview Reports: Review Your Data by June 29

Claims, Pricers & Codes

- ICD-10-PCS Procedure Codes: FY 2021

Events

- COVID-19: Lessons from the Front Lines Call — June 5

MLN Matters® Articles

- Claim Status Category Codes and Claim Status Codes Update
- 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
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules
- Value-Based Insurance Design (VBID) Model – Implementation of the Hospice Benefit Component
- Supplier Education on Use of Upgrades for Multi-Function Ventilators — Revised
- Therapy Codes Update — Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update — Rescinded

Publications

- Medicare Secondary Payer — Revised

.

As a reminder, the comment period for the following proposed local coverage determination (LCD) is currently open and will close on June 13, 2020. We encourage you to submit your comments as soon as possible to allow ample time for us to review them thoroughly.

- Implantable Continuous Glucose Monitors (I-CGM) (DL38617)
  Submit comments

The following draft billing and coding article is related to the above Proposed LCD.

- Billing and coding: Implantable Continuous Glucose Monitors (I-CGM) (DA58110)

The following billing and coding article has been added:

- Billing and coding: Screening for Cervical Cancer with Human Papillomavirus (HPV)(A58216)

The following billing and coding article has been revised:

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

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May 2020 top claim submission errors

The May 2020 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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June 3, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11461 – National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS)

  Change request 11461 notifies Medicare administrative contractors that effective for claims with dates of service on or after February 15, 2019, the Centers for Medicare & Medicaid Services will cover Food and Drug Administration approved VNS devices for treatment resistant depression through coverage with evidence development for patients that meet specific conditions of coverage and criteria. Please make sure your billing staffs are aware of this change.

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  On June 1, 2020, the Centers for Medicare & Medicaid Services revised the article to add a section on clarification for using the “CR” modifier and “DR” condition code. All other information remains the same.

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June 1, 2020

Special Edition – Monday, June 1, 2020

Provider Education Message:

COVID-19: Using the CR Modifier and DR Condition Code

CMS revised MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) to clarify when you must use modifier CR (catastrophe/disaster related) and/or condition code DR (disaster related) when submitting claims to Medicare. The update includes a chart of blanket waivers and flexibilities that require the modifier or condition code.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11754 – Value-Based Insurance Design (VBID) Model – Implementation of the Hospice Benefit Component

  This article informs you of the implementation of the hospice benefit component associated with the VBID Model, being tested by the Centers for Medicare & Medicaid Services Innovation

Center and starting in calendar year (CY) 2021. The hospice benefit component of the model will be tested through CY 2024. Please make sure your billing staffs are aware of this update as **providers must still submit claims for these services to Medicare**. Non-contracting providers must also submit the same billing forms used to bill original Medicare to plans participating in the VBID model's hospice benefit component for payment.

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May 29, 2020

Special Edition – Friday, May 29, 2020

Provider Education Message:

New COVID-19 FAQs on Medicare Fee-for-Service Billing

CMS released additional Frequently Asked Questions (FAQs) on our recent COVID-19-related waivers to help providers, including physicians, hospitals, and rural health clinics. Find more answers to questions on:

- Outpatient therapy
- Telehealth and appropriate coding
- Federally qualified health centers

Bookmark this document and check back for additional updates.

For More Information:

- Coronavirus.gov
- CMS Current Emergencies website

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May 28, 2020

CMS Provider Education Message:

COVID-19: Adjusting Operations to Manage Patient Surge

MLN Connects® for Thursday, May 28, 2020

View this edition as a PDF

News

- COVID-19: Adjusting Operations to Manage Patient Surge
- PECOS/NPPES/EHR Identity & Access Management System: Role Renamed
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- COVID-19: Lessons from the Front Lines Call — May 29

MLN Matters® Articles

- Medicare Continues to Modernize Payment Software

Publications

- Acute Care Hospital Inpatient Prospective Payment System — Revised

.

The following local coverage determinations (LCDs) posted for comment on December 26, 2019, have been posted for notice. The LCDs and related billing and coding articles will become effective July 12, 2020:

- Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (L38495)
  - Billing and coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (A57839)
- Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (L35130)
  - Billing and coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (A57752)

The following response to comments articles contain summaries of all comments received and Novitas' responses:

- Response to comments: Magnetic-Resonance-Guided-Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (A58049)
- Response to comments: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (A58195)

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Prior authorization (PA) program for certain hospital outpatient department (OPD) services

The Centers for Medicare & Medicaid Services (CMS) is implementing a PA program for certain hospital OPD services, effective June 17, 2020, for dates of service (DOS) on or after July 1, 2020, nationwide. As a condition of payment for DOS on or after July 1, 2020, a prior authorization request (PAR) is required for the following hospital OPD services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation.

CMS recently issued an OPD Frequently Asked Questions document and the OPD Operational Guide. Find these documents and more on our dedicated webpage for the OPD PA program.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11709 – 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

  This article informs you of updates that the Medicare Administrative Contractors and Shared System Maintainers will make to systems based on the CORE 360 uniform use of CARC, RARC, and CAGC rule publications. These system updates are based on the CORE code combination list to be published on or about June 1, 2020. Make sure that your billing staffs are aware of these updates.

Rescinded:

- MM11749 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update

  This article was rescinded on May 26, 2020, as the related change request (CR) 11749, transmittal 10092, dated May 1, 2020, was rescinded in its entirety. Therefore, any coding changes to NCD 90.2, Next generation sequencing, contained in CR 11749 are null and void.

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May 27, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11699 – Claim Status Category Codes and Claim Status Codes Update

  Change request 11699 updates 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 ASC X12 277 health care claim acknowledgment transactions. Make sure your billing staff is aware of this update.

- MM11708 – Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  Change request 11708 updates the RARC and CARC lists and instructs the viable information processing system Medicare system and the fiscal intermediary shared system to update MREP and PC Print. Make sure your billing staffs are aware of these updates. If they use the MREP or PC Print software, they will need to get the updates of that software.

- MM11805 – Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules

  This article provides a summary of policies in the CY 2020 MPFS PHE interim final rule with comment (IFC) entitled, “Medicare and Medicaid programs; policy and regulatory revisions in response to the COVID-19 public health emergency (CMS-1744-IFC) and Medicare and Medicaid programs, basic health program, and exchanges; additional policy and regulatory revisions in response to the COVID-19 public health emergency and delay of certain reporting requirements for the skilled nursing facility quality reporting program (CMS-5531-IFC).” Please make sure your billing staffs are aware of these changes.

Revised:

- MM11791 – Therapy Codes Update

  The Centers for Medicare & Medicaid Services (CMS) revised this article to reflect a revised Change request (CR) 11791. The CR revision changed the implementation date for the Medicare administrative contractors in the article. The CR release date, transmittal number, and the web address were also revised. All other information is the same.

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May 26, 2020

The following local coverage determination (LCD) posted for notice on April 9, 2020, became effective May 24, 2020. The related billing and coding article also became effective May 24, 2020.

- Thrombolytic Agents (L35428)

- Billing and coding: Thrombolytic Agents (A55237)

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May 22, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20018 – COVID-19 Blanket Swing Bed Waiver for Addressing Barriers to Nursing Home Placement for Hospitalized Individuals

  Under the COVID-19 PHE blanket waiver entitled, **"Expanded ability for hospitals to offer long-term care services ("swing-beds") for patients that do not require acute care but do meet the Skilled Nursing Facility (SNF) level of care criteria as set forth at 42 CFR 409.31"**, all Medicare enrolled hospitals (except psychiatric and long term care hospitals) that need to provide post-hospital SNF level swing-bed services for non-acute care patients in hospitals can apply for swing bed approval to provide these services, so long as the waiver is not inconsistent with the state's emergency preparedness or pandemic plan.

  Under Section 1135(b)(1) of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services has waived the requirements at 42 CFR 482.58, "Special Requirements for hospital providers of long-term care services ("swing-beds")" subsections (a)(1)-(4) "Eligibility," to allow hospitals to establish SNF swing beds payable under the SNF Prospective Payment System to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF.

  Note: All other hospital conditions of participation and those SNF provisions at 42 CFR 482.58(b), to the extent not waived, continue to apply. See swing bed waiver for additional requirements.

  This MLN Matters Special Edition article provides answers to the key question's hospitals may have as they pursue this option for treating their patients.

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May 21, 2020

CMS Provider Education Message:

Join Upcoming COVID-19 Calls

MLN Connects® for Thursday, May 21, 2020

View this edition as a PDF

News

- CMS Releases Additional Waivers for Hospitals and Ground Ambulance Organizations
- Hospice Quality Reporting Program: Quarterly Update for January - March
- Nursing Home Quality Initiative: Updated MDS 3.0 Item Sets
- Hospitals: Submit Medicare GME Affiliation Agreements by October 1 During the COVID-19 PHE

Events

- COVID-19: Lessons from the Front Lines Calls — May 22 and 29
- COVID-19: Home Health and Hospice Call — May 26

- COVID-19: Office Hours Call — May 26
- COVID-19: Nursing Home Call — May 27
- COVID-19: Dialysis Organization Call — May 27
- COVID-19: Nurses Call — May 28
- Prior Authorization Process and Requirements for Certain Outpatient Hospital Department Services Special Open Door Forum — May 28

MLN Matters® Articles

- COVID-19 Blanket Swing Bed Waiver for Addressing Barriers to Nursing Home Placement for Hospitalized Individuals
- Manual Update to Pub. 100-04, Chapter 38, to Remove Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico Section
- National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM)
- National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)
- New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2020 Update
- Therapy Codes Update

Multimedia

- Procedure Coding: Using the ICD-10-PCS Web-Based Training Course — Revised

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Prior authorization program for certain hospital outpatient department services webinar – date change

Due to CMS hosting a special open door forum call to discuss the prior authorization process and requirements for certain outpatient hospital department services on Thursday, May 28, from 1:30 p.m. to 3:00 p.m. ET, Novitas must change the date and time of the JH JL Part A/B webinar Prior authorization (PA) program for certain hospital outpatient department services previously scheduled for Thursday, May 28, 2020. The **new date and time for the Novitas webinar is Friday, May 29, 2020, at 10:00 a.m. ET/9:00 a.m. CT**. We sincerely apologize for any inconvenience this may cause; If you were previously enrolled in this webinar, we have automatically enrolled you into the rescheduled webinar. If you would like to register for this webinar, please visit our Learning Center to register (JH) (JL).

Novitas will be presenting this webinar on the prior authorization program being implemented by CMS for certain hospital outpatient department (OPD) services on June 17, 2020, for dates of service on or after July 1, 2020. If your facility bills these services, or you are a provider that performs these services on Medicare beneficiaries, join us for this webinar. We'll review the guidelines for submitting a prior authorization request (PAR) and the potential results and options available, with specialists present to answer questions relating to the process.

As a condition of payment for DOS on or after July 1, 2020, a prior authorization request (PAR) is required for the following hospital OPD services:

- Blepharoplasty, eyelid surgery, brow lift, and related services
- Botulinum toxin injections
- Panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy), and related services
- Rhinoplasty and related services
- Vein ablation and related services

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April 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The April 2020 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the appeals, general information and return to provider categories. Please take time to review these and other FAQs for answers to your questions.

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Appeals Corner Newsletter May 2020

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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The following billing and coding article has been revised. It will become effective on May 24, 2020, with its corresponding local coverage determination L35428 which was posted for notice on April 9, 2020.

- Billing and coding: Thrombolytic Agents (A55237)

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May 20, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20019 – Medicare Continues to Modernize Payment Software

  This article informs providers about efforts by the Centers for Medicare & Medicaid Services (CMS) to modernize payment grouping and code editing software. A previous article, Special Edition (SE) 19013 provided initial information on this modernization. SE20019 informs providers that in October 2020, CMS will expand this modernization effort to include the inpatient rehabilitation facilities (IRF) case-mix group grouper and the IRF pricer and PC pricer software products.

  Note: A similar conversion for the skilled nursing facility patient driven payment model grouper is planned for October 2021.

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May 19, 2020

Special Edition – Tuesday, May 19, 2020

Provider Education Message:

COVID-19: Payment for Lab Tests, Safely Reopening Nursing Homes, Lab & Ambulance Claims

- COVID-19: Payment for Diagnostic Laboratory Tests
- Trump Administration Issues Guidance to Ensure States Have a Plan in Place to Safely Reopen Nursing Homes
- COVID-19: Which Laboratory Claims Require the NPI of the Ordering/Referring Professional?
- COVID-19: Ambulance Claims for Alternative Sites.

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COVID-19: Payment for Diagnostic Laboratory Tests

Earlier this year, CMS took action to ensure America's patients, health care facilities, and clinical laboratories were prepared to respond to the 2019-Novel Coronavirus (COVID-19). To help increase testing and track new cases, CMS developed two HCPCS codes that laboratories can use to bill for certain COVID-19 diagnostic tests. Health care providers and laboratories may bill Medicare and other health insurers for SARS-CoV2 tests performed on or after February 4 using:

- HCPCS code U0001 for tests developed by the Centers for Disease Control and Prevention (CDC)
- HCPCS code U0002 for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

Laboratories and other health providers can also bill Medicare for tests using CPT codes created by the American Medical Association, provided testing uses the method specified by each CPT code:

- CPT code 87635 for infectious agent detection by nucleic acid tests for dates of service on or after March 13
- CPT codes 86769 and 86328 for serology tests for dates of service on or after April 10

Finally, for dates of service on or after April 14, 2020, Medicare pays $100 for laboratory tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 making use of high throughput technologies. Laboratories can bill Medicare for these tests using:

- U0003: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.
- U0004: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.

Neither U0003 nor U0004 should be used to bill for tests that detect COVID-19 antibodies.

For COVID-19 tests that do not use high throughput technology, Medicare Administrative Contractors developed payment amounts for claims in their jurisdictions that will be used until we establish national payment rates though the annual laboratory meeting process. There is no cost-sharing for Medicare patients.

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Trump Administration Issues Guidance to Ensure States Have a Plan in Place to Safely Reopen Nursing Homes

On May 18, under the leadership of President Trump, CMS announced new guidance for state and local officials to ensure the safe reopening of nursing homes across the country. The guidance released is part of President Trump's Guidelines for Opening Up America Again. The recommendations issued would allow states to make sure nursing homes are continuing to take the appropriate and necessary steps to ensure resident safety and are opening their doors when the time is right. This also serves to help states and nursing homes reunite families with their loved ones in a safe, phased manner.

Press Release

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COVID-19: Which Laboratory Claims Require the NPI of the Ordering/Referring Professional?

During the COVID-19 Public Health Emergency, CMS is relaxing billing requirements for a limited number of laboratory tests required for a COVID-19 diagnosis. Any health care professional authorized under state law may order these tests. Medicare will pay for these tests without a written order from the treating physician or other practitioner:

- If an order is not written, you do not need to provide the National Provider Identifier (NPI) of the ordering or referring professional on the claim
- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines

For More Information:

- Laboratory Tests with modified requirements
- Interim Final Rule

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COVID-19: Ambulance Claims for Alternative Sites

During the COVID-19 Public Health Emergency, Medicare covers medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished.

Medicare Administrative Contractors are now processing claims according to the details provided in the April 7 message. If you believe that your previously processed claims were denied in error, contact your Medicare Administrative Contractor to have these claims reprocessed.

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As a reminder, the comment period for the following proposed local coverage determination (LCD) is currently open and will close on June 13, 2020. We encourage you to submit your comments as soon as possible to allow ample time for us to review them thoroughly.

- Implantable Continuous Glucose Monitors (I-CGM) (DL38617)

Submit comments

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May 18, 2020

Special Edition – Friday, May 15, 2020

Provider Education Message:

COVID-19: Deadlines, New Releases, and Important Calls

- Deadline Approaching: Notification Requirements of Confirmed and Suspected COVID-19 Cases Among Nursing Home Residents and Staff
- CMS Releases Nursing Home Toolkit with Best Practices and Additional Resources
- Telephone Evaluation and Management Visits
- Hospitals: Physician Time Studies During the COVID-19 PHE
- Trump Administration Announces Call for Nominations for Nursing Home Commission
- COVID-19: Home Health and Hospice Call — May 19
- COVID-19: Nursing Home Call — May 20
- COVID-19: Dialysis Organization Call — May 20
- COVID-19: Nurses Call — May 21
- COVID-19: Office Hours Call — May 21
- COVID-19: Lessons from the Front Lines Call — May 22

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Deadline Approaching: Notification Requirements of Confirmed and Suspected COVID-19 Cases Among Nursing Home Residents and Staff

On April 19, CMS announced the agency will be requiring facilities to report COVID-19 information to the CDC and to families. Within three weeks of that announcement, on April 30, CMS issued an Interim Final Rule with Comment Period with new regulatory requirements. With the new regulatory requirements, nursing homes are required to report the first week of data to the CDC beginning May 8 but no later than May 17. For the first time, all 15,000 nursing homes will be reporting this data directly to the CDC through its reporting tool.

In order to report, facilities must enroll in the CDC's National Healthcare Safety Network (NHSN). Information on how to enroll is available here. As nursing homes report this data to the CDC, CMS will be taking swift action and publicly posting this information, so all Americans have access to accurate and timely information on COVID-19 in nursing homes. More information on the CDC's NHSN COVID-19 module can be found here.

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CMS Releases Nursing Home Toolkit with Best Practices and Additional Resources

CMS released a new toolkit developed to aid nursing homes, Governors, states, departments of health, and other agencies who provide oversight and assistance to these facilities. These additional resources will help in the fight against the COVID-19 pandemic within nursing homes. The toolkit builds on previous actions taken by CMS, which provide a wide range of tools and guidance to states, healthcare providers and others during the public health emergency. The toolkit is comprised of best practices from a variety of front line health care providers, Governors' COVID-19 task forces, associations and other organizations, and experts, and is intended to serve as a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19.

Press Release
Toolkit

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Telephone evaluation and management visits

The March 30 Interim final rule with comment period added coverage during the Public Health Emergency for audio-only telephone evaluation and management visits (CPT codes 99441, 99442, and 99443) retroactive to March 1. On April 30, a new Physician Fee Schedule was implemented increasing the payment rate for these codes. Medicare administrative contractors (MACs) will reprocess claims for those services that they previously denied and/or paid at the lower rate.

There are also a number of add on services (CPT codes 90785, 90833, 90836, 90838, 96160, 96161, 99354, 99355, and G0506) which Medicare may have denied during this Public Health Emergency. MACs will reprocess those claims for dates of service on or after March 1.

You do not need to do anything.

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Hospitals: Physician time studies during the COVID-19 PHE

Hospitals that incur physician compensation costs must allocate those costs based on the percentage of total time spent furnishing:

- Part A services
- Part B services

Non-Medicare allowable activities

Hospitals must submit physician allocation agreements annually as part of the cost report filing process. During the Public Health Emergency (PHE), any one of these time study options is acceptable:

- One week time study every 6 months (two weeks per year)
- Time studies completed in the cost report period prior to January 27, the PHE effective date (e.g., hospital with a 7/1/2019 -- 6/30/2020 cost reporting period, could use the time studies collected 7/1/2019 through 1/26/2020; no time studies needed for 1/27/2020 -- 6/30/2020)
- Time studies from the same period in CY 2019 (e.g., if unable to complete time studies during February through July 2020, use time studies completed February through July 2019)

For more information, see the Provider Reimbursement Manual:

- Chapter 21, section 2182.3.E.3 - allocation agreements
- Chapter 23, section 2313.2.E and Chapter 21, section 212182.3.E - instructions for time studies

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Trump Administration Announces Call for Nominations for Nursing Home Commission

CMS announced a call for nominations for the new contractor-led Coronavirus Commission on Safety and Quality in Nursing Homes. The commission's work will build on the Trump Administration's long history of decisive actions to protect nursing home residents. The commission will conduct a comprehensive assessment of the overall response to the COVID-19 pandemic in nursing homes and will inform immediate and future actions to safeguard the health and quality of life for an especially vulnerable population of Americans.

Press Release
Nursing Home Commission Nominations

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COVID-19: Home Health and Hospice Call — May 19

Tuesdays from 3 to 3:30 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To Participate on May 19:

- Conference lines are limited; we encourage you to join via audio webcast
- Or, call 833-614-0820; Access Passcode: 6477704

For More Information:

- Coronavirus.gov
- CMS Current Emergencies website
- Podcast and Transcripts webpage: Audio recordings and transcripts

Target Audience: Home health and hospice providers

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COVID-19: Nursing Home Call — May 20

Wednesdays from 4:30 to 5 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To Participate on May 20:

Conference lines are limited; we encourage you to join via audio webcast

Or call 833-614-0820; Access Passcode: 4879622

For More Information:

- Coronavirus.gov
- CMS Current Emergencies website
- Podcast and Transcripts webpage: Audio recordings and transcripts

Target Audience: Nursing home providers

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COVID-19: Dialysis Organization Call — May 20

Wednesdays from 5:30 to 6 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To participate on May 20:

Conference lines are limited; we encourage you to join via audio webcast

Or call 833-614-0820; Access Passcode: 3287645

For more information:

- Coronavirus.gov
- CMS Current Emergencies website

- Podcast and Transcripts webpage: Audio recordings and transcripts

Target audience: Dialysis organizations

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COVID-19: Nurses Call — May 21

Thursdays from 3 to 3:30 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To participate on May 21:

- Conference lines are limited; we encourage you to join via audio webcast
- Or call 833-614-0820; Access Passcode: 2874976

For more information:

- Coronavirus.gov
- CMS Current Emergencies website
- Podcast and Transcripts webpage: Audio recordings and transcripts

Target audience: Nurses

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COVID-19: Office Hours Call — May 21

Tuesdays and Thursdays from 5 to 6 pm ET

Hospitals, health systems, and providers: Ask CMS questions about our temporary actions that empower you to:

- Increase hospital capacity – CMS Hospitals Without Walls
- Rapidly expand the health care workforce
- Put patients over paperwork
- Promote telehealth

To participate on May 21:

- Conference lines are limited; we encourage you to join via audio webcast
- Or call 833-614-0820; Access Passcode: 9984433

For more information:

- Coronavirus.gov
- CMS Current Emergencies website
- Podcast and Transcripts webpage: Audio recordings and transcripts

Target audience: Physicians and other clinicians

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COVID-19: Lessons from the Front Lines Call — May 22

Fridays from 12:30 to 2 pm ET

These weekly calls are a joint effort between CMS Administrator Seema Verma, Food and Drug Administration Commissioner Stephen Hahn, MD, and the White House Coronavirus Task Force. Physicians and other clinicians: Share your experience, ideas, strategies, and insights related to your COVID-19 response. There is an opportunity to ask questions.

To participate on May 22:

- Conference lines are limited; we encourage you to join via audio webcast
- Or call 877-251-0301; Access Code: 6086125

For more information:

- Coronavirus.gov
- CMS Current Emergencies website
- Podcast and Transcripts webpage: Audio recordings and transcripts

Target audience: Physicians and other clinicians

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11791 – Therapy Codes Update

  This article informs you of updates to the list of codes that sometimes or always describe therapy services. The additions to the therapy code list reflect those made in the Calendar Year 2020 for the COVID-19 Public Health Emergency. Please make sure your billing staffs are aware of these changes.

- MM11778 – Manual Update to Pub. 100-04, Chapter 38, to Remove Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico Section

  This article informs you that Medicare will remove section 20 (and all of its subsections) of the Medicare Claims Processing Manual (Identification of items or services related to the 2010 oil spill in the Gulf of Mexico). The key impact is that modifier CS is no longer to be used to denote services related to the 2010 oil spill.

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May 15, 2020

Prior authorization program for certain hospital outpatient department services webinars

Novitas will be presenting a webinar on the prior authorization program being implemented by CMS for certain hospital outpatient department (OPD) services on June 17, 2020, for dates of service on or after July 1, 2020. The webinar will be presented on Thursday, May 28, 2020, at 1:00 p.m. ET/12:00 p.m. ET and repeated on Thursday, June 11, 2020, at 10:00 a.m. ET/9:00 a.m. ET. If your facility bills these services, or you are a provider that performs these services on Medicare beneficiaries, join us for this webinar. We'll review the guidelines for submitting a Prior Authorization Request (PAR) and the potential results and options available, with specialists present to answer questions relating to the process. To participate in this webinar, please visit our Learning Center to register (JH) (JL).

As a condition of payment for DOS on or after July 1, 2020, a Prior Authorization Request (PAR) is required for the following hospital OPD services:

- Blepharoplasty, eyelid surgery, brow lift, and related services

- Botulinum toxin injections
- Panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy), and related services
- Rhinoplasty and related services
- Vein ablation and related services

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Prior authorization (PA) program for certain hospital outpatient department (OPD) services - submitting the prior authorization request (PAR)

CMS is implementing a Prior authorization (PA) program for certain hospital outpatient department (OPD) services effective June 17, 2020, for dates of service (DOS) on or after July 1, 2020, nationwide. The hospital OPD provider must submit the PAR to Novitas before the service is provided to the beneficiary and before the claim is submitted for processing. The PAR must include all documentation necessary to show that the service meets applicable Medicare coverage, coding, and payment rules. Please review this article for additional information.

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May 14, 2020

CMS Provider Education Message:

MLN Connects® for Thursday, May 14, 2020

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News

- IPPS and LTCH PPS: FY 2021 Proposed Rule
- Medicare FFS 2nd Level Appeals: Submission Options

Events

- COVID-19: Office Hours Call — May 14
- COVID-19: Lessons from the Front Lines Call — May 15

MLN Matters® Articles

- Medicare Clarifies Recognition of Interstate License Compacts
- Extension of Payment for Section 3712 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act)
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update
- Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) to Correct the Adjustment Process
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

Publications

- How to Use the Medicare Coverage Database — Revised

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Medicare administrative contractors (MACs) will host a Multi-Jurisdictional Contractor Advisory Committee (CAC) meeting regarding facet joint and medial nerve branch procedures on May 28, 2020, from 1-3 pm CST

The purpose of the meeting is to obtain advice from CAC members and subject matter experts (SMEs) regarding the strength of published evidence on facet joint and medial nerve branch procedures. In addition to discussion, the CAC and SME panel will vote on pre-distributed questions. The public is invited to attend as observers.

The meeting will be hosted by seven MACs and there will be a panel of experts discussing the facet joint and medial nerve branch procedures. CAC panels do not make coverage determinations, but MACs benefit from their advice.

The meeting agenda, bibliography, and voting questions are now available. Please refer to our Multi-Jurisdictional CAC website for additional information.

Teleconference/webinar link for registration here EXT .

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11755 – National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)

  This article informs you that the Centers for Medicare & Medicaid Services (CMS) will cover acupuncture for cLBP effective for claims with dates of service on and after January 21, 2020. Note that CMS still determines that acupuncture for treatment of fibromyalgia or osteoarthritis is still not considered reasonable and necessary and remain non-covered by Medicare. Make sure your billing staffs are aware of these changes.

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The following billing and coding article has been revised:

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

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May 13, 2020

Special Edition – Tuesday, May 12, 2020

Provider Education Message:

COVID-19: Additional Waivers, Price Transparency, and CMS Letter to Nursing Homes

- CMS Releases Additional Waivers for Hospitals and Other Facilities
- Price Transparency: Requirement to Post Cash Prices Online for COVID-19 Diagnostic Testing
- CMS Letter to Nursing Home Facility Management and Staff

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CMS Releases additional waivers for hospitals and other facilities

CMS continues to release waivers for the health care community that provide the flexibilities needed to take care of patients during the COVID-19 Public Health Emergency (PHE). CMS recently provided additional blanket waivers for the duration of the PHE that:

Expand hospitals' ability to offer long-term care services ("swing beds")

Waive distance requirements, market share, and bed requirements for sole community hospitals

Waive certain eligibility requirements for Medicare-dependent, small rural hospitals (MDHs)

Update specific life safety code requirements for hospitals, hospice, and long-term care facilities

For more information, see Emergency Declaration Blanket Waivers.

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Price transparency: Requirement to post cash prices online for COVID-19 diagnostic testing

The Coronavirus Aid, Relief, and Economic Security (CARES) Act includes a number of provisions to provide relief to the public from issues caused by the pandemic, including price transparency for COVID -19 testing. Section 3202(b) of the CARES Act requires providers of diagnostic tests for COVID-19 to post the cash price for a COVID-19 diagnostic test on their website from March 27 through the end of the public health emergency. For more information, see the FAQs.

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CMS letter to nursing home facility management and staff

On May 11, CMS Administrator Seema Verma penned a letter to nursing home management and staff. Administrator Verma shared her gratitude for the unwavering dedication and commitment of nursing home management and staff in keeping residents safe and for continuing to compassionately care for those who rely on them during this unprecedented time. The letter also provides links to previously shared infection control resources.

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A/B MAC and DME MAC collaborative nebulizer webinar

Do some of your patients require inhalation medication with a nebulizer? The Provider Outreach and Education staff from your A/B and DME MACs has scheduled a national webinar to address Medicare's coverage criteria and documentation requirements for medications and the related nebulizer equipment. The webinar will take place at 2:00 PM Eastern (1:00 PM Central) on May 21, 2020. The webinar moderators will leave time for your questions after the presentation portion of the webinar.

Register today!

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11650 – National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM)

  This article informs you that, for dates of service on and after July 2, 2019, the Centers for Medicare & Medicaid Services will cover ABPM for the diagnosis of hypertension in Medicare beneficiaries under updated criteria.

- MM11788 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2020 Update

  This article informs you that the Centers for Medicare & Medicaid Services issued payment files to the Medicare administrative contractors based upon the 2020 MPFS Final Rule.

Change request 11788 amends those payment files. Make sure your billing staffs are aware of these changes.

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SNF waiver to extend the benefit period

Due to the COVID-19 pandemic, CMS utilized its authority under section 1812(f) of the Social Security Act to waive certain Medicare requirements under the SNF PPS. Please review details on the Coronavirus COVID-19 information page for further details.

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April 2020 Part A Newsletter

The April 2020 Part A Newsletter is now available. Please take a moment to review.

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May 12, 2020

A/B MAC and DME MAC collaborative nebulizer webinar

Do some of your patients require inhalation medication with a nebulizer? The Provider Outreach and Education staff from your A/B and DME MACs has scheduled a national webinar to address Medicare's coverage criteria and documentation requirements for medications and the related nebulizer equipment. The webinar will take place at 2:00 PM Eastern (1:00 PM Central) on May 21, 2020. The webinar moderators will leave time for your questions after the presentation portion of the webinar.

Register today!

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11750 – New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services

  This article informs you of new physician specialty codes for MDS (D7), and ACHD (D8), and a new supplier specialty code for Home Infusion Therapy Services (D6). Make sure that your billing staffs are aware of these changes.

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May 11, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11727 – Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) to Correct the Adjustment Process

  Change request 11727 contains updates to Medicare's claims processing systems to make corrections to processing of adjustments and other billing issues for SNF PDPM claims. Make sure your billing staffs are aware of these updates.

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May 8, 2020

Special Edition – Friday, May 8, 2020

Provider Education Message:

COVID-19: Nursing Home Reporting, Updated Telehealth Video, Pharmacies & Other Suppliers Can Enroll as Labs, IRF Flexibilities

- New Guidance Available on Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes
- Telehealth Video: Medicare Coverage and Payment of Virtual Services
- Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing MLN Matters® Article
- COVID-19: IRF Flexibilities During the PHE
- COVID-19: IRF Interdisciplinary Team Meetings During the Pandemic

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New guidance available on requirements for notification of confirmed and suspected COVID-19 cases among residents and staff in nursing homes

Nursing homes are now required to report the first week of COVID-19 data to the Centers for Disease Control and Prevention (CDC) beginning May 8 but no later than May 17. For the first time, all 15,000 nursing homes will be reporting this data directly to the CDC through its reporting tool. This reporting requirement is the first action of its kind in the agency's history. On April 19, CMS announced the agency would be requiring facilities to report COVID-19 information to the CDC and to families. Within three weeks of that announcement, on April 30, CMS issued an Interim Final Rule with Comment Period with the new regulatory requirements. As nursing homes report this data to the CDC, we will be taking swift action and publicly posting this information so all Americans have access to accurate and timely information on COVID-19 in nursing homes.

CMS has a longstanding requirement for nursing homes to report cases of communicable diseases, such as COVID-19, to the appropriate state or local health department. This new requirement not only helps health departments intervene when needed but serves to provide awareness to the public (e.g., families) and surveillance for public health agencies and the CDC. The importance of ongoing transparency and information sharing has proven to be one of the keys to the battle against this pandemic. Building upon the successes of the Trump Administration prior to COVID-19, CMS has strongly supported transparency, such as the work done over the past several years to improve public access and understanding of nursing home inspection reports and expand the information available to consumers on Nursing Home Compare. The agency remains committed to greater transparency and plans to publicly release new data by the end of May. CMS will never stop working to give patients, residents, and families the clearest and most accurate information possible.

Guidance and Frequently Asked Questions

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Telehealth video: Medicare coverage and payment of virtual services

This updated video provides answers to common questions about the expanded Medicare telehealth services benefit under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

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Medicare pharmacies and other suppliers may temporarily enroll as independent clinical diagnostic laboratories to help address COVID-19 testing MLN Matters® Article

A new MLN Matters Special Edition Article SE20017 on Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing is available. Learn how to temporarily enroll to be an additional laboratory resource to meet the urgent need to increase COVID-19 testing capability.

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COVID-19: IRF flexibilities during the PHE

CMS is exercising regulatory flexibilities for inpatient rehabilitation facilities (IRFs) during the COVID-19 Public Health Emergency (PHE) to waive the 60 percent rule.

We are also waiving IRF coverage and classification requirements if all of these criteria are satisfied:

- Patient is admitted to a freestanding IRF to alleviate acute care hospital bed capacity issues
- IRF is located in an area that is in Phase 1 or has not entered Phase 1; see Guidelines for Opening Up America Again

Add the following letters at the end of your unique hospital patient identification number (the number that identifies the patient's medical record in the IRF) to identify patients eligible for each waiver:

- D- 60 percent rule
- DS- Coverage and classification requirements
- DDS- Both 60 percent rule and coverage and classification requirements

For More Information:

- COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers: See page 10 for 60 percent rule
- Interim Final Rule: Coverage and classification requirements

.

COVID-19: IRF interdisciplinary team meetings during the pandemic

CMS expects inpatient rehabilitation facilities (IRFs) to hold in-person weekly interdisciplinary team meetings to discuss Medicare Part A fee-for-service patients. During the public health emergency, it may be safest to conduct meetings electronically. We will accept all appropriate forms of social distancing precautions.

.

May 7, 2020

CMS Provider Education Message:

More COVID-19 Updates

MLN Connects® for Thursday, May 7, 2020

View this edition as a PDF

News

- CMS Announces Independent Commission to Address Safety and Quality in Nursing Homes

- Home Health Plans of Care: NPs, CNSs and PAs Allowed to Certify
- Health Care Supply Chain, Provider Self-Care, and Emergency Preparedness Resources

Claims, Pricers & Codes

- COVID-19: Modified Ordering Requirements for Laboratory Billing
- Hospital OPPS: New Coronavirus Specimen Collection Code

Events

- COVID-19: Office Hours Call — May 7
- COVID-19: Lessons from the Front Lines Calls — May 8

MLN Matters® Articles

- Addition of the QW modifier to Healthcare Common Procedure Coding System (HCPCS) code U0002 and 87635
- Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan
- New Codes for Therapist Assistants Providing Maintenance Programs in the Home Health Setting
- Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy — Revised

Publications

- Evaluation and Management Services — Revised

.

The following billing and coding article has been revised:

- Billing and coding: Services That Are Not Reasonable and Necessary (A56967)

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April 2020 top claim submission errors

The April 2020 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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May 6, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20008 – Medicare Clarifies Recognition of Interstate License Compacts

  This MLN Matters article clarifies the Centers for Medicare & Medicaid Services recognition of interstate license compacts as valid and full licenses for purposes of meeting federal license requirements.

Revised:

- MM11661 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update

  The Centers for Medicare & Medicaid Services revised this article on May 4, 2020, to reflect the revised Change request (CR) 11661, issued on May 1, 2020, to revise the relative value units for codes 99441, 99442, and 99443, and add information for codes G2025 and G0071, listed in the CR attachment. The statement at the end of page 4 was updated. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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May 5, 2020

Limited systems availability

There will be a Common Working File "dark day" on May 8, 2020, to perform a history archive.

Due to this systems upgrade, Novitasphere portal, our interactive voice response unit, and customer service will have limited availability.

Customer service representatives will not be able to assist providers with the following:

- Eligibility inquiries
- Claim status inquiries related to eligibility
- Claim denial inquiries related to eligibility

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11749 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update

  Change request 11749 informs providers about updated ICD-10 conversions as well as coding updates specific to NCDs. Please make sure your billing staffs are aware of these updates.

.

May 4, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11580 – Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan

  Change request 11580 modifies Medicare system edits on inpatient claims when a beneficiary's MA plan becomes effective during the inpatient admission. Also, the Centers for Medicare & Medicaid Services is streamlining the editing for MA plans' claims when it is determined that certain services are being disallowed on MA plans that are considered a significant cost under Section 422.109(a)(2) of title 42 of the Code of Federal Regulations (CFR). Original FFS Medicare will pay for services obtained by beneficiaries enrolled in MA plans in this circumstance.

Revised:

- MM11559 – Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy

  The Centers for Medicare & Medicaid Services (CMS) revised this article to reflect a revised change request (CR)11559, issued on April 30, 2020. The CR changes had no impact on the substance of the article. In the article, CMS revised the release date, transmittal number, and the web address of the CR. All other information remains the same.

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May 1, 2020

Special Edition – Thursday, April 30, 2020

Provider Education Message:

COVID-19: Second Round of Sweeping Changes, RHC & FQHC Flexibilities, EMTALA

- Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic
- New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) MLN Matters Article
- New Frequently Asked Questions on EMTALA

.

Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic

At President Trump's direction and building on its recent historic efforts to help the U.S. healthcare system manage the 2019 Novel Coronavirus (COVID-19) pandemic, on April 30, 2020, the Centers for Medicare & Medicaid Services, issued another round of sweeping regulatory waivers and rule changes to deliver expanded care to the nation's seniors and provide flexibility to the healthcare system as America reopens. These changes include making it easier for Medicare and Medicaid beneficiaries to get tested for COVID-19 and continuing CMS's efforts to further expand beneficiaries' access to telehealth services.

Full press release

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New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) MLN Matters Article

A revised MLN Matters Special Edition Article SE20016 on New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) is available. Learn new information on billing for distant site telehealth services during the COVID-19 PHE, including:

- New telehealth services that can be provided by RHCs and FQHCs, including audio only telephone evaluation and management services
- Revised bed count methodology for determining the exemption to the RHC payment limit for provider-based RHCs

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New Frequently Asked Questions on EMTALA

CMS issued Frequently Asked Questions (FAQs) clarifying requirements and considerations for hospitals and other providers related to the Emergency Medical Treatment and Labor Act (EMTALA) during the COVID-19 pandemic. The FAQs address questions around patient presentation to the emergency department, EMTALA applicability across facility types, qualified medical professionals, medical screening exams, patient transfer and stabilization, telehealth, and other topics.

Frequently Asked Questions

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April 30, 2020

CMS Provider Education Message:

COVID-19: Lessons from the Front Lines

MLN Connects® for Thursday, April 30, 2020

View this edition as a PDF

News

- Infection Control Guidance to Home Health Agencies on COVID-19
- Now Available: Nursing Home Five Star Quality Rating System Updates, Nursing Home Staff Counts, and Frequently Asked Questions
- CMS Adds New COVID-19 Clinical Trials Improvement Activity to the Quality Payment Program
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Home Health Claims: Correcting Recoding Errors

Events

- COVID-19: Lessons from the Front Lines Calls — May 1 and 8
- COVID-19: Home Health and Hospice Call — May 5
- COVID-19: Office Hours Call — May 5
- COVID-19: Nursing Homes Call — May 6

MLN Matters® Articles

- July 2020 Quarterly Update to the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2020 Pricer
- Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendment (CLIA) Edits — Revised
- 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 — Revised

Publications

- April 2020 Medicare Quarterly Provider Compliance Newsletter

- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants — Revised
- Ambulatory Surgical Center Payment System — Revised
- Dual Eligible Beneficiaries Under Medicare and Medicaid — Revised
- Hospital Outpatient Prospective Payment System — Revised
- How to Use the Searchable Medicare Physician Fee Schedule — Revised
- Long-Term Care Hospital Prospective Payment System — Revised

Multimedia

- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course — Revised
- Medicare Parts C and D General Compliance Training Web-Based Training Course — Revised

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Online registration available for May 15, 2020, Open meeting and proposed LCD now posted

Online registration for the May 15, 2020, Open Meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, May 13, 2020. **Important:** During this unprecedented time, our Open Meeting will be held via teleconference only. The Novitas Solutions proposed local coverage determination (LCD) is 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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New codes for laboratory tests for the novel coronavirus (COVID-19)

Allowances are now available for new codes for COVID-19 testing.

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The following proposed local coverage determination (LCD) has been posted for comments. The comment period will end on June 13, 2020; however you are encouraged to submit your comments as soon as possible to allow ample time for us to review them thoroughly.

- Implantable Continuous Glucose Monitors (I-CGM) (DL38617)

  Submit comments

The following Draft billing and coding article is related to the above Proposed LCD.

- Billing and coding: Implantable Continuous Glucose Monitors (I-CGM) (DA58110)

The following LCD has been revised:

- Anorectal Manometry, Anal Electromyography, and Biofeedback Training for Perineal Muscles and Anorectal or Urethral Sphincters (L34977)

The following billing and coding articles have been revised:

- Billing and coding: Allergy Testing (A56558)

- Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)
- Billing and coding: Micro-Invasive Glaucoma Surgery (MIGS) (A56633)

The following billing and coding articles have been retired:

- Billing and coding: NCD on Pneumatic Compression Therapy (A53133)
- Billing and Coding: Ophthalmic Biometry for Intraocular Lens (IOL) Power Calculation (A53131)
- Billing and coding: Use of Vaccines or Inoculations for Treatment of Injury or Exposure (A53130)

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April 29, 2020

Prior authorization requirement for certain hospital outpatient department services begins July 1, 2020

CMS is implementing a Prior Authorization program for certain hospital outpatient department (OPD) services for dates of service on or after July 1, 2020, nationwide. CMS believes prior authorization for certain hospital OPD services will ensure that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare trust fund from improper payments and keeping the medical necessity documentation requirements unchanged for providers. For details, links, and submission guidelines refer to Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services.

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April 27, 2020

Special Edition – Monday, April 27, 2020

Provider Education Message:

CMS Reevaluates Accelerated Payment Program and Suspends Advance Payment Program

On April 26, the Centers for Medicare & Medicaid Services (CMS) announced that it is reevaluating the amounts that will be paid under its Accelerated Payment Program and suspending its Advance Payment Program to Part B suppliers effective immediately. The agency made this announcement following the successful payment of over $100 billion to health care providers and suppliers through these programs and in light of the $175 billion recently appropriated for health care provider relief payments.

CMS had expanded these temporary loan programs to ensure providers and suppliers had the resources needed to combat the beginning stages of the 2019 Novel Coronavirus (COVID-19). Funding will continue to be available to hospitals and other health care providers on the front lines of the coronavirus response primarily from the Provider Relief Fund. The Accelerated and Advance Payment (AAP) Programs are typically used to give providers emergency funding and address cash flow issues for providers and suppliers when there is disruption in claims submission or claims processing, including during a public health emergency or Presidentially-declared disaster.

Since expanding the AAP programs on March 28, 2020, CMS approved over 21,000 applications totaling $59.6 billion in payments to Part A providers, which includes hospitals. For Part B suppliers, including doctors, non-physician practitioners and durable medical equipment suppliers, CMS approved almost 24,000 applications advancing $40.4 billion in payments. The AAP programs are not

a grant, and providers and suppliers are typically required to pay back the funding within one year, or less, depending on provider or supplier type. Beginning today, CMS will not be accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments in light of historical direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund.

Significant additional funding will continue to be available to hospitals and other health care providers through other programs. Congress appropriated $100 billion in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (PL 116-136) and $75 billion through the Paycheck Protection Program and Health Care Enhancement Act (PL 116-139) for health care providers. HHS is distributing this money through the Provider Relief Fund, and these payments do not need to be repaid.

The CARES Act Provider Relief Fund is being administered through HHS and has already released $30 billion to providers and is in the process of releasing an additional $20 billion, with more funding anticipated to be released soon. This funding will be used to support health care-related expenses or lost revenue attributable to the COVID-19 pandemic and to ensure uninsured Americans can get treatment for COVID-19.

For more information on the CARES Act Provider Relief Fund and how to apply, visit: hhs.gov/providerrelief.

For an updated fact sheet on the Accelerated and Advance Payment Programs, visit: https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11742 – Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer

  Change request (CR)11742 updates the LTCH Pricer software used in original Medicare claims processing. The new version includes the payment policy for an LTCH that is subject to the Discharge Payment Percentage payment adjustment described in CR 11616. In addition, the CR includes new payment policy for COVID-19. Make sure your billing staffs are aware of these changes.

- MM11764 – July 2020 Quarterly Update to the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2020 Pricer

  Change request (CR) 11764 updates the FY 2020 IPPS pricer software used in original Medicare claims processing. The new version includes new payment policy for individual diagnosed with COVID-19. Please be sure your billing staffs are aware of these updates.

Revised:

- MM11490 – 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

  The Centers for Medicare & Medicare Services revised this article on April 23, 2020, to reflect the revised change request (CR)11490 issued on April 23, 2020. The CR revision updated the Washington Publishing Company website address and the same change is made to this

article. In the article, we also revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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April 24, 2020

Qualified Independent Contractor (QIC) Appeals Demonstration April 2020 Newsletter

C2C Innovative Solutions has added their April 2020 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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Appeals Corner Newsletter

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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April 23, 2020

CMS Provider Education Message:

Report Clinical Trial Data to Fight COVID-19 & Earn MIPS Credit

MLN Connects® for Thursday, April 23, 2020

View this edition as a PDF

News

- Trump Administration Champions Reporting of COVID-19 Clinical Trial Data through Quality Payment Program, Announces New Clinical Trials Improvement Activity
- CMS Releases Additional Blanket Waivers for Long-Term Care Hospitals, Rural Health Clinics, Federally Qualified Health Centers and Intermediate Care Facilities
- IRF PPS FY 2021 Proposed Rule
- Bill Correctly for Inhalant Drugs

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — May 7

MLN Matters® Articles

- New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)
- New Waived Tests
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1 — Revised
- April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

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

Publications

- Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet — Revised

Multimedia

- Medicare Home Health Benefit Web-Based Training Course — Revised

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The following local coverage article has been revised. Due to the current public health emergency the effective date for the addition of Tremfya® (J1628) and Stelara® (J3357) will be deferred until 45 days after the public health emergency ends. Please continue to watch our website for updates.

- Self-Administered Drug Exclusion List (A53127)

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April 21, 2020

Proper billing for inhalation drugs

The provider compliance tips for nebulizers and related drugs fact sheet has been revised.

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April 20, 2020

Special Edition – Monday, April 20, 2020

Provider Education Message:

COVID-19: Nursing Home Transparency, Recommendations for Areas with Low Incidence of Disease

- Trump Administration Announces New Nursing Homes COVID-19 Transparency Effort
- CMS Issues Recommendations to Re-Open Health Care Systems in Areas with Low Incidence of COVID-19

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Trump Administration Announces New Nursing Homes COVID-19 Transparency Effort

Agencies partner with nursing homes to keep nursing home residents safe

On April 19, under the leadership of President Trump, the Centers for Medicare & Medicaid Services (CMS) announced new regulatory requirements that will require nursing homes to inform residents, their familiwwes, and representatives of COVID-19 cases in their facilities. In addition, as part of President Trump's Opening Up America, CMS will now require nursing homes to report cases of COVID-19 directly to the Centers for Disease Control and Prevention (CDC). This information must be reported in accordance with existing privacy regulations and statute. This measure augments longstanding requirements for reporting infectious disease to state and local health departments. Finally, CMS will also require nursing homes to fully cooperate with CDC surveillance efforts around COVID-19 spread.

CDC will be providing a reporting tool to nursing homes that will support federal efforts to collect nationwide data to assist in COVID-19 surveillance and response. This joint effort is a result of the CMS-CDC Work Group on Nursing Home Safety. CMS plans to make the data publicly available. This effort builds on recent recommendations from the American Health Care Association and Leading Age, two large nursing home industry associations, that nursing homes quickly report COVID-19 cases.

This data sharing project is only the most recent in the Trump Administration's rapid and aggressive response to the COVID-19 pandemic. More details are available in the Press Release and Guidance Memo.

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CMS Issues Recommendations to Re-Open Health Care Systems in Areas with Low Incidence of COVID-19

On April 19, the Centers for Medicare & Medicaid Services issued new recommendations specifically targeted to communities that are in Phase 1 of the Guidelines for President Trump's Opening Up America Again with low incidence or relatively low and stable incidence of COVID-19 cases. The recommendations update earlier guidance provided by CMS on limiting non-essential surgeries and medical procedures. The new CMS guidelines recommend a gradual transition and encourage health care providers to coordinate with local and state public health officials and to review the availability of Personal Protective Equipment (PPE) and other supplies, workforce availability, facility readiness, and testing capacity when making the decision to re-start or increase in-person care.

The new recommendations can be found here: https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf

The Guidelines for Opening Up America Again can be found here: https://www.whitehouse.gov/openingamerica/#criteria

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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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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20016 - New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)

  To provide as much support as possible to RHCs and FQHCs and their patients during the COVID-19 PHE, both Congress and the Centers for Medicare & Medicaid Services (CMS) have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will make additional discretionary changes as necessary to assure that RHC and FQHC patients have access to the services they need during the pandemic. For additional information, please visit the RHC/FQHC COVID-19 FAQs on the CMS website.

Revised:

- MM11680 - April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1

The Centers for Medicare & Medicaid Services (CMS) revised this article on April 16, 2020, to reflect a revised change request (CR) 11680. The CR revisions added changes to the summary of quarterly release modifications in table 1. CMS made corresponding revisions in the article. The CR release date, transmittal number, and the web address of the article were also revised. All other information remains the same.

- MM11489 - Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  The Centers for Medicare & Medicaid Services revised this article on April 16, 2020, to reflect an updated change request (CR) 11489 that revised the Washington Publishing Company website address in the background section of the CR (page 2 in this article). All other information remains the same.

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April 17, 2020

Special Edition - Wednesday, April 17, 2020

Provider Education Message:

COVID-19: RHC & FQHC Flexibilities, Increased Payment for Lab Tests, Hospital Waivers, Call Audio and Transcript

- RHC & FQHC Flexibilities During COVID-19 Public Health Emergency
- CMS Increases Medicare Payment for High-Production Coronavirus Lab Tests
- CMS Implements CARES Act Hospital Payment and Inpatient Rehabilitation Facility Waivers
- COVID-19 Call: Audio Recording and Transcript

RHC & FQHC Flexibilities During COVID-19 Public Health Emergency

To support Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and their patients, Congress and CMS made changes to requirements and payments during the COVID-19 Public Health Emergency. See MLN Matters Special Edition Article 20016 to learn about:

- New payment for telehealth services, including how to bill Medicare
- Expansion of virtual communication services
- Revision of home health agency shortage requirement for visiting nursing services
- Consent for care management and virtual communication services
- Accelerated/advance payments

CMS Increases Medicare Payment for High-Production Coronavirus Lab Tests

CMS announced that Medicare will nearly double payment for certain lab tests that use high-throughput technologies to rapidly diagnose large numbers of COVID-19 cases. This is another action the Trump Administration is taking to rapidly expand COVID-19 testing. Along with the March 30 announcement that Medicare will pay new specimen collection fees for COVID-19 testing, CMS's actions will expand capability to test more vulnerable populations, like nursing home patients, quickly and provide results faster. Medicare will pay laboratories for the tests at $100 effective April 14, 2020, through the duration of the COVID-19 national emergency.

Press Release

CMS Implements CARES Act Hospital Payment and Inpatient Rehabilitation Facility Waivers

The Coronavirus Aid, Relief, and Economic Security (CARES) Act increases payment for Inpatient Prospective Payment System (IPPS) and long-term care hospital (LTCH) inpatient hospital care attributable to COVID-19. CMS provided guidance for IPPS hospitals and LTCHs on how to code claims to receive the higher payment.

The CARES Act also waives the requirement that Medicare Part A fee-for-service patients treated in inpatient rehabilitation facilities receive at least 15 hours of therapy per week.

MLN Matters Article
Emergency Declaration Waivers Summary

COVID-19 Call: Audio Recording and Transcript

An audio recording and transcript are available for the April 7 Medicare Learning Network call on 2019 Novel Coronavirus (COVID-19) Updates. Learn about CMS waivers and COVID-19 response.

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Coronavirus disease 2019 (COVID-19): Telehealth and telephone-only services during the emergency

A new article was developed to assist providers with telehealth and telephone services during the emergency. Please review the article to ensure you are keeping up to date with the most current information.

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Postponed - Revision of local coverage article A53127 self-administered drug (SAD) exclusion list

Novitas will postpone the May 3, 2020, implementation of local coverage article A53127 Self-Administered Drug Exclusion List due to the COVID-19 Public Health Emergency. The article will not become effective until after the end of the Public Health Emergency and receipt of CMS technical direction for resuming normal operations.

The effective date for the inclusion of Guselkumab (Tremfya®) (J1628) and Ustekinumab (Stelara®) (J3357) to the SAD exclusion list will be deferred 45 days after the public health emergency ends.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11638 - Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  The Centers for Medicare & Medicaid Services revised this article on April 16, 2020, to reflect an updated Change request (CR) 11638 that revised the Washington Publishing Company

website address in the background section of the CR (page 2 in this article). All other information remains the same.

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April 16, 2020

CMS Provider Education Message:

3 Proposed Payment Rules

MLN Connects® for Thursday, April 16, 2020

View this edition as a PDF

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News

- Hospice Payment Rate Update Proposed Rule for FY 2021
- IPF Prospective Payment System Proposed Rule for FY 2021
- SNF Proposed Payment and Policy Changes for FY 2021

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — May 7

MLN Matters® Articles

- April 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Quarterly Update to the Fiscal Year 2020 Inpatient Psychiatric Facilities Pricer
- Claim Status Category and Claim Status Codes Update — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications

- Inpatient Rehabilitation Facility Prospective Payment System — Revised
- Medicare Overpayments — Revised
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services— Revised

Multimedia

- Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course — Revised
- Medicare Part C and Part D Data Validation Web-Based Training Course — Revised

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20015 – New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act

This article provides a brief summary of certain provisions of the Coronavirus Aid, Relief, and Economic Security (CARES) Act that relate to IPPS hospitals, LTCHs, and IRFs. The Centers for Medicare & Medicaid Services is aware of these provisions and is working on their implementation. These provisions are in Sections 3710 and 3711 of the CARES Act.

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The following local coverage determination and related billing and coding article have been revised:

- Services That Are Not Reasonable and Necessary (L35094)
  - Billing and coding: Services That Are Not Reasonable and Necessary (A56967)

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April 15, 2020

Special Edition – Wednesday, April 15, 2020

Provider Education Message:

COVID-19: Reprocessing Hospital Claims, Essential Diagnostic Services, Non-Invasive Ventilators

- IPPS Hospitals, LTCHs: Reprocessing Claims for CARES Act
- Trump Administration Announces Expanded Coverage for Essential Diagnostic Services Amid COVID-19 Public Health Emergency
- Removal of Non-Invasive Ventilator Product Category from DMEPOS Competitive Bidding Program

.

IPPS Hospitals, LTCHs: Reprocessing Claims for CARES Act

CMS is implementing changes to increase payments to Inpatient Prospective Payment System (IPPS) hospitals and Long-Term Care Hospitals (LTCHs) under Sections 3710 and 3711 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. When you submit an IPPS claim for discharges on or after January 27, 2020, or an LTCH claim for admissions on or after January 27, 2020, and we receive it:

- April 20, 2020, and earlier, Medicare will reprocess. You do not need to take any action.
- On or after April 21, 2020, Medicare will process in accordance with the CARES Act.

For more information, see MLN Matters Special Edition Article SE20015.

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Trump Administration Announces Expanded Coverage for Essential Diagnostic Services Amid COVID-19 Public Health Emergency

CMS, together with the Departments of Labor and the Treasury, issued guidance to ensure Americans with private health insurance have coverage of COVID-19 diagnostic testing and certain other related services, including antibody testing, at no cost. This includes urgent care visits, emergency room visits, and in-person or telehealth visits to the doctor's office that result in an order for or administration of a COVID-19 test. As part of the effort to slow the spread of the virus, this guidance is another action the Trump Administration is taking to remove financial barriers for Americans to receive necessary COVID-19 tests and health services, as well as encourage the use of

antibody testing that may help to enable health care workers and other Americans to get back to work more quickly.

Press Release
Guidance

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Removal of Non-Invasive Ventilator Product Category from DMEPOS Competitive Bidding Program

CMS is removing the non-invasive ventilator (NIV) product category from Round 2021 of the DMEPOS Competitive Bidding Program due to the novel COVID-19 pandemic, the President's exercise of the Defense Production Act, public concern regarding access to ventilators, and the NIV product category being new to the DMEPOS Competitive Bidding Program.

DME Competitive Bidding Program

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March 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The March 2020 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the general information and return to provider categories. Please take time to review these and other FAQs for answers to your questions.

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March 2020 Part A Newsletter

The March 2020 Part A newsletter is now available. Please take a moment to review.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11661 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update

  The Centers for Medicare & Medicaid Services revised this article to reflect the revised change request (CR) 11661, issued on April 6, to make MPFSDB file revisions for COVID-19. In the article, we added updates for codes G2023, G2024, 87635, 98966, 98967, 98968, 99441, 99442, and 99443 to the April 2020 MPFSDB update file. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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April 14, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11759 – Quarterly Update to the Fiscal Year 2020 Inpatient Psychiatric Facilities Pricer

  Change request 11759 updates the Inpatient Psychiatric Facilities (IPF) Pricer software used in Medicare claims processing. The software package will be released on or about April 1, 2020,

and contain an update to the comorbidity tables to include the new ICD-10 diagnosis code, for the Novel Coronavirus Disease, COVID-19, U07.1, effective for claims with discharges occurring on or after April 1, 2020. Please make sure your billing staffs are aware of this update.

Revised:

- MM11467 – Claim Status Category and Claim Status Codes Update

  The Centers for Medicare & Medicaid Services revised this article on April 10, 2020, to reflect a revised Change Request (CR) 11467. CR 11467 was revised to update the uniform resource locators' references (page 2 in this article) in the background section of the CR. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same. All other information remains the same.

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised this article on April 10, 2020, to link to all the blanket waivers related to COVID-19 , provide place of service coding guidance for telehealth claims, link to the Telehealth Video for COVID-19, add information on the waiver of coinsurance and deductibles for certain testing and related services, add information on the expanded use of ambulance origin/destination modifiers, provide new specimen collection codes for clinical diagnostic laboratories billing, and add guidance regarding delivering notices to beneficiaries. All other information is the same.

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April 10, 2020

Special Edition – Friday, April 10, 2020

Provider Education Message:

COVID-19: Infection Control, Maximizing Workforce, Updated Q&A, CS Modifier for Cost-Sharing, Payment Adjustment Suspended

- CMS Issues New Wave of Infection Control Guidance to Protect Patients and Healthcare Workers from COVID-19
- Trump Administration Acts to Ensure U.S. Healthcare Facilities Can Maximize Frontline Workforces to Confront COVID-19 Crisis
- Updated Questions and Answers on COVID-19
- Using CS Modifier When Cost-Sharing is Waived
- Medicare FFS Claims: 2% Payment Adjustment Suspended (Sequestration)

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CMS Issues New Wave of Infection Control Guidance to Protect Patients and Healthcare Workers from COVID-19

CMS issued a series of updated guidance documents focused on infection control to prevent the spread of the 2019 Novel Coronavirus (COVID-19) in a variety of inpatient and outpatient care settings. The guidance, based on Centers for Disease Control and Prevention (CDC) guidelines, will help ensure infection control in the context of patient triage, screening and treatment, the use of alternate testing and treatment sites and telehealth, drive-through screenings, limiting visitations, cleaning and disinfection guidelines, staffing, and more.

Press release

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Trump Administration Acts to Ensure U.S. Healthcare Facilities Can Maximize Frontline Workforces to Confront COVID-19 Crisis

At President Trump's direction, the Centers for Medicare & Medicaid Services (CMS) today temporarily suspended a number of rules so that hospitals, clinics, and other healthcare facilities can boost their frontline medical staffs as they fight to save lives during the 2019 Novel Coronavirus (COVID-19) pandemic.

These changes affect doctors, nurses, and other clinicians nationwide, and focus on reducing supervision and certification requirements so that practitioners can be hired quickly and perform work to the fullest extent of their licenses. The new waivers sharply expand the workforce flexibilities CMS announced on March 30.

For a fact sheet detailing additional information on the waivers announced today and previously, go to: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

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Updated Questions and Answers on COVID-19

Review CMS' updated FAQs to equip the American health care system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Check this resource often as CMS updates it on a regular basis - we insert the date at the end of each FAQ when it is new or updated.

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Using CS Modifier When Cost-Sharing is Waived

This clarifies a prior message that appeared in our April 7, 2020 Special Edition.

CMS now waives cost-sharing (coinsurance and deductible amounts) under Medicare Part B for Medicare patients for certain COVID-19 testing-related services. Previously, CMS made available the CS modifier for the gulf oil spill in 2010; however, CMS recently repurposed the CS modifier for COVID-19 purposes. Now, for services furnished on March 18, 2020, and through the end of the Public Health Emergency, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under specific payment systems outlined in the April 7 message should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and to get 100% of the Medicare-approved amount. Additionally, they should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

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Medicare FFS Claims: 2% Payment Adjustment Suspended (Sequestration)

Section 3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act temporarily suspends the 2% payment adjustment currently applied to all Medicare Fee-For-Service (FFS) claims due to sequestration. The suspension is effective for claims with dates of service from May 1 through December 31, 2020.

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April 9, 2020

CMS Provider Education Message:

Important COVID-19 Updates

MLN Connects® for Thursday, April 9, 2020

View this edition as a PDF

News

- CMS Approves Approximately $34 Billion for Providers with the Accelerated/Advance Payment Program for Medicare Providers in One Week
- COVID-19: Dear Clinician Letter
- COVID-19: Non-Emergent, Elective Medical Services and Treatment Recommendations
- Quality Payment Program: MIPS Extreme and Uncontrollable Circumstances Policy in Response to COVID-19
- Multi-Factor Authentication Requirement Delayed for PECOS, I&A, and NPPES
- Open Payments: Pre-Publication Review and Dispute through May 15

Claims, Pricers & Codes

- Pneumococcal Pneumonia Vaccination: Eligibility Transactions Includes DOS Starting April 13

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — May 7

MLN Matters® Articles

- Supplier Education on Use of Upgrades for Multi-Function Ventilators
- Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised

Publications

- Civil Rights, HIPAA, and COVID-19
- Medicare Advance Written Notices of Noncoverage — Revised
- Medicare Preventive Services — Revised
- Medicare Preventive Services Poster — Revised

.

The following local coverage determination (LCD) posted for comment on October 31, 2019, has been posted for notice. The LCD and related billing and coding article will become effective May 24, 2020:

- Thrombolytic Agents (L35428)
  - Billing and coding: Thrombolytic Agents (A55237)

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

- Response to comments: Thrombolytic Agents (A58012)

The following billing and coding articles have been revised:

- Billing and coding: Implantable Automatic Defibrillators (A56355)
- Billing and coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions (A53134)

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Medicare administrative contractors (MACs) will host a multi-jurisdictional Contractor Advisory Committee (CAC) meeting regarding facet joint and medial nerve branch procedures on May 28, 2020, from 1-3 pm CST

The purpose of the meeting is to obtain advice from CAC members and subject matter experts (SMEs) regarding the strength of published evidence on Facet Joint and Medial Nerve Branch Procedures. In addition to discussion, the CAC and SME panel will vote on pre-distributed questions. The public is invited to attend as observers.

The meeting will be hosted by seven Medicare administrative contractors (MACs) and there will be a panel of experts discussing the facet joint and medial nerve branch procedures. CAC panels do not make coverage determinations, but MACs benefit from their advice.

Complete details will be available by May 14th, 2020 (background material, questions, agenda, time, and place). Teleconference/webinar link for registration here EXT .

Please refer to our Multi-Jurisdictional CAC website for additional information.

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April 8, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11691 – April 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  Change request 11691 describes changes to and billing instructions for various payment policies implemented in the April 2020 Hospital OPPS update. Please make sure your billing staffs are aware of these updates.

Revised:

- MM11681 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  The Centers for Medicare & Medicaid Services revised this article on April 6, 2020, to reflect revisions to Change request (CR) 11681. The CR revisions added code 87635 to the healthcare common procedure coding system file, effective March 13, 2020, added two new COVID-19 test codes (G2023 and G2024), effective March 1, 2020, and removed the section on the delay of the clinical laboratory fee schedule reporting period. This revised article reflects these revisions. Also, in the article, we revised the CR release date, transmittal number and the web address of the CR. All other information remains the same.

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April 7, 2020

Special Edition – Tuesday, April 7, 2020

Provider Education Message:

COVID-19: Telehealth Video, Coinsurance and Deductible Waived, ASC Attestations, Ambulance Modifiers, Lessons From Front Lines, MLN Call Today

New Video Available on Medicare Coverage and Payment of Virtual Services

Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services

Guidance for Processing Attestations from Ambulatory Surgical Centers (ASCs) Temporarily Enrolling as Hospitals during the COVID-19 Public Health Emergency

COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers

Lessons from The Front Lines: COVID-19

CMS COVID-19 Update Call Today.

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New video available on Medicare coverage and payment of virtual services

CMS released a video providing answers to common questions about the Medicare telehealth services benefit. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Video

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Families First Coronavirus Response Act waives coinsurance and deductibles for additional COVID-19 related services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

For professional claims, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment.

For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the CS modifier must resubmit applicable claims submitted on or after 3/18/2020, with the CS modifier to visit lines to get 100% payment.

Additional CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

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Guidance for processing attestations from ambulatory surgical centers (ASCs) temporarily enrolling as hospitals during the COVID-19 Public Health Emergency

CMS is providing needed flexibility to hospitals to ensure they have the ability to expand capacity and to treat patients during the COVID-19 public health emergency. As part of the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers CMS is allowing Medicare-enrolled ASCs to temporarily enroll as hospitals and to provide hospital services to help address the urgent need to increase hospital capacity to take care of patients.

Guidance

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COVID-19: Expanded use of ambulance origin/destination modifiers

During the COVID-19 Public Health Emergency, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. On an interim basis, we are expanding the list of destinations that may include but are not limited to:

- Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)
- Community mental health centers
- Federally Qualified Health Centers (FQHCs)
- Rural health clinics (RHCs)
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility is not available
- Beneficiary's home

CMS expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
- Modifier E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
- Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N - Alternative care site for SNF
- Modifier P - Physician's office
- Modifier R - Beneficiary's home

For the complete list of ambulance origin and destination claim modifiers see Medicare Claims Processing Manual Chapter 15, Section 30 A.

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Lessons from the front lines: COVID-19

On April 3, CMS Administrator Seema Verma, Deborah Birx, MD, White House Coronavirus Task Force, and officials from the FDA, CDC, and FEMA participated in a call on COVID-19 Flexibilities. Several physician guests on the front lines presented best practices from their COVID-19 experiences. You can listen to the conversation here.

CMS COVID-19 Update Call Today

Tuesday, April 7 from 2 to 3 pm ET

Register for Medicare Learning Network events. Registration closes at 12pm ET.

CMS update on recent actions taken to address the COVID-19 public health emergency.

Target Audience: All Medicare fee-for-service providers and interested stakeholders.

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Part A: Open issues log

CMS has identified an overpayment for several 340B codes on claims billed with the "JG" modifier for dates of service on and after January 1, 2020.

The corrected rates were loaded with the April 6, 2020, quarterly release files.

Novitas will be identifying and reprocessing these claims. Providers may also initiate their own adjustments to correct the pricing. We will post an update when the mass adjustments actually begin.

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Update to the Part A Open Issues log April 7, 2020

Adjustments for the certain outpatient clinic visit services provided at excepted off-campus Provider-Based Departments (PBD) have started.

Due to the volume of claims identified, the adjustments will continue over the next several weeks. We will post a final notice when all of the adjustments have been initiated.

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Request for cost report documentation extension information

Due to the COVID-19 outbreak and the various complications involved, Novitas Solutions will be suspending our requests for documentation for Medicare Cost Report activities.

Providers do not have to request an extension but will have this additional time if needed.

For more information view the full article on our website, Request for cost report documentation extension information.

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March 2020 top claim submission errors

The March 2020 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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Supplemental accelerated payments being issued for certain Part A facilities

Novitas identified an error with the maximum payment amounts for acute care hospitals, cancer hospitals, and children's hospitals when they requested accelerated payments. We are working diligently to identify the impacted facilities and determine the appropriate maximum payments.

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April 6, 2020

Call centers closed Friday, April 10, 2020

Please note that due to the holiday, our offices and call centers will be closed Friday, April 10, 2020. We will reopen Monday, April 13, 2020.

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April 3, 2020

Special Edition – Friday, April 3, 2020

Provider Education Message:

COVID-19: Telehealth Billing Correction, Nursing Home Recommendations, Billing for Multi-Function Ventilators, New ICD-10-CM Diagnosis Code

- Billing for Professional Telehealth Distant Site Services During the Public Health Emergency — Revised
- Trump Administration Issues Key Recommendations to Nursing Homes, State and Local Governments
- Billing for Multi-Function Ventilators (HCPCS Code E0467) under the COVID-19 Public Health Emergency and Otherwise
- New ICD-10-CM diagnosis code, U07.1, for COVID-19

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Billing for Professional Telehealth Distant Site Services During the Public Health Emergency — Revised

This corrects a prior message that appeared in our March 31, 2020 Special Edition.

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Modifier 95, indicating that the service rendered was actually performed via telehealth

As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

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Trump Administration Issues Key Recommendations to Nursing Homes, State and Local Governments

On April 3, at the direction of President Trump, the Centers for Medicare & Medicaid Services (CMS), in consultation with the Centers for Disease Control and Prevention (CDC), issued critical recommendations to state and local governments, as well as nursing homes, to help mitigate the spread of the 2019 Novel Coronavirus (COVID-19) in nursing homes. The recommendations build on and strengthen recent guidance from CMS and CDC related to effective implementation of longstanding infection control procedures.

Press Release

Guidance

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Billing for Multi-Function Ventilators (HCPCS Code E0467) under the COVID-19 Public Health Emergency and Otherwise

CMS recognizes that in these important times, in particular, beneficiaries, health care clinicians, suppliers, and manufacturers are looking for the broadest possible access to ventilators for their care needs. We are taking a number of steps to increase access to and remind suppliers about certain options available to them and beneficiaries regarding multi-function ventilators.

Effective immediately, CMS is suspending claims editing for multi-function ventilators when there are claims for separate devices in history that have not met their reasonable useful lifetime.

For more information on multi-function ventilators, see MLN Matters Special Edition Article SE20012.

New ICD-10-CM diagnosis code, U07.1, for COVID-19

In response to the national emergency that was declared concerning the COVID-19 outbreak, a new diagnosis code, U07.1, COVID-19, has been implemented, effective April 1, 2020.

As a result, an updated ICD-10 MS-DRG GROUPER software package to accommodate the new ICD-10-CM diagnosis code, U07.1, COVID-19, effective with discharges on and after April 1, 2020, is available on the CMS MS-DRG Classifications and Software webpage.

This updated GROUPER software package (V37.1 R1) replaces the GROUPER software package V37.1 that was developed in response to the new ICD-10-CM diagnosis code U07.0, Vaping-related disorder, also effective with discharges on and after April 1, 2020, that is currently available on the MS-DRG Classifications and Software webpage.

Providers should use this new code, U07.1, where appropriate, for discharges on or after April 1, 2020. Refer to the updated MLN Matters Articles for additional Medicare Fee-For-Service information:

- Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder and 2019 Novel Coronavirus (COVID-19)
- Update to the Home Health Grouper for New Diagnosis Codes for Vaping Related Disorder and COVID-19
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1 R1

For detailed information regarding the assignment of new diagnosis code U07.1, COVID-19, under the ICD-10 MS-DRGs, visit the MS-DRG Classifications and Software webpage. The announcement is located under the “Latest News” heading.

For additional information related to the new COVID-19 diagnosis code, visit the CDC website.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11632 – Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

  Change request (CR) 11632 alerts providers that CR11152 erroneously made modifications to edits and the Centers for Medicare & Medicaid Services needs to omit and make corrections to allow for proper claims processing. Make sure your billing staffs are aware of these changes.

- MM11623 – Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder and 2019 Novel Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised this article to reflect an updated change request (CR) 11623. The CR revision added the new ICD-10-CM code for COVID-19 and we made corresponding revisions in the article. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

- MM11680 – April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1

  The Centers for Medicare & Medicaid Services revised this article on April 2, 2020, to reflect a revised change request (CR) 11680. The CR revisions added information to Table 1, including COVID-19 changes, and we made corresponding revisions in the article. Also, we revised the CR release date, transmittal number, and the web address of the article. All other information remains the same.

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April 2, 2020

CMS Provider Education Message:

Interoperability and Patient Access Final Rule Call — April 7

MLN Connects® for Thursday, April 2, 2020

View this edition as a PDF

News

- IRF Provider Preview Reports: Review Your Data by April 13
- LTCH Provider Preview Reports: Review Your Data by April 13
- Hospice Provider Preview Reports: Review Your Data by April 13

Events

- Interoperability and Patient Access Final Rule Call — April 7

MLN Matters® Articles

- July 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR)
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2020
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.2, Effective July 1, 2020
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations – Update — Revised
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020 — Revised

Publications

- MLN Catalog – April 2020 Edition

Multimedia

- Open Payments Call: Audio Recording and Transcript

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Explore telehealth service expansion during the Coronavirus public health emergency webinar, April 9, 2020

The original Explore Telehealth Services webinar that was scheduled for Thursday, April 9, 2020, at 2:00 p.m. ET/1:00 p.m. CT has been canceled. This event has been replaced with a combined Part A/B webinar Explore Telehealth Service Expansion During the Coronavirus Public Health Emergency being held Thursday, April 9, 2020, at 10:00 a.m. ET/9:00 a.m. CT. This webinar will address the latest information regarding telehealth coverage expansion specifically related to the COVID-19 pandemic and review waivers to telehealth requirements issued under the Public Health Emergency declaration. Providers should be aware that Novitas may not be able to address all questions on this topic during the webinar; however, we will gather questions requiring further research and clarification

following the webinar and distribute responses via our website as more information becomes available Access our calendar of events to register

.

March 31, 2020

Special Edition – Tuesday, March 31, 2020

Provider Education Message:

COVID-19: Regulatory Changes, Telehealth Billing, and Specimen Collection Codes

- Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge
- Billing for Professional Telehealth Services During the Public Health Emergency
- New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

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Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge

At President Trump's direction, the Centers for Medicare & Medicaid Services (CMS) issued an unprecedented array of temporary regulatory waivers and new rules to equip the American health care system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. CMS sets and enforces essential quality and safety standards for the nation's health care system and is the nation's largest health insurer serving more than 140 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and Federal Exchanges.

Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. health care system for the duration of the emergency declaration. This allows hospitals and health systems to deliver services at other locations to make room for COVID-19 patients needing acute care in their main facility.

The changes complement and augment the work of FEMA and state and local public health authorities by empowering local hospitals and health care systems to rapidly expand treatment capacity that allows them to separate patients infected with COVID-19 from those who are not affected. CMS's waivers and flexibilities will permit hospitals and health care systems to expand capacity by triaging patients to a variety of community-based locales, including ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories. Transferring uninfected patients will help hospital staffs to focus on the most critical COVID-19 patients, maintain infection control protocols, and conserve Personal Protective Equipment (PPE).

"Every day, heroic nurses, doctors, and other health care workers are dedicating long hours to their patients. This means sacrificing time with their families and risking their very lives to care for coronavirus patients," said CMS Administrator Seema Verma. "Front line health care providers need to be able to focus on patient care in the most flexible and innovative ways possible. This unprecedented temporary relaxation in regulation will help the health care system deal with patient surges by giving it tools and support to create non-traditional care sites and staff them quickly."

CMS's announcement will also waive certain requirements to enable and encourage hospitals to hire local physicians and other providers to address potential surges. New rules allow hospitals to support physician practices by transferring critical equipment, including items used for telehealth, as well as providing meals and childcare for their health care workers.

Other temporary CMS waivers and rule changes dramatically lessen administrative burdens, knowing that front line providers will be operating with high volumes and under extraordinary system stresses.

CMS recently approved hundreds of waiver requests from health care providers, state governments, and state hospital associations in the following states: Ohio, Tennessee, Virginia, Missouri, Michigan, New Hampshire, Oregon, California, Washington, Illinois, Iowa, South Dakota, Texas, New Jersey, and North Carolina. With this announcement of blanket waivers, other states and providers do not need to apply for these waivers and can begin using the flexibilities immediately.

Administrator Verma added that she applauds the March 23, 2020, pledge by America's Health Insurance Plans (AHIP) to match CMS's waivers for Medicare beneficiaries in areas where in-patient capacity is under strain. "It's a terrific example of public-private partnership and will expand the impact of Medicare's changes," Verma said.

CMS's temporary actions empower local hospitals and health care systems to:

Increase Hospital Capacity – CMS Hospitals Without Walls

CMS will allow communities to take advantage of local ambulatory surgery centers that have canceled elective surgeries, per federal recommendations. Surgery centers can contract with local health care systems to provide hospital services, or they can enroll and bill as hospitals during the emergency declaration as long as they are not inconsistent with their state's Emergency Preparedness or Pandemic Plan. The new flexibilities will also leverage these types of sites to decant services typically provided by hospitals such as cancer procedures, trauma surgeries, and other essential surgeries.

CMS will now temporarily permit non-hospital buildings and spaces to be used for patient care and quarantine sites, provided that the location is approved by the state and ensures the safety and comfort of patients and staff. This will expand the capacity of communities to develop a system of care that safely treats patients without COVID-19 and isolate and treat patients with COVID-19.

CMS will also allow hospitals, laboratories, and other entities to perform tests for COVID-19 on people at home and in other community-based settings outside of the hospital. This will both increase access to testing and reduce risks of exposure. The new guidance allows health care systems, hospitals, and communities to set up testing sites exclusively for the purpose of identifying COVID-19-positive patients in a safe environment.

In addition, CMS will allow hospital emergency departments to test and screen patients for COVID-19 at drive-through and off-campus test sites.

During the public health emergency, ambulances can transport patients to a wider range of locations when other transportation is not medically appropriate. These destinations include community mental health centers, federally qualified health centers, physician's offices, urgent care facilities, ambulatory surgery centers, and any locations furnishing dialysis services when an ESRD facility is not available.

Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms. For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the public health emergency.

In addition, hospitals can bill for services provided outside their four walls. Emergency departments of hospitals can use telehealth services to quickly assess patients to determine the most appropriate site of care, freeing emergency space for those that need it most. New rules ensure that patients can be screened at alternate treatment and testing sites which are not subject to the Emergency Medical Labor and Treatment Act (EMTALA) as long as the national emergency remains in force. This will allow hospitals, psychiatric hospitals, and critical access hospitals to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19.

Rapidly Expand the Health Care Workforce

Local private practice clinicians and their trained staff may be available for temporary employment since nonessential medical and surgical services are postponed during the public health emergency. CMS's temporary requirements allow hospitals and health care systems to increase their workforce capacity by removing barriers for physicians, nurses, and other clinicians to be readily hired from the local community, as well as those licensed from other states without violating Medicare rules.

These health care workers can then perform the functions they are qualified and licensed for, while awaiting completion of federal paperwork requirements.

CMS is issuing waivers so that hospitals can use other practitioners, such as physician assistants and nurse practitioners, to the fullest extent possible, in accordance with a state's emergency preparedness or pandemic plan. These clinicians can perform services such as order tests and medications that may have previously required a physician's order where this is permitted under state law.

CMS is waiving the requirements that a Certified Registered Nurse Anesthetist (CRNA) is under the supervision of a physician. This will allow CRNAs to function to the fullest extent allowed by the state and free up physicians from the supervisory requirement and expand the capacity of both CRNAs and physicians.

CMS also is issuing a blanket waiver to allow hospitals to provide benefits and support to their medical staffs, such as multiple daily meals, laundry service for personal clothing, or child care services while the physicians and other staff are at the hospital and engaging in activities that benefit the hospital and its patients.

CMS will also allow health care providers (clinicians, hospitals and other institutional providers, and suppliers) to enroll in Medicare temporarily to provide care during the public health emergency.

Put Patients over Paperwork

CMS is temporarily eliminating paperwork requirements and allowing clinicians to spend more time with patients. Medicare will now cover respiratory-related devices and equipment for any medical reason determined by clinicians so that patients can get the care they need; previously Medicare only covered them under certain circumstances.

During the public health emergency, hospitals will not be required to have written policies on processes and visitation of patients who are in COVID-19 isolation. Hospitals will also have more time to provide patients a copy of their medical record.

CMS is providing temporary relief from many audit and reporting requirements so that providers, health care facilities, Medicare Advantage health plans, Medicare Part D prescription drug plans, and states can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

This is being done by extending reporting deadlines and suspending documentation requests which would take time away from patient care.

Further Promote Telehealth in Medicare

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. During the public health emergencies, individuals can use interactive apps with audio and video capabilities to visit with their clinician for an even broader range of services. Providers also can evaluate beneficiaries who have audio phones only.

These temporary changes will ensure that patients have access to physicians and other providers while remaining safely at home.

Providers can bill for telehealth visits at the same rate as in-person visits. Telehealth visits include emergency department visits, initial nursing facility and discharge visits, home visits, and therapy

services, which must be provided by a clinician that is allowed to provide telehealth. New as well as established patients now may stay at home and have a telehealth visit with their provider.

CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice, and home health.

CMS is making it clear that clinicians can provide remote patient monitoring services to patients with acute and chronic conditions and for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.

In addition, CMS is allowing physicians to supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence.

For additional background information on the waivers and rule changes, go to: https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient

For more information on the COVID-19 waivers and guidance, and the Interim Final Rule, please go to the CMS COVID-19 flexibilities webpage: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.

These actions, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

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Billing for professional telehealth services during the public health emergency

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth. As a reminder, CMS is not requiring the "CR" modifier on telehealth services. However, consistent with current rules for traditional telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

Traditional Medicare telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

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New specimen collection codes for laboratories billing for COVID-19 testing

Clinical diagnostic laboratories: To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

These codes are billable by clinical diagnostic laboratories.

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April 7, 2020, Contractor Advisory Committee (CAC) meeting cancelled

The decision has been made to cancel the April 7, 2020, CAC meeting and our online registration has been closed.

We believe that during this unprecedented time, the primary focus is the care of your patients and families. We will continue to keep you informed of any updates regarding future CAC meetings. Thank you for your dedication to the healthcare community.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11745 – July 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  Change request 11745 informs Medicare administrative contractors (MACs) about new and revised ASP and ASP not otherwise classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) supplies MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system are incorporated into the outpatient code editor through separate instructions that are available in chapter 4, section 50 of the Medicare claims processing manual. Make sure your billing staffs are aware of these changes.

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Accelerated and advance payment requests

To increase cash flow to providers of services and suppliers impacted by the 2019 Novel Coronavirus (COVID-19) pandemic, CMS expanded their current Accelerated and Advance Payment Program to a broader group of Medicare Part A and Part B providers / suppliers. Learn about accessing and submitting our Payment Request Form.

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Update to Qualified Independent Contractor (QIC) appeal submission

We are sending this information at the request of the Qualified Independent Contractor (QIC). C2C conducts second-level Medicare Part A Fee-For-Service claims appeals, for claims submitted in your MAC jurisdiction. If you appeal to C2C as the Part A East QIC, as of April 3, 2020, they are limiting their on-site mailroom operations in response to the COVID-19, public health emergency. During this public health emergency, Part A East providers and Medicare beneficiaries are encouraged to submit new second-level Medicare appeals and related correspondence via fax or a portal. For additional information including the QIC fax numbers and a link to their portal, please visit, www.C2Cinc.com.

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March 30, 2020

Special Edition – Monday, March 30, 2020

Provider Education Message:

COVID-19: Financial Relief, Nursing Home Telehealth, Quality Reporting, Clinical Laboratories, Hospital Data Sharing

- Trump Administration Provides Financial Relief for Medicare Providers
- Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit
- Quality Payment Program and Quality Reporting Program/Value Based Purchasing Program COVID-19 Relief
- Clinical Laboratory Improvement Amendments (CLIA) Guidance During COVID-19 Emergency
- Trump Administration Engages America's Hospitals in Unprecedented Data Sharing

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Trump Administration Provides Financial Relief for Medicare Providers

Under the President's leadership, the Centers for Medicare & Medicaid Services (CMS) is announcing an expansion of its accelerated and advance payment program for Medicare participating health care providers and suppliers, to ensure they have the resources needed to combat the 2019 Novel Coronavirus (COVID-19). This program expansion, which includes changes from the recently enacted Coronavirus Aid, Relief, and Economic Security (CARES) Act, is one way that CMS is working to lessen the financial hardships of providers facing extraordinary challenges related to the COVID-19 pandemic and ensures the nation's providers can focus on patient care. There has been significant disruption to the health care industry, with providers being asked to delay non-essential surgeries and procedures, other health care staff unable to work due to childcare demands, and disruption to billing, among the challenges related to the pandemic.

"With our nation's health care providers on the front lines in the fight against COVID-19, dollars and cents shouldn't be adding to their worries," said CMS Administrator Seema Verma. "Unfortunately, the major disruptions to the health care system caused by COVID-19 are a significant financial burden on providers. Today's action will ensure that they have the resources they need to maintain their all-important focus on patient care during the pandemic."

Medicare provides coverage for 37.4 million beneficiaries in its Fee for Service (FFS) program, and made $414.7 billion in direct payments to providers during 2019. This effort is part of the Trump Administration's White House Coronavirus Task Force effort to combat the spread of COVID-19 through a whole-of-America approach, with a focus on strengthening and leveraging public-private relationships.

Accelerated and advance Medicare payments provide emergency funding and address cash flow issues based on historical payments when there is disruption in claims submission and/or claims processing. These expedited payments are typically offered in natural disasters to accelerate cash flow to the impacted health care providers and suppliers. In this situation, CMS is expanding the program for all Medicare providers throughout the country during the public health emergency related to COVID-19. The payments can be requested by hospitals, doctors, durable medical equipment suppliers, and other Medicare Part A and Part B providers and suppliers.

To qualify for accelerated or advance payments, the provider or supplier must:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/ supplier's request form,

- Not be in bankruptcy,
- Not be under active medical review or program integrity investigation, and
- Not have any outstanding delinquent Medicare overpayments.

Medicare will start accepting and processing the Accelerated/Advance Payment Requests immediately. CMS anticipates that the payments will be issued within seven days of the provider's request.

An informational fact sheet on the accelerated/advance payment process and how to submit a request can be found here: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

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Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit

On March 27, CMS issued an electronic toolkit regarding telehealth and telemedicine for Long Term Care Nursing Home Facilities. Under President Trump's leadership to respond to the need to limit the spread of community COVID-19, CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. This document contains electronic links to reliable sources of information regarding telehealth and telemedicine, including the significant changes made by CMS over the last week in response to the National Health Emergency. Most of the information is directed towards providers who may want to establish a permanent telemedicine program, but there is information here that will help in the temporary deployment of a telemedicine program as well. There are specific documents identified that will be useful in choosing telemedicine vendors, equipment, and software, initiating a telemedicine program, monitoring patients remotely, and developing documentation tools. There is also information that will be useful for providers who intend to care for patients through electronic virtual services that may be temporarily used during the COVID-19 pandemic.

Toolkit

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Quality Payment Program and Quality Reporting Program/Value Based Purchasing Program COVID-19 Relief

On March 22, 2020, CMS announced relief for clinicians, providers, hospitals, and facilities participating in quality reporting programs in response to the 2019 Novel Coronavirus (COVID-19). This memorandum and factsheet supplements and provides additional guidance to health care providers with regard to the announcement. CMS has extended the 2019 Merit-based Incentive Payment System (MIPS) data submission deadline from March 31 by 30 days to April 30, 2020. This and other efforts are to provide relief to clinicians responding to the COVID-19 pandemic. In addition, the MIPS automatic extreme and uncontrollable circumstances policy will apply to MIPS eligible clinicians who do not submit their MIPS data by the April 30, 2020, deadline.

You can find a copy of the memo here: Memo

You can find a copy of the fact sheet here: Fact Sheet

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Clinical Laboratory Improvement Amendments (CLIA) Guidance During COVID-19 Emergency

CMS issued important guidance ensuring that America's clinical laboratories are prepared to respond to the threat of the 2019 Novel Coronavirus (COVID-19.) CMS is committed to taking critical steps to ensure America's clinical laboratories are prepared to respond to the COVID-19 threat and other respiratory illnesses by implementing flexibilities around requirements for a Clinical Laboratory Improvement Amendments (CLIA) certificate during public health emergencies.

While there is no formal waiver authority under CLIA, CMS continue to exercise flexibilities under current regulations and through enforcement discretion to address temporary and remote testing sites, use of alternate specimen collection devices, and implementation of laboratory developed tests. Our hope is that this guidance provides the steps needed for all U.S. Labs wanting to apply for a CLIA certificate to test for COVID-19.

Guidance

FAQ

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Trump Administration Engages America's Hospitals in Unprecedented Data Sharing

On March 29, the Centers for Medicare & Medicaid Services (CMS) sent a letter to the nation's hospitals on behalf of Vice President Pence requesting they report data in connection with their efforts to fight the 2019 Novel Coronavirus (COVID-19). Specifically, the Trump Administration is requesting that hospitals report COVID-19 testing data to the U.S. Department of Health and Human Services (HHS), in addition to daily reporting regarding bed capacity and supplies to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) COVID-19 Patient Impact and Hospital Capacity Module. CMS, the federal agency with oversight of America's Medicare-participating health care providers – including hospitals – is helping the Trump Administration obtain this critical information to help identify supply and bed capacity needs, as well as enhance COVID-19 surveillance efforts. Hospitals will report data without personal identifying information to ensure patient privacy.

"The nation's nearly 4,700 hospitals have access to testing data that's updated daily. This data will help us better support hospitals to address their supply and capacity needs, as well as strengthen our surveillance efforts across the country," said CMS Administrator Seema Verma. "America's hospitals are demonstrating incredible resilience in this unprecedented situation and we look forward to partnering further with them going forward."

The White House Coronavirus Task Force is already collecting data from public health labs and private laboratory companies but does not have data from hospital labs that conduct laboratory testing in their hospital. This hospital data is needed at the federal level to support the Federal Emergency Management Agency (FEMA) and CDC in their efforts to support states and localities in addressing and responding to the virus.

Academic, University and Hospital "in-house" labs are performing thousands of COVID-19 tests each day, but unlike private laboratories, the full results are not shared with government agencies working to track and analyze the virus. By sharing this critical data, hospitals can help Federal and state government mitigate the effects of COVID-19 and direct needed resources from Federal Emergency Management Agency (FEMA) and the U.S. Government during this unprecedented crisis.

In Vice President Pence's letter to America's hospitals, he asks all hospitals to report data on COVID-19 testing performed in their "in-house" laboratories, which are hospitals' onsite laboratories. To monitor the rapid emergence of COVID-19 and the impact on the health care system, the White House Coronavirus Task Force is requesting hospitals to report testing data to HHS each day and to the CDC's NHSN. This new data request by the Trump Administration will help monitor the spread of

severe COVID-19 illness and death as well as the impact to our nation's hospitals. Because private and commercial laboratories already report, this letter is not applicable to them.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

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Development requests

You can submit and track your enrollment application through the Provider Enrollment, Chain and Ownership System. If you submitted a paper application, you can view the status in our Provider Enrollment Status Tool.

If we need additional information, a development letter will be sent to the contact person listed in Section 13 of your enrollment application. It is vital that you submit the requested information within the development letter.

Note: There is a 30-day development window from the date on the letter. The quicker we receive the requested information, the faster we can process your application.

If the status shows in development and the contact person didn't receive the letter, please contact our Provider Enrollment Helpdesk to request a copy.

JH: 1-855-252-8782, Option 4
JL: 1-877-235-8073, Option 4

For questions regarding the requested information in the letter, please contact your credentialing specialist. The phone number will be at the bottom of the development letter.

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Cost report due date extension information

Due to the COVID-19 outbreak and the various complications involved, 42 CFR § 413.24 (f) (2) (ii) allows the flexibility to approve a cost report filing extension. Novitas Solutions has approved an automatic extension in the normal filing deadlines for the following fiscal year end dates. The filing deadline of FYE 10/31/2019, cost reports due by March 31, 2020, and FYE 11/30/2019, cost reports due by April 30, 2020, has been extended to June 30, 2020. We have also extended the filing deadline of the FYE 12/31/2019, cost reports due by June 1, 2020, to July 31, 2020. Providers do not have to request an extension, but will have this additional time if needed.

Please note that the sooner you file your cost report, we can begin to process a tentative settlement.

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March 26, 2020

Provider Education Message:

Special Edition – Thursday, March 26, 2020

COVID-19: Enrollment Relief, Open Payments, Beneficiary Notices

- 2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)
- Frequently Asked Questions (FAQs) on Enforcing Open Payments Deadlines

- Beneficiary Notice Delivery Guidance in light of COVID-19

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2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)

CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19 including the toll-free hotlines available to Medicare Administrative Contractors (MACs). CMS has established toll-free hotlines at each MAC to allow physicians and non-physician practitioners to initiate temporary Medicare billing privileges. These hotlines provide expedited enrollment and answer questions related to COVID-19 enrollment requirements. FAQ

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Frequently Asked Questions (FAQs) on Enforcing Open Payments Deadlines

CMS released an updated comprehensive list of Frequently Asked Questions (FAQs) about the Open Payments program. Tuesday, March 31, 2020, is the Open Payments Program Year 2019 data submission deadline for applicable manufacturers and group purchasing organizations (GPOs) to submit and attest to data for the June 2020 publication of Program Year 2019 data. The deadline cannot be extended past March 31, 2020; therefore, CMS will exercise enforcement discretion for submissions completed after the statutory deadline due to circumstances beyond the reporting entity's control related to the pandemic. FAQ

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Beneficiary Notice Delivery Guidance in light of COVID-19

If you are treating a patient with suspected or confirmed COVID-19, CMS encourages the provider community to be diligent and safe while issuing the following beneficiary notices to beneficiaries receiving institutional care:

- Important Message from Medicare (IM)_CMS-10065
- Detailed Notices of Discharge (DND)_CMS-10066
- Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
- Detailed Explanation of Non-Coverage (DENC)_CMS-10124
- Medicare Outpatient Observation Notice (MOON)_CMS-10611
- Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
- Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)_CMS-10055
- Hospital Issued Notices of Non-Coverage (HINN)

In light of concerns related to COVID-19, current notice delivery instructions provide flexibilities for delivering notices to beneficiaries in isolation. These procedures include:

- Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely. A contact phone number should be provided for a beneficiary to ask questions about the notice, if the individual delivering the notice is unable to do so. If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also delivered via email, if a beneficiary has access in the isolation room. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent.

- Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

We encourage the provider community to review all of the specifics of notice delivery, as set forth in Chapter 30 of the Medicare Claims Processing Manual. https://www.cms.gov/media/137111

CMS has taken several recent actions in response to the Coronavirus Disease 2019 (COVID-19), as part of the ongoing White House Task Force efforts. A summary of recent CMS activities can be found here: https://www.cms.gov/newsroom/press-releases/cms-news-alert-march-26-2020

To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For information specific to CMS, please visit the CMS News Room and Current Emergencies Website.

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CMS Provider Education Message:

COVID-19: New Targeted Plan for Health Care Facility Inspections

MLN Connects® for Thursday, March 26, 2020

View this edition as a PDF

News

- CMS Announces Findings at Kirkland Nursing Home and New Targeted Plan for Health Care Facility Inspections in light of COVID-19
- SNF Quality Reporting Program: MDS 3.0 v1.18.1 Release Delayed
- Home Health Quality Reporting Program: Draft OASIS-E Instrument
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

MLN Matters® Articles

- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2018 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)
- April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- April 2020 Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- April Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- New Medicare Beneficiary Identifier (MBI) Get It, Use It — Revised
- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS — Revised

Multimedia

- Ground Ambulance Data Collection System Call: Audio Recording and Transcript

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Direct data entry (DDE) screen changes

Effective April 1, 2020, the eligibility detail inquiry in the Fiscal Intermediary Standard System (FISS) was modified to add new screen, MAP175R – PPV HCPCS Aux File. This new screen will show the pneumococcal pneumonia vaccination (PPV) Healthcare Common Procedure Coding System (HCPCS) codes billed along with the date of service. Our online FISS manual has been updated to reflect this change.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11660 – NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR)

  Change request (CR) 11660 informs MACs that effective June 21, 2019, the Centers for Medicare & Medicaid Services (CMS) will continue coverage of TAVR under coverage with evidence development when the procedure is provided for the treatment of symptomatic aortic valve stenosis and according to a food & drug administration (FDA)-approved indication for use with an approved device, in addition to the coverage criteria outlined in the Medicare national coverage determinations (NCD) manual (Pub. 100-03). CMS will also continue coverage of TAVR for uses that are not expressly listed as an FDA-approved indication in clinical studies that meet specific requirements and are approved by CMS.

  These changes relate to Chapter 1, Part 1, Section 20.32 of the NCD Manual and Chapter 32, Section 290 of the Medicare Claims Processing Manual (Pub. 100-04). Both relevant sections are attached to CR 11660.

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March 25, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised

- SE19007 – Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update

  The Centers for Medicare & Medicaid Services revised this article on March 24, 2020, to announce a delay until further notice to the activation of systematic validation edits for OPPS providers with multiple service locations.

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March 24, 2020

Provider Education Message:

Special Edition – Monday, March 23, 2020

COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

- Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19
- COVID-19 Provider Enrollment Relief FAQs

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Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

On March 22, CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The action comes as part of the Trump Administration's response to 2019 Novel Coronavirus (COVID-19).

CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for several CMS programs. For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report.

CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions, and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period.

You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

CMS will continue monitoring the developing COVID-19 situation and assess options to provide additional relief to clinicians, facilities, and their staff so they can focus on caring for patients.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Webpage on CMS.Gov.

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COVID-19 Provider Enrollment Relief FAQs

On March 22, CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19, including the toll-free hotlines available to provide expedited enrollment and answer questions related to COVID-19 enrollment requirements.

A copy of the FAQs can be found here: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

These tools, and earlier CMS actions in response to the COVID-19 emergency, are all part of ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, guidance, and other information in response to COVID-19, please visit the Current Emergencies Website.

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Provider enrollment assistance in response to COVID-19

Novitas Solutions implemented provider enrollment relief for providers impacted by COVID-19, retroactive to March 1, 2020. We have also established a hotline to help healthcare providers that have been impacted by COVID-19. Please visit our full article for further information.

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Online registration now available for the April 7, 2020, Contractor Advisory Committee (CAC) meeting

Online registration for the April 7, 2020, CAC Meeting is now available and will close at 3:00 PM Eastern Time (ET) on Friday, April 3, 2020.

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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March 23, 2020

Provider Education Message:

Special Edition – Friday, March 20, 2020

COVID-19: Telehealth and Non-Essential Procedures

- CMS Releases Telehealth Toolkits for General Practitioners and End-Stage Renal Disease (ESRD) Providers
- Medicare FFS Response to the Public Health Emergency on the Coronavirus (COVID-19) — Revised
- COVID-19 Elective Surgeries and Non-Essential Procedures Recommendations

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CMS Releases Telehealth Toolkits for General Practitioners and End-Stage Renal Disease (ESRD) Providers

On March 18, the Centers for Medicare & Medicaid Services (CMS) released two comprehensive toolkits on telehealth that are specific to general practitioners as well as providers treating patients with End-Stage Renal Disease (ESRD).

Under President Trump's leadership to respond to the need to limit the spread of COVID-19, CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. These benefits are part of the broader effort by CMS and the White House Task Force to ensure that all Americans – particularly those at high-risk of complications from the virus that causes the disease COVID-19 are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the community spread of this virus.

Each toolkit contains electronic links to reliable sources of information on telehealth and telemedicine, which will reduce the amount of time providers spend searching for answers and increase their time with patients. Many of these links will help providers learn about the general concept of telehealth, choose telemedicine vendors, initiate a telemedicine program, monitor patients remotely, and develop

documentation tools. Additionally, the information contained within each toolkit will also outline temporary virtual services that could be used to treat patients during this specific period of time.

You can find the Telehealth Toolkit for General Practitioners here: https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

You can find the End-Stage Renal Disease Providers Toolkit here: https://www.cms.gov/files/document/esrd-provider-telehealth-telemedicine-toolkit.pdf

CMS continues to monitor the developing COVID-19 situation and assess options to bring relief to clinicians. To keep up with the important work the Task Force is doing in response to COVID-19 visit the coronavirus.gov webpage. For complete and updated information specific to CMS, please visit the Current Emergencies Website.

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Medicare FFS Response to the Public Health Emergency on the Coronavirus (COVID-19) — Revised

The MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) (PDF) was updated to cover the use of modifiers on telehealth claims and to explain that the DR condition code is not needed on telehealth claims under the waiver.

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COVID-19 Elective Surgeries and Non-Essential Procedures Recommendations

On March 18, at the White House Task Force Press Briefing, the Centers for Medicare & Medicaid Services (CMS) announced that all elective surgeries, non-essential medical, surgical, and dental procedures be delayed during the 2019 Novel Coronavirus (COVID-19) outbreak.

You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental

You can find a copy of the guidance here: https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf

These recommendations, and earlier CMS guidance and actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit the coronavirus.gov webpage for further information. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

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Limited systems availability - Friday, April 3, 2020 through Sunday, April 5, 2020

There will be Common Working File (CWF) "Dark" days from Friday, April 3rd, 2020, through Sunday, April 5th, 2020 due to the April 2020 release upgrades. The interactive voice response (IVR) unit and our Customer Service representatives will have limited availability. Customer service representatives will not be able to assist providers with eligibility inquiries, claim status inquiries relating to eligibility or claim denial inquiries relating to eligibility.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11701 – April 2020 Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  Change request 11701 informs Medicare administrative contractors (MAC) about new and revised Average Sales Price (ASP) and ASP not otherwise classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services supplies MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system are incorporated into the outpatient code editor through separate instructions that are available in Chapter 4, Section 50 of the Medicare claims processing manual. Make sure your billing staffs are aware of these changes.

- MM11702 – April Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

  Change request 11702 informs durable medical equipment Medicare administrative contractors about the changes to the DMEPOS fee schedule that Medicare updates on a quarterly basis when necessary to implement fee schedule amounts for new codes. In addition, the update corrects any fee schedule amounts for existing codes and updates to the DMEPOS Rural ZIP code file. The update process for the DMEPOS fee schedule is available in the Medicare Claims Processing Manual, Chapter 23, Section 60. Make sure your billing staff is aware of this update.

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised this article on March 20, 2020, to add a note in the telehealth section to cover the use of modifiers on telehealth claims and to explain the DR condition code is not needed on telehealth claims under the waiver. All other information is the same.

March 20, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11335 – Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS

  The Centers for Medicare & Medicaid Services revised this article on March 19, 2020, and updated the Provider Types Affected, What You Need to Know, and Background sections.

- SE18006 – New Medicare Beneficiary Identifier (MBI) Get It, Use It

  The Centers for Medicare & Medicaid Services revised the article on March 19, 2020, to clarify that you need the beneficiary's first name, last name, date of birth, and social security number to use the Medicare beneficiary identifier look-up tool. All other information remains the same

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March 19, 2020

CMS Provider Education Message:

Interoperability and Patient Access

MLN Connects® for Thursday, March 19, 2020

View this edition as a PDF

News

- Quality Payment Program: 2020 Facility-Based Status
- Lower Extremity Joint Replacement: Comparative Billing Report in March
- IRF Provider Preview Reports: Review Your Data by April 13
- LTCH Provider Preview Reports: Review Your Data by April 13
- Hospice Provider Preview Reports: Review Your Data by April 13
- IRF Compare Refresh
- LTCH Compare Refresh
- LTCH CARE Data Submission Specifications
- Hospital Quality Reporting: Updated 2020 QRDA I Schematron and Sample File

Influenza Activity Continues: Are Your Patients Protected?

Compliance

- Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

- SNF Claims Incorrectly Cancelled

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2
- Interoperability and Patient Access Final Rule Call — April 7

MLN Matters® Articles

- Ensure Required Patient Assessment Information for Home Health Claims
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits
- Medicare FFS Response to the Public Health Emergency on the Coronavirus (COVID-19) — Revised

Publications

- Administrative Simplification: Code Set Basics
- Medicare Parts A & B Appeals Process — Revised
- Clinical Laboratory Fee Schedule — Revised

Multimedia

- Part A Appeals Demonstration Call: Audio Recording and Transcript
- Introduction to IRF Quality Reporting Program Web-Based Training
- Introduction to SNF Quality Reporting Program Web-Based Training

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Local coverage determination (LCD) and article update history

The following local coverage determination (LCD) has been revised:

- Ambulance Services (Ground Ambulance) (L35162)

The following local coverage article has been revised and is posted for notice. The article will become effective May 3, 2020:

- Self-Administered Drug Exclusion List (A53127)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Centers for Medicare & Medicaid Services revised this article on March 18, 2020, to include information about the telehealth waiver. All other information remains the same.

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March 17, 2020

Special Edition – Tuesday, March 17, 2020

Provider Education Message:

President Trump Expands Telehealth Benefits for Medicare Beneficiaries During

COVID-19 Outbreak

CMS Outlines New Flexibilities Available to People with Medicare

The Trump Administration today announced expanded Medicare telehealth coverage that will enable beneficiaries to receive a wider range of healthcare services from their doctors without having to travel to a healthcare facility. Beginning on March 6, 2020, Medicare—administered by the Centers for Medicare & Medicaid Services (CMS)—will temporarily pay clinicians to provide telehealth services for beneficiaries residing across the entire country.

“The Trump Administration is taking swift and bold action to give patients greater access to care through telehealth during the COVID-19 outbreak,” said Administrator Seema Verma. “These changes allow seniors to communicate with their doctors without having to travel to a healthcare facility so that they can limit risk of exposure and spread of this virus. Clinicians on the frontlines will now have greater flexibility to safely treat our beneficiaries.”

On March 13, 2020, President Trump announced an emergency declaration under the Stafford Act and the National Emergencies Act. Consistent with President Trump’s emergency declaration, CMS is expanding Medicare’s telehealth benefits under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. This guidance and other recent actions by CMS provide regulatory flexibility to ensure that all Americans—particularly high-risk individuals—are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the spread of coronavirus disease 2019 (COVID-19).

Prior to this announcement, Medicare was only allowed to pay clinicians for telehealth services such as routine visits in certain circumstances. For example, the beneficiary receiving the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a

remote location. In addition, the beneficiary would generally not be allowed to receive telehealth services in their home.

The Trump Administration previously expanded telehealth benefits. Over the last two years, Medicare expanded the ability for clinicians to have brief check-ins with their patients through phone, video chat and online patient portals, referred to as “virtual check-ins”. These services are already available to beneficiaries and their physicians, providing a great deal of flexibility, and an easy way for patients who are concerned about illness to remain in their home avoiding exposure to others.

A range of healthcare providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to Medicare beneficiaries. Beneficiaries will be able to receive telehealth services in any healthcare facility including a physician’s office, hospital, nursing home or rural health clinic, as well as from their homes.

Medicare beneficiaries will be able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor’s office or hospital which puts themselves or others at risk. This change broadens telehealth flexibility without regard to the diagnosis of the beneficiary, because at this critical point it is important to ensure beneficiaries are following guidance from the CDC including practicing social distancing to reduce the risk of COVID-19 transmission. This change will help prevent vulnerable beneficiaries from unnecessarily entering a healthcare facility when their needs can be met remotely.

President Trump’s announcement comes at a critical time as these flexibilities will help healthcare institutions across the nation offer some medical services to patients remotely, so that healthcare facilities like emergency departments and doctor’s offices are available to deal with the most urgent cases and reduce the risk of additional infections. For example, a Medicare beneficiary can visit with a doctor about their diabetes management or refilling a prescription using telehealth without having to travel to the doctor’s office. As a result, the doctor’s office is available to treat more people who need to be seen in-person and it mitigates the spread of the virus.

As part of this announcement, patients will now be able to access their doctors using a wider range of communication tools including telephones that have audio and video capabilities, making it easier for beneficiaries and doctors to connect.

Clinicians can bill immediately for dates of service starting March 6, 2020. Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services. Medicare coinsurance and deductible still apply for these services. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Medicaid already provides a great deal of flexibility to states that wish to use telehealth services in their programs. States can cover telehealth using various methods of communication such as telephonic, video technology commonly available on smart phones and other devices. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.

This guidance follows on President Trump’s call for all insurance companies to expand and clarify their policies around telehealth.

To read the Fact Sheet on this announcement visit: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

To read the Frequently Asked Questions on this announcement visit: https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

This guidance, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19 click here https://protect2.fireeye.com/url?k=1dc3b044-4196b994-1dc3817b-0cc47a6a52de-daff918c3d41b4a0&u=http://www.coronavirus.gov/. For information specific to CMS, please visit the Current Emergencies Website.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20011 – Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

  The Secretary of the Department of Health & Human Services declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020, Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to March 1, 2020. The Centers for Medicare & Medicaid Services is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

  More Information:

  - Current Emergencies webpage.
  - Instructions to request an individual waiver if there is no blanket waiver.

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March 16, 2020

Special Edition – Monday, March 16, 2020

Provider Education Message:

COVID-19: FFS Response and Nursing Home Visitor Guidance

Medicare FFS Response to COVID-19

The HHS Secretary declared a public health emergency, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus is available. Learn about blanket waivers issued by CMS. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency.

See the press release outlining our announcement.

COVID-19 Nursing Home Visitor Guidance

On March 13, as part of the broader Trump Administration announcement, CMS announced critical new measures designed to keep America's nursing home residents safe from the 2019 Novel Coronavirus (COVID-19). The measures take the form of a memorandum and is based on the newest recommendations from the Centers for Disease Control and Prevention (CDC). It directs nursing homes to significantly restrict visitors and nonessential personnel, as well as restrict communal activities inside nursing homes. The new measures are CMS's latest action to protect America's seniors, who are at highest risk for complications from COVID-19. While visitor restrictions may be difficult for residents and families, it is an important temporary measure for their protection.

For More Information:

- Press Release
- Memo Nursing Home Guidance QSO-20-14 –NH

This guidance, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit the coronavirus.gov webpage.

For information specific to CMS, visit the Current Emergencies website.

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Special Edition – Friday, March 13, 2020

Provider Education Message:

COVID-19: Test Pricing, Diagnostic Lab Tests, Pricing & Codes, and EHB Coverage

- COVID-19: Test Pricing; Diagnostic Lab Tests, Pricing & Codes; and EHB Coverage
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article
- Essential Health Benefits (EHB) Coverage

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COVID-19: Test Pricing; Diagnostic Lab Tests, Pricing & Codes; and EHB Coverage

On March 12, CMS posted a fact sheet with information relating to the pricing of both the Centers for Disease Control and Prevention (CDC) and non-CDC tests.

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Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article

A new MLN Matters Article MM 11681 on Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment is available. Learn about Advanced Diagnostic Laboratory Tests, pricing, and new codes. On page 3, we reference new COVID-19 codes.

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Essential Health Benefits (EHB) Coverage

On March 12, CMS issued Frequently Asked Questions (FAQs) about EHB to ensure individuals, issuers, and states have clear information on coverage benefits for COVID-19. This action is part of the broader, ongoing effort by the White House Coronavirus Task Force to ensure that all Americans – particularly those at high-risk of complications from the COVID-19 virus – have access to the health benefits that can help keep them healthy while helping to contain the spread of this disease.

These FAQs, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19; visit the CDC's Coronavirus Disease 2019 webpage.

For information specific to CMS, please visit the Current Emergencies website.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11679 – The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2018 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)

  Change request 11679 provides updated data for determining the Disproportionate Share (DSH) adjustment for IPPS hospitals and the low-income patient adjustment for IRFs. It also updates payments as applicable for LTCH discharges (such as those paid the IPPS comparable amount under the short-stay outlier payment adjustment). SSI/Medicare beneficiary data for hospitals are available electronically and contain the name of the hospital, the Centers for Medicare & Medicaid Services (CMS) certification number, SSI days, total Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients.

  These files are available at:

  - IPPS
  - IRF
  - LTCH

  The data are used for settlement purposes for IPPS hospitals and IRFs with cost-reporting periods beginning and during Fiscal Year 2018 (cost-reporting periods beginning on or after October 1, 2017, and before October 1, 2018), except when explicitly directed otherwise by CMS.

- MM11681 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  Change request 11681 informs Medicare administrative contractors about the changes in the April 2020 quarterly update to the clinical laboratory fee schedule. Make sure that your billing staffs are aware of these changes.

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Local coverage cetermination (LCD) and article update history

The following local coverage determination (LCD) which was posted for notice on January 30, 2020, is now effective. The companion article for this LCD is also now effective:

- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38385)
  - Billing and coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (A56938)

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Coming soon! The March 31, 2020, Deadline for the completion of the transport of portable x-ray equipment survey

Time is running out to complete the Reimbursement survey for transport of portable x-ray equipment (R0070 and R0075). Novitas is requesting your assistance to ensure that the Transport of portable x-ray equipment survey is submitted no later than March 31, 2020, when a final reimbursement determination will be made.

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March 13, 2020

The following billing and coding article has been revised:

- Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)

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March 12, 2020

CMS Provider Education Message:

2019 Novel Coronavirus Guidance

MLN Connects® for Thursday, March 12, 2020

View this edition as a PDF

News

- CMS Sends More Detailed Guidance to Providers about COVID-19
- HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data
- Quality Payment Program: MIPS 2019 Data Submission Deadline March 31
- Hospital Quality Reporting: Comment on Draft QRDA I Implementation Guide by April 1
- Inclusion of Lower Limb Prosthetics in DMEPOS Prior Authorization
- Clean Hands Count: Prevent and Control Infections
- March is National Colorectal Cancer Awareness Month

Compliance

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Open Payments: Your Role in Health Care Transparency Call — March 19
- Medicare Promoting Interoperability Program Call for Measures Webinar — March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2
- Interoperability and Patient Access Final Rule Call — April 7
- LTCH and IRF Quality Reporting Programs: SPADEs Webinar — April 14

MLN Matters® Articles

- NCD 20.4 Implantable Cardiac Defibrillators (ICDs)
- Section 1876 and 1833 Cost Plan Enrollee Access to Care through Original Medicare
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1
- Proper Use of Modifier 59 — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

Publications

- Evacuating and Receiving Patients in the Midst of a Wildfire
- Administrative Simplification: Eligibility and Benefits Transaction Basics

Multimedia

- Dementia Care Call: Audio Recording and Transcript

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February 2020 top inquiries FAQs for DE, DC, MD, NJ, & PA

The February 2020 Part A top inquiries FAQs, received by our Provider Contact Center, have been reviewed. New questions / answers have been added to the claim status and general information categories. Please take time to review these and other FAQs for answers to your questions.

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March 10, 2020

February 2020 Part A Newsletter

The February 2020 Part A Newsletter is now available. Please take a moment to review.

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March 9, 2020

Special Edition – Monday, March 9, 2020

Provider Education Message:

COVID-19 Response: CMS Issues FAQs to Assist Medicare Providers

On March 6, CMS issued frequently asked questions and answers (FAQs) for health care providers regarding Medicare payment for laboratory tests and other services related to the 2019-Novel Coronavirus (COVID-19). The agency is receiving questions from providers and created this document to be transparent and share answers to some of the most common questions.

Included in the FAQs is:

- Guidance on how to bill and receive payment for testing patients at risk of COVID-19.
- Details of Medicare's payment policies for laboratory and diagnostic services, drugs, and vaccines under Medicare Part B, ambulance services, and other medical services delivered by physicians, hospitals, and facilities accepting government resources.
- Information on billing for telehealth or in-home provider services. Since 2019, the Trump Administration has expanded flexibilities for CMS to pay providers for virtual check-ins and other digital communications with patients, which will make it easier for sick patients to stay home and lower the risk of spreading the infection.

This FAQ, and earlier CMS actions in response to the COVID-19 virus are part of the ongoing White House Task Force efforts. To keep up with the important work CMS is doing in response to COVID-19, visit the Current Emergencies website.

Below is an updated list of CMS' actions to date:

- March 5: Issued a second Healthcare Common Procedure Coding System (HCPCS) code for certain COVID-19 laboratory tests, in addition to three fact sheets about coverage and benefits for medical services related to COVID-19 for CMS programs
- March 4: Issued a call to action to health care providers nationwide and offered important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare
- February 13: Issued a new HCPCS code for providers and laboratories to test patients for COVID-19

- February 6: Gave CLIA-certified laboratories information about how they can test for SARS-CoV-2
- February 6: Issued a memo to help the nation's health care facilities take critical steps to prepare for COVID-19

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11680 – April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1

  Change Request 11680 provides updated I/OCE instructions and specifications for April 1, 2020. Please make sure your billing staff is aware of this update.

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March 6, 2020

MLN Connects Special Edition for Friday, March 6, 2020

Provider Education Message:

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for

them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies.

Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: CMS Announces Actions to Address Spread of Coronavirus.

On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

On February 6, 2020, CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: Suspension of Survey Activities memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

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March 5, 2020

CMS Provider Education Message:

Ambulance Fee Schedule, Transports & Data Collection

MLN Connects® for Thursday, March 5, 2020

View this edition as a PDF

News

- DMEPOS Suppliers: HCPCS Codes Affected by Further Consolidated Appropriations Act
- Medicare Promoting Interoperability Program: CAH Reconsideration Forms due March 6
- Medicare Promoting Interoperability Program: Submit Proposals for New Measures by July 1
- PEPPERs for Short-term Acute Care Hospitals
- 2018 Geographic Variation Public Use File
- Help Your Patients Make Informed Food Choices

Compliance

- Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

- Average Sales Price Files: April 2020

Events

- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19
- Anesthesia Modifiers: Comparative Billing Report Webinar — March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2
- LTCH and IRF Quality Reporting Programs: SPADEs In-Depth Training Event — June 9-10

MLN Matters® Articles

- Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) -- July 2020 Update

Publications

- Administrative Simplification: Claim Status Basics
- Hospice Quality Reporting Program: Timeliness Compliance Threshold for HIS Submissions
- Guide to Reducing Chronic Kidney Disease Disparities in the Primary Care Setting

Multimedia

- Ambulance Services Call: Audio Recording and Transcript

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February 2020 top claim submission errors

The February 2020 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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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20001 – Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

  The Centers for Medicare & Medicaid Services is aware that some providers are submitting claims incorrectly to Medicare using healthcare common procedure code L8679. This article reminds providers of Medicare policy regarding these devices. Make sure your billing staff are aware of the correct policy.

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March 4, 2020

Special Edition – Wednesday, March 4, 2020

Provider Education Message:

CMS Announces Actions to Address Spread of Coronavirus

CMS calls on all health care providers to activate infection control practices and issues guidance to inspectors as they inspect facilities affected by Coronavirus

On March 4, the Centers for Medicare & Medicaid Services (CMS) announced several actions aimed at limiting the spread of the Novel Coronavirus 2019 (COVID-19). Specifically, CMS is issuing a call to action to health care providers across the country to ensure they are implementing their infection control procedures, which they are required to maintain at all times. Additionally, CMS is announcing that, effective immediately and, until further notice, State Survey Agencies and Accrediting Organizations will focus their facility inspections exclusively on issues related to infection control and other serious health and safety threats, like allegations of abuse – beginning with nursing homes and hospitals. Critically, this shift in approach, first announced yesterday by Vice President Pence, will allow inspectors to focus their energies on addressing the spread of COVID-19.

As the agency responsible for Medicare and Medicaid, CMS requires facilities to maintain infection control and prevention policies as a condition for participation in the programs. CMS is also issuing three memoranda to State Survey Agencies, State Survey Agency directors and Accrediting Organizations – to inspect thousands of Medicare-participating health care providers across the country, including nursing homes and hospitals.

“Today’s actions, taken together, represent a call to action across the health care system,” said CMS Administrator Seema Verma. “All health care providers must immediately review their procedures to ensure compliance with CMS’ infection control requirements, as well as the guidelines from the Centers for Disease Control and Prevention (CDC). We sincerely appreciate the proactive efforts of the nursing home and hospital associations that have already galvanized to provide up-to-the-minute information to their members. We must continue working together to keep American patients and residents safe and healthy and prevent the spread of COVID-19.”

The first memorandum provides important detail with respect to the temporary focus of surveys on infection control and other emergent issues. Importantly, it notes that, in addition to the focused inspections, statutorily-required inspections will also continue in the 15,000 nursing homes across the

country using the approximately 8,200 state survey agency surveyors. Surveys will be conducted according to the following regime:

- All immediate jeopardy complaints (a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect;
- Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses;
- Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities);
- Any re-visits necessary to resolve current enforcement actions;
- Initial certifications;
- Surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years;
- Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy.

The memorandum also includes protocols for the inspection process in situations in which COVID-19 is identified or suspected. These protocols include working closely with CMS regional offices, coordinating with CDC, and other relevant agencies at all levels of government. The agency is also providing key guidance related to inspectors' usage of adequate personal protective equipment.

The other two memoranda provide critical answers to common questions that nursing homes and hospitals may have with respect to addressing cases of COVID-19. For example, the memoranda discuss concerns like screening staff and visitors with questions about recent travel to countries with known cases and the severity of infection that would warrant hospitalization instead of self-isolation. They detail the process for transferring patients between nursing homes and hospitals in cases for which COVID-19 is suspected or diagnosed. They also describe the circumstances under which providers should take precautionary measures (like isolation and mask wearing) for patients and residents diagnosed with COVID-19, or showing signs and symptoms of COVID-19.

Finally, the agency is announcing that it has deployed an infection prevention specialist to CDC's Atlanta headquarters to assist with real-time in guidance development.

These actions from CMS are focused on protecting American patients and residents by ensuring health care facilities have up-to-date information to adequately respond to COVID-19 concerns while also making it clear to providers that as always, CMS will hold them accountable for effective infection control standards. The agency is also supplying inspectors with necessary and timely information to safely and accurately inspect facilities.

To view each memo, please visit:

- Suspension of Survey Activities
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

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A/B MAC and DME MAC collaborative nebulizer webinar

Your A/B MAC and DME MAC education staff are excited to bring you another collaborative webinar opportunity. Please join us on March 18, 2020, at 2:00 PM Eastern (1:00 PM Central) as we detail the coverage criteria for inhalation medication and nebulizers. The standard written order will also be discussed during the webinar. After the presentation portion of the webinar, the educators will take questions from attendees.

Register today.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20006 – NCD 20.4 Implantable Cardiac Defibrillators (ICDs)

  Special Edition (SE) 20006 updates providers on Medicare coverage rules and policies for National Coverage Determination (NCD) 20.4 – Implantable Cardiac Defibrillators (ICDs). SE20006 outlines the coding requirements (including the heart failure codes) and is not more restrictive than the NCD. Please make sure your billing staffs are aware of these updates.

- SE20009 – Section 1876 and 1833 Cost Plan Enrollee Access to Care through Original Medicare

  This Medicare learning network matters article reinforces existing Medicare policy that allows non-network providers to bill original Medicare for services provided to Medicare cost plan enrollees.

Revised:

- SE1418 – Proper Use of Modifier 59

  This special edition article is being provided by the Centers for Medicare & Medicaid Services to clarify the proper use of Modifiers 59 and –X{EPSU}. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of Modifiers 59 and –X{EPSU}.

- MM11661 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update

  The Centers for Medicare & Medicaid Services revised this article on February 27, 2020, to reflect the revised Change Request (CR)11661 issued on that date. In the article, we changed the MP relative value units for code G2013 in Table 2 to 0.28. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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Conditional payment

A provider may submit a claim to Medicare for conditional payment for services for which another payer is responsible. If payment has not been made or cannot be expected to be made promptly from the other payer, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment or when a settlement, judgment, award, or other payment is secured. Be sure to follow the guidelines in this article to ensure proper claim processing for a conditional payment request.

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March 3, 2020

The 2020 MSI is Here: Evaluate Our Services!

The MAC Satisfaction Indicator (MSI) is the best way to share your opinions directly with the Centers for Medicare & Medicaid Services (CMS) about your experience with us. These survey results will help us gain valuable insights and determine process improvements.

https://www.surveygizmo.com/s3/5439699/?MAC_BRNC=8&MAC=JL-Novitas

Thank you for your feedback.

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Novitas listened to you and wants to say "Thanks!"

Our Novitas Solutions team would like to take a moment to say ‘thank you’ to our providers. We appreciate the feedback you provided us in the last year through surveys such as the MSI. Your opinion of the service we provide matters to us. Over the past year, we’ve implemented several improvements influenced by how we can better serve you. Here are some of the positive changes:

- Customer service: We’re decreasing the time it takes to resolve your complex questions. We reduced our average callback rate by almost 50% for telephone inquiries, providing resolution to your questions at first contact.
- Written Inquiries: We reduced our overall processing time by 20%, answering your written inquiries within an average of 35 days. Our intent is to further improve our response time in 2020.
- Provider Outreach and Education: We completed our project to streamline our website’s content centers to allow you to find popular topics and new self-service tools (including a modifier lookup and an enrollment decision tree) even faster.
- Website Usability: We enhanced our web search for cleaner results and upgraded our navigation and layout for easier mouse use on desktops as well as touchscreen tablets and phones.

To these points, as well as others you have brought our way in the past, we say "Thank you!" We look forward to our continued partnership.

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February 28, 2020

The 2020 MAC Satisfaction Indicator (MSI): Coming in March

The 2020 Medicare administrative contractor (MAC) Satisfaction Indicator (MSI), a survey administered by the Centers for Medicare & Medicaid Services (CMS), is coming in March. The MSI measures your satisfaction with our processes and service delivery so we can gain valuable insights and determine process improvements.

We appreciate your feedback in 2019. Novitas Solutions used your feedback and survey results to make improvements to our services that better serve you. Watch for an announcement on our website on how you can participate in the 2020 survey.

For additional information on the survey, you may visit the MSI page and the MSI frequently asked questions on the CMS website.

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February 27, 2020

CMS Provider Education Message:

COVID-19 Coding Guidance

MLN Connects® for Thursday, February 27, 2020

View this edition as a PDF

News

- Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31
- Anesthesia Modifiers: Comparative Billing Report in March

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Claims, Pricers & Codes

- COVID-19: New ICD-10-CM Code and Interim Coding Guidance
- SNF PDPM Claims Issue
- FQHC: Mass Adjustment of Claims

Events

- Dementia Care: CMS Toolkits Call — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19

MLN Matters® Articles

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update
- Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims — Revised
- Accepting Payment from Patients with a Medicare Set-Aside Arrangement — Revised
- January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 — Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2
- Quality Payment Program: 2020 Resources

.

February 26, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11655 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) -- July 2020 Update

  Change request 11655 informs providers about updated ICD-10 conversions as well as coding updates specific to NCDs. Please make sure your billing staffs are aware of these updates.

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February 25, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20007 – Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements

  Special Edition 20007 informs providers that the Calendar Year 2020 End Stage Renal Disease Prospective Payment System Final Rule CMS-1713-F (84 Fed. Reg Vol 217) (https://www.federalregister.gov/documents/2019/11/08/2019-24063/medicare-program-end-stage-renal-disease-prospective-payment-system-payment-for-renal-dialysis) goes into effect January 1, 2020.

  This rule, in part, streamlines the requirements for ordering DMEPOS items through the identification of a standard set of elements to be included in a written order/prescription. It also develops a new Master List of DMEPOS items potentially subject to a face-to-face encounter, written orders prior to delivery and, or prior authorization requirements as a condition of payment (thereby harmonizing prior lists). This standard written order and Master list will simplify the ordering of DMEPOS items and eliminate multiple lists of DMEPOS items potentially subject to conditions of payment.

- MM11638 – Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  Change Request 11638 updates the RARC and CARC lists and instructs the ViPS Medicare System and Fiscal Intermediary Shared System maintainers to update MREP and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print versions if they use that software.

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February 21, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE17019 – Accepting Payment from Patients with a Medicare Set-Aside Arrangement

  The Centers for Medicare & Medicaid services revised this article on February 19, 2020, to add information about submitting electronic attestations via the WCMSAP. This is in the Additional Information Section of the article. We added a note on page 2, regarding workers' compensation Medicare set-aside arrangement (WCMSA) funds. We also updated the link to an updated version of the WCMSA Reference Guide. All other information remains the same.

- SE20002 – Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims

The Centers for Medicare & Medicaid services revised this article on February 20, 2020, to include the listing of clinical decision support mechanisms (CDSMs) (page 6) and to update paper billing instruction to direct providers to the National uniform billing committee for instructions on reporting the ordering physician national provider identifier (page 2) and special reporting required for the CDSMs using Healthcare Common Procedure Coding System G1011 on paper claims (page 3). The article release date was also changed. All other information is the same.

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February 20, 2020

CMS Provider Education Message:

Bill Correctly for Medicare Telehealth Services

MLN Connects® for Thursday, February 20, 2020

View this edition as a PDF

News

- CMS Develops New Code for Coronavirus Lab Test
- CMS Program Statistics: 2018 Data
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Bill Correctly for Medicare Telehealth Services

Events

- Dementia Care: CMS Toolkits Call — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19

MLN Matters® Articles

- The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)
- Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)
- New Medicare Beneficiary Identifier (MBI) Get It, Use It — Revised
- What New Home Health Agencies (HHAs) Need to Know about Being Placed in a Provisional Period of Enhanced Oversight — Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - April 2020 Update — Revised

Publications

- Administrative Simplification: EFT and ERA Transactions

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February 19, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11661 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update

  Change request (CR) 11661 informs you that the Centers for Medicare & Medicaid Services issued payment files to the Medicare administrative contractors based upon the 2020 MPFS Final Rule, published in the Federal register on November 15, 2019. CR 11661 amends those payment files. Make sure your billing staffs are aware of these changes.

- MM11616 – Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment

  Change request 11616 prepares the Medicare claims processing systems to calculate the LTCH prospective payment system payment when an LTCH is subject to the discharge payment percentage payment adjustment. Please be sure your billing staffs are aware of these updates.

Revised:

- MM11564 – January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0

  The Centers for Medicare & Medicaid Services revised this article on February 13, 2020, due to a revised Change Request (CR) that added two new attachments due to legislation. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

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February 18, 2020

Claims timely filing calculator

Novitas has developed a Claims Timely Filing Calculator to assist you in determining the timely filing limit for your services. In general, Medicare claims must be filed to the Medicare claims processing contractor no later than 12 months, or 1 calendar year, from the date the services were furnished. For institutional claims that include span dates of service (i.e., a “from” and “through” date span on the claim), the “through” date on the claim is used for determining the date of service for claims filing timeliness. For professional claims submitted by physicians and other suppliers that include span dates of service, the line item “from” date is used for determining the date of service for claims filing timeliness.

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February 17, 2020

Qualified independent contractor PAE appeals demonstration newsletter

C2C Innovative Solutions has added their February 2020 newsletter to the Part A east (PAE) 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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February 13, 2020

CMS Provider Education Message:

Protect Your Patients from Influenza

MLN Connects® for Thursday, February 13, 2020

View this edition as a PDF

News

- DMEPOS Items Subject to Prior Authorization
- Influenza Activity Continues: Are Your Patients Protected?

Compliance

- Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing

Events

- Substance Use Disorders: Availability of Benefits Listening Session — February 18
- Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20
- Dementia Care: CMS Toolkits Call — March 3
- Hospice Item Set Data Submission Requirements Webinar — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12

MLN Matters® Articles

- Update to the Home Health Grouper for New Diagnosis Code for Vaping Related Disorder
- Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy
- Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder — Revised
- January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised

Publications

- Diabetes Management Resources
- Caring for Medicare Patients is a Partnership — Revised

Multimedia

- MAC Listening Session: Audio Recording and Transcript

.

The following local coverage determinations (LCDs) have been revised:

- Hemophilia Factor Products (L35111)
- Hyperbaric Oxygen (HBO) Therapy (L35021)

The following billing and coding articles have been revised:

- Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)

- Billing and coding: Biomarkers Overview (A56541)
- Billing and coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- 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: Intensity Modulated Radiation Therapy (IMRT) (A56725)
- Billing and coding: Intravenous Immune Globulin (IVIG) (A56786)
- Billing and coding: Non-Coronary Vascular Stents (A56365)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- SE18006 – New Medicare Beneficiary Identifier (MBI) Get It, Use It

  The Centers for Medicare & Medicaid Services revised the article on February 12, 2020, to add a sentence to the Medicare beneficiary identifier (MBI) look-up tool option for getting an MBI to show what happens if the beneficiary record has a date of death. All other information remains the same.

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Part A Top Inquiries / FAQs for DE, DC, MD, NJ, & PA

The Part A top inquiries / FAQs, received by our customer contact center, have been reviewed for January 2020. New questions / answers have been added to the categories listed below.

- Claim denials
- General information
- Return to provider

Please take time to review these and other FAQs for answers to your questions.

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February 12, 2019

Development requests

You can submit and track your enrollment application through the Provider Enrollment, Chain and Ownership System. If you submitted a paper application, you can view the status in our Provider Enrollment Status Tool.

If we need additional information, a development letter will be sent to the contact person listed in Section 13 of your enrollment application. It is vital that you submit the requested information within the development letter.

Note: There is a 30-day development window from the date on the letter. The quicker we receive the requested information, the faster we can process your application.

If the status shows in development and the contact person didn't receive the letter, please contact our Provider Enrollment Helpdesk to request a copy.

- JL: 1-877-235-8073, Option 4

For questions regarding the requested information in the letter, please contact your credentialing specialist. The phone number will be at the bottom of the development letter.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11632 – Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

  Change Request (CR) 11632 alerts providers that CR11152 erroneously made modifications to edits and the Centers for Medicare & Medicaid Services needs to omit and make corrections to allow for proper claims processing. Make sure your billing staffs are aware of these changes.

Revised:

- MM11491– International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2020 Update

  The Centers for Medicare & Medicaid Services (CMS) revised this article on February 10, 2020, to reflect a revised Change Request (CR) 11491, issued on February 4. The CR was revised to amend the spreadsheet for NCD 110.4. This revision did not impact the substance of the article. In the article, CMS revised the CR release date, transmittal number and the web address. All other information remains the same.

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February 11, 2020

Interactive Cost Outlier Tool

Novitas has developed an Interactive Cost Outlier Tool to assist you in determining the proper billing of your IPPS outlier claims. The tool is to be used to advise on billing scenarios and is not to be used in determining whether an outlier payment will be received.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11559 – Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy

  Change Request 11559 informs Medicare Administrative Contractors about changes to Medicare Common Working File edits to ensure the original 1-Day and 3-Day Payment Window edits' set and bypass conditions are consistent with current policy.

  There are no policy changes. Current policy is in the Medicare Claims Processing Manual, Chapter 4, Section 10.12, "Payment Window for Outpatient Services Treated as Inpatient Services" and Chapter 3, Section 40.3, "Outpatient Services Treated as Inpatient Services"

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February 10, 2020

Local coverage determination (LCD) and article update history

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 articles and finalized billing and coding articles will be related to the final LCDs when they are posted for notice.

- Magnetic-Resonance-Guided-Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (DL38495)
- Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (DL35130)

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February 7, 2020

January 2020 Part A Newsletter

The January 2020 Part A Newsletter is now available. Please take a moment to review.

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February 6, 2020

CMS Provider Education Message:

Medicare Learning Network Celebrates 20 Years

MLN Connects® for Thursday, February 6, 2020

View this edition as a PDF

News

- Open Payments Registration
- Promoting Interoperability Programs: Deadline to Submit 2019 Data is March 2
- Quality Payment Program: Updated Explore Measures Tool
- Quality Payment Program: MIPS 2020 Call for Measures and Activities
- Medicare Promoting Interoperability Program: Requirements for 2020
- SNF Quality Reporting Program: FY 2022 APU Table
- Reassignment of Medicare Benefits: Revised CMS-855R Required May 1
- February is American Heart Month

Compliance

- Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements

Claims, Pricers & Codes

- ICD-10-CM: New Diagnosis Code for Vaping-related Disorders Effective April 1

Events

- Substance Use Disorders: Availability of Benefits Listening Session — February 18
- Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20
- Dementia Care: CMS Toolkits Call — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5

MLN Matters® Articles

- Provider Enrollment Appeals Procedure
- Quarterly Influenza Virus Vaccine Code Update - July 2020
- 2020 Annual Update to the Therapy Code List — Revised
- 2020 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List — Revised

Publications

- Medicare Mental Health
- Medicare Provider Enrollment

Multimedia

- MAC Listening Session: Audio Recording and Transcript

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Diagnostic testing for sleep disorders FAQs

Our diagnostic testing for sleep disorders FAQs has been updated to include new questions and link to the Provider Compliance Tips for Polysomnography (Sleep Studies).

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February 5, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11210 – Provider Enrollment Appeals Procedure

  Change Request (CR) 11210 updates the provider enrollment policy that outlines corrective action plans and reconsideration requests. The CR also updates applicable model letters, including initial determinations, the Medicare Administrative Contractors use to advise providers and suppliers of their review rights. Please make sure your billing staffs are aware of these updates.

- MM11603 – Quarterly Influenza Virus Vaccine Code Update - July 2020

  The influenza virus vaccine code set is updated on a quarterly basis. Change Request (CR) 11603 provides instructions for payment and edits for Medicare's Common Working File and the Fiscal Intermediary Shared System to include and update new or existing influenza virus vaccine codes. In addition, the CR instructs Medicare Administrative Contractors to modify existing editing to allow influenza and a pneumococcal polysaccharide vaccine vaccination on the same date on separate roster bills. Make sure your billing staffs are aware of these changes.

Revised:

- MM11623 – Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder

  The Centers for Medicare & Medicaid services revised this article on January 31, 2020, to reflect an updated Change Request (CR) that changed the CR type from a recurring update notification to a one time notification. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

- MM11605 – January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  The Centers for Medicare & Medicaid services (CMS) revised this article on February 4, 2020, due to an updated Change Request (CR) 11605. To reflect the updated CR in the article, we added section 12.d. and section 19 extravascular implantable cardioverter defibrillator. We renumbered existing sections 12.d through 12.e. and changed section 19 to Section 20. CMS also added table 11 and Table 14. We renumbered existing tables 11 through 13. The CR release date, transmittal numbers and link to the transmittals were also changed. All other information remains the same.

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February 4, 2020

Part A Top Claims Submission / Reason Code Errors

The January 2020 top claim submission and reason code 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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February 3, 2020

The comment period will close on February 8, 2020, for the following proposed local coverage determinations (LCDs):

- Magnetic-Resonance-Guided-Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (DL38495)
- Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (DL35130)

Submit comments

January 31, 2020

2020 MEDPARD available now!

The 2020 MEDPARD (Medicare Participation Physicians / Suppliers Directory) is now available. As in the past, there will be no hardcopy distributions. Beneficiaries can use the Physician Compare website or contact 1-800-MEDICARE for assistance in locating a participating supplier near their home. Please use the following links to access the online MEDPARD Directory (JH) (JL).

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11501 – 2020 Annual Update to the Therapy Code List

  The Centers for Medicare & Medicaid Services revised this article on January 29, 2020, to reflect an updated Change Request (CR) 11501.The update removed the sentence (When furnished to hospital outpatients, these two new biofeedback services will continue to be paid

under the OPPS.) from the CR policy section (1. below) about how the two new biofeedback codes are paid when furnished to hospital outpatients. Note that the two new biofeedback codes will be paid under the Medicare Physician Fee Schedule. The CR release date, transmittal number and link to the CR also changed. All other information is unchanged.

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New inpatient rehabilitation facility (IRF) Specialty Page

We are pleased to announce the addition of inpatient rehabilitation facility (IRF) to the Provider Specialties/Services page of our website.

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January 30, 2020

CMS Provider Education Message:

Genetic Testing and Innovative Antibiotics

MLN Connects® for Thursday, January 30, 2020

View this edition as a PDF

News

- CMS Expands Coverage of NGS as Diagnostic Tool for Patients with Breast and Ovarian Cancer
- Nursing Home Quality Initiative: Draft MDS 3.0 Item Set Change History
- Nursing Homes: Use Updated Infection Control Worksheet
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Compliance

- Hospice Care: Safeguards for Medicare Patients

Claims, Pricers & Codes

- OPPS Pricer File: January 2020

Events

- Ground Ambulance Organizations: Reporting Staff and Labor Costs Open Door Forum — February 6
- Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20

MLN Matters® Articles

- Increasing Access to Innovative Antibiotics for Hospital Inpatients Using New Technology Add-On Payments: Frequently Asked Questions
- January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder
- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS — Revised

- Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications

- Safeguards for Medicare Patients in Hospice Care
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Revised
- Skilled Nursing Facility Prospective Payment System — Revised

Multimedia

- ESRD Quality Incentive Program: Audio Recording and Transcript
- MAC Listening Session: Audio Recording and Transcript

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The following local coverage determination (LCD) posted for comment on August 29, 2019, has been posted for notice. The LCD and related billing and coding article will become effective March 15, 2020:

- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38385)
  - Billing and coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (A56938)

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

- Response to comments: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A57928)

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Reimbursement survey for transport of portable x-ray equipment (R0070 and R0075)

The opportunity to complete the survey has been extended. Novitas is requesting your assistance to ensure that the Transport of portable x-ray equipment survey is submitted no later than March 31, 2020, when a final reimbursement determination will be made.

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January 27, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11623 – Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder

  Change Request 11623 announces the addition of a new ICD-10-CM code for vaping related disorder to the Medicare Severity – Diagnosis Related Groups grouper and Medicare code editor software, effective for discharges on and after April 1, 2020. Make sure your billing staffs are aware of these changes related to the new code.

Revised:

- MM11598 – Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  The Centers for Medicare & Medicaid Services revised this article on January 23, 2020, due to an updated Change Request (CR) 11598 that changed the policy section. Per the CR, the article notes that "Next Clinical Laboratory Fee Schedule Data Reporting Period — Delayed to January 2021 (page 1)." That is also noted on page 3. The article also has policy changes on page 2. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

- MM11335 – Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS

  The Centers for Medicare & Medicaid Services revised this article on January 23, 2020, due to an updated Change Request (CR) 11335 that deleted references to certain inquiry screens. In the article, we changed the CR release date, transmittal number and link to the transmittal. All other information remains the same.

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January 23, 2020

CMS Provider Education Message:

Medicare Learning Network Celebrates 20 Years

MLN Connects® for Thursday, January 23, 2020

View this edition as a PDF

News

- Medicare Learning Network Celebrates 20 Years
- CMS Updates Open Payments Data
- Open Payments Search Tool: New Features
- Shoulder Arthroscopy: Comparative Billing Report in January
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Issues Viewing the CMS Website?
- Continue Seasonal Influenza Vaccination through January and Beyond

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 29
- Shoulder Arthroscopy: Comparative Billing Report Webinar — February 4
- CMS Quality Conference — February 25-27
- Highly Pathogenic Infectious Disease Training and Exercise Resources Webinar — March 5

MLN Matters® Articles

- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020
- 2020 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List
- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation — Revised
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised

Publications

- Quality Payment Program: 2020 Resources

Multimedia

- Quality Payment Program: 2019 Data Submission Videos
- Health Care Challenges in Chemical Incidents Webinar Recording
- Infection Prevention and Control: Environmental Safety Web-Based Training Course — Revised
- Infection Prevention and Control: Hand Hygiene Web-Based Training Course — Revised
- Infection Prevention and Control: Injection Safety Web-Based Training Course — Revised

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Provider compliance tips for polysomnography (sleep studies) - Revised

A revised Provider Compliance Tips for Polysomnography (Sleep Studies) fact sheet is available. Learn about coverage requirements, documentation, and how to prevent claim denials.

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Modifier 77 Fact Sheet

Our fact sheet on the proper use of modifier 77 has been updated. Please take time to review the fact sheet to ensure that you are reporting and documenting the modifier correctly.

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January 22, 2020

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11641 – Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

  Change Request 11641 revises the payment of travel allowances when billed on a per mileage basis using Healthcare Common Procedure Code System (HCPCS) code P9603 and when billed on a flat rate basis using HCPCS code P9604 for Calendar Year 2020. Make sure your billing staffs are aware of these changes.
- MM11605 – January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Change Request 11605 describes changes to and billing instructions for various payment policies that Medicare is implementing in the January 2020 OPPS update. Make sure your billing staffs are aware of these changes.

- SE20004 – Increasing Access to Innovative Antibiotics for Hospital Inpatients Using New Technology Add-On Payments: Frequently Asked Questions

  This Medicare Learning Network Matters Special Edition Article informs providers of changes made by the Centers for Medicare & Medicaid Services to develop an alternative New Technology Add-On Payment (NTAP) to increase access to innovative antibiotics for hospital inpatients. Special Edition 20004 answers Frequently Asked Questions about NTAP.

Revised:

- MM11003 – Implementation to Exchange the list of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System

  The Centers for Medicare & Medicaid Services revised this article on January 16, 2020, to link to Change Request 11141, which shows the effective date is now February 3, 2020. All other information remains the same.

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January 17, 2020

Direct Data Entry (DDE) screen changes-Update

The Fiscal Intermediary Shared System Manual has been updated to include the New Healthcare Common Procedure Coding System (HCPCS) Information Inquiry screens (MAP1E01 & MAP1E02). In addition, the Inquiry Menu (MAP1702) was updated to add New HCPC Screen menu selection, 1E.

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January 16, 2020

CMS Provider Education Message:

Quality Payment Program: Learn About the MIPS 2020 Performance Period

MLN Connects® for Thursday, January 16, 2020

View this edition as a PDF

News

- CMS Reduces Psychiatric Hospital Burden with New Survey Process
- Quality Payment Program: MIPS 2020 Payment Adjustments
- Quality Payment Program: New MIPS Participation Framework for 2021 Performance Period
- Part A Providers: Talk to a QIC Adjudicator About Your Appeal
- Comparative Billing Reports: Access via CBR Portal
- January is Cervical Health Awareness Month

Compliance

- Bill Correctly for Polysomnography Services

Events

- Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 22 or 29
- Quality Payment Program: MIPS for 2020 Performance Period Webinar — January 22

MLN Matters® Articles

- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Encounters
- Medicare Fee-for-Service (FFS) Response to the 2020 Commonwealth of Puerto Rico Earthquakes
- January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0
- Manual Updates Related to Calendar Year (CY) 2020 Home Health Payment Policy Changes, Maintenance Therapy, and Remote Patient Monitoring
- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System — Revised
- Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment — Revised
- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS — Revised
- CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule — Revised
- Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

Publications

- Provider Compliance Tips for Polysomnography (Sleep Studies) - Revised

.

The following local coverage determination (LCD) has been revised.

- Wound Care (L35125)

The following articles have been revised to reflect the annual CPT/HCPCS code updates effective for dates of service on and after January 1, 2020:

- Billing and coding: Anorectal Manometry, Anal Electromyography, and Biofeedback Training for Perineal Muscles and Anorectal or Urethral Sphincters (A56530)
- Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)
- Billing and coding: Barium Swallow Studies, Modified (A56589)
- Billing and coding: Biomarkers for Oncology (A52986)
- Billing and coding: Cardiac Rhythm Device Evaluation (A56602)
- Billing and coding: Cataract Extraction (including Complex Cataract Surgery) (A56615)
- Billing and coding: Cosmetic and Reconstructive Surgery (A56587)
- Billing and coding: Endovascular Repair of Aortic and/or Iliac Aneurysms (A53124)
- Billing and coding: Independent Diagnostic Testing Facility (IDTF) (A53252)

- Billing and coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions (A53134)
- Billing and coding: Non-Invasive Peripheral Venous Studies (A52993)
- Billing and coding: Pulmonary Function Testing (A57320)
- Billing and coding: Services That Are Not Reasonable and Necessary (A56967)
- Billing and coding: Speech Language Pathology (SLP) Services: Communication Disorders (A54111)
- Billing and coding: Therapy and Rehabilitation Services (PT, OT) (A57703)
- Billing and coding: Wound Care (A53001)

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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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January 14, 2020

Two new aays to communicate with our Website & Portal teams

We are pleased to announce two new, easy ways to send comments to the Novitas Solutions website and portal teams.

While accessing our provider website and Novitasphere, you may be invited to complete a satisfaction survey though a message bar that appears across the top of your browsing window. This optional survey gives you the chance to rate your satisfaction with your visit, answer a few questions about why you came to the website or portal today, and if you were able to accomplish your task. This survey is offered at random.

Additionally, a new “feedback” tab, which appears as a button on the right side of your screen, offers an instant way to leave direct comments on that particular page or function. The Feedback feature is available to all customers at all times.

Thank you in advance for your participation. Your opinion is important to us, and we look forward to hearing from you soon.

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December 2019 Part A Newsletter

The December 2019 Part A Newsletter is now available. Please take a moment to review.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE2003– Medicare Fee-for-Service (FFS) Response to the 2020 Commonwealth of Puerto Rico Earthquakes

  The Secretary of the Department of Health & Human Services declared a Public Health Emergency in the Commonwealth of Puerto Rico on January 8, 2020, and authorized waivers

and modifications under Section 1135 of the Social Security Act (the Act), retroactive to December 28, 2019, and are in effect for 90 days.

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January 13, 2020

Upcoming Direct Data Entry (DDE) screen changes

Effective January 20, 2020, two new Healthcare Common Procedure Coding System (HCPCS) screens (MAP1E01/MAP1E02) will be added to the Fiscal Intermediary Shared System (FISS). These new screens allow you to view HCPCS in DDE. Additionally, the Inquiry Menu (MAP1702) will be updated to include 1E-New HCPC Screen. Our online FISS Manual will be updated shortly to reflect these changes.

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE20002 – Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims

  This article provides guidance for processing claims for certain institutional claims that are subject to the AUC program for advanced diagnostic imaging services. The Centers for Medicare & Medicaid Services (CMS) will begin to accept claims with this information as of January 1, 2020. This is the beginning of the education and operations testing period for the AUC program. While there will not be payment penalties during this period, stakeholders and CMS can use this time to practice reporting and accepting AUC information on claims. The K3 segment will be used to report line level ordering professional information on institutional claims.

  For other claims processing information for the AUC program including Healthcare Common Procedure Code System modifiers and codes, please see Medicare Learning Network Matters article MM11268, Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements. For general information regarding the AUC program please visit the CMS website.

Revised:

- MM11513 – Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

  The Centers for Medicare & Medicaid Services (CMS) revise this article on January 10, 2020, to reflect an updated Change Request (CR) that changed the CR type from a One Time Notification to a Standard CR type, which adds a manual attachment that updates Chapter 6 of CMS publication 100-04. This correction also revises the CR background section and adds two new requirements (11513.4 and 11513.5), which are included in this article at the end of the Background Section. All other information remains the same.

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January 10, 2020

2020 complete fee schedule download files are available

Please note that due to legislative changes just before the end of 2019, you may have downloaded previously posted fee schedule files with amounts that have changed since first announced in November. We are recommending that customers who have saved downloaded files in PDF, Text, or Excel formats visit our Fee Lookup Tool and download current versions of any files to ensure that you have the correct data to reference.

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January 9, 2020

CMS Provider Education Message:

Read the Latest Quality Payment Program Updates

MLN Connects® for Thursday, January 9, 2020

View this edition as a PDF

News

- Quality Payment Program: 2018 Performance Data
- Quality Payment Program APM Incentive Payment: Verify Banking Information
- Quality Payment Program: Participation Status Tool Includes Third Snapshot of Data
- Quality Payment Program: Recheck Your Final 2019 MIPS Eligibility
- Quality Payment Program: Check Your Initial 2020 MIPS Eligibility
- Quality Payment Program: Qualified Registries and QCDRs for CY 2020
- Hospice Provider Preview Reports: Review Your Data by January 15
- Feedback on Scope of Practice: Send Recommendations by January 17
- Promoting Interoperability Programs: Deadline to Submit 2019 Data is March 2
- Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31
- Hospitals: New Beneficiary Notices (IM, DND, and MOON) Required April 1
- Hospital Outpatient Departments: Prior Authorization Process Begins July 1
- Home Health Compare: Preview Reports for April Refresh
- Clinical Laboratory Data Reporting Delayed
- ICD-10-CM Browser Tool
- Provider Enrollment Application Fee Amount for CY 2020
- Nursing Home Quality Initiative: Draft 2020 MDS Item Sets
- Hospice Quality Reporting Program News
- Qualified Medicare Beneficiary Billing Requirements
- Get Your Patients Off to a Healthy Start in 2020
- Looking for Educational Materials?

Compliance

- Chiropractic Services: Comply with Medicare Billing Requirements

Events

- Quality Payment Program: QCDR Measures Webinar — January 13

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14
- Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 15, 22, or 29

MLN Matters® Articles

- Internet Only Manual Update to Pub 100-04, Chapter 16, Section 40.8 – Laboratory Date of Service Policy
- IVIG Demonstration: Payment Update for 2020
- January 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- Manual Update to Publication (Pub.) 100-04, Chapter 20, to Revise the Subsection 10 - Where to Bill Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Items and Services
- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update
- New Medicare Beneficiary Identifier (MBI) Get It, Use It — Reissued
- Home Health Patient-Driven Groupings Model (PDGM) -Split Implementation — Revised

Publications

- MLN Catalog – January 2020 Edition
- Quality Payment Program and MIPS Resources
- Diabetes Resources
- Hospice Payment System — Revised
- Medicare Diabetes Prevention and Diabetes Self-Management Training — Revised
- Provider Compliance Tips for Hospital Based Hospice — Revised

Multimedia

- eCQM: CMS Measure Collaboration Workspace

.

Part A Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part A Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for December 2019. 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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Part A Top Claims Submission / Reason Code Errors

The December 2019 Top Claim Submission / Reason Code 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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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11564 – January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0

  This article, based on Change Request (CR) 11564, informs Medicare Administrative Contractors (MACs), including

  Home Health and Hospice MACs, and the Fiscal Intermediary Shared System that the I/OCE is being updated for January 1, 2020. The I/OCE routes all institutional outpatient claims (which includes non-Outpatient Prospective Payment System (OPPS) hospital claims) through a single integrated OCE.

  CR 11564 provides the Integrated OCE instructions and specifications for the Medicare Integrated OCE version 21.0 that will be used as follows:

  - Under the OPPS
  - For Non-OPPS for hospital outpatient departments, community mental health centers, and all non-OPPS providers
  - For limited services when provided in a home health agency not under the Home Health Prospective Payment System
  - For a hospice patient for the treatment of a non-terminal illness

  Make sure your billing staffs are aware of these changes.

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January 7, 2020

Direct Data Entry (DDE) screen changes-Update

The Fiscal Intermediary Shared System Manual has been updated to include new Eligibility screens: PBRO Auxiliary File Inquiry (MAP175Q) for information on the Radiation Oncology Model, and MAP175M for additional Bone Density Study codes. In addition, the Claims and Attachments Correction Menu (MAP1704) was updated to remove the Therapy Attachment Option.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11570 – CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  The Centers for Medicare & Medicaid Services revised this article on January 3, 2020, to reflect an updated Change request (CR) that corrected the Calendar Year 2020 maintenance and servicing fee for certain oxygen equipment to $73.02 in the CR' s business requirement 11570.9. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same.

Reissued:

- SE18006 – New Medicare Beneficiary Identifier (MBI) Get It, Use It

  The Centers for Medicare & Medicaid Services reissued this article on January 2, 2020, to update certain language to show the use of the MBI is fully implemented.

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January 6, 2020

Direct Data Entry (DDE) screen changes

Effective January 6, 2020, the Eligibility Detail Inquiry or MAP1751 in the Fiscal Intermediary Shared System (FISS) was modified to add new screen PBRO Auxiliary File Inquiry or MAP175Q. This new screen will provide information on the Radiation Oncology Model. In addition, Claims and Attachments Correction Menu or MAP1704, is being updated to remove the Therapy Attachment Options. Our online FISS Manual will be updated shortly to reflect these changes.

January 2, 2020

Online registration available for January 16, 2020, Open meeting and proposed LCDs now posted

Online registration for the January 16, 2020, Open Meeting is now available and will close at 3:00 PM Eastern Time (ET) on Monday, January 13, 2020, or before January 13th if room capacity is filled. The Novitas Solutions Proposed Local Coverage Determinations (LCDs) are now posted. **Important:** The open meeting will be held at Novitas Solutions, 2020 Technology Parkway, Suite 100, Mechanicsburg, PA 17050 at 10:00 AM ET. Due to limited room capacity, registered presenters will be given priority for seating and registered observers will be accepted until remaining seats are filled**.**

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.

December 30, 2019

The following local coverage determinations (LCDs) which were posted for notice on November 14, 2019, are now effective. The related billing and coding articles for these LCDs are also now effective:

- 4Kscore Test Algorithm (L37792)
  - Billing and Ccoding: 4Kscore Test Algorithm (A56653)
- 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)
- Micro-Invasive Glaucoma Surgery (MIGS) (L38223)
  - Billing and coding: Micro-Invasive Glaucoma Surgery (MIGS) (A56633)

Please note: Billing and coding: 4Kscore test algorithm article (A56281) will be retired effective 12/29/2019. Please refer to A56653 for services on and after 12/30/2019.

December 26, 2019

The following local coverage determinations (LCDs) has have been posted for comments. The comment period will end on February 8, 2020.

- Magnetic-Resonance-Guided-Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (DL38495)
- Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (DL35130)

Submit Comments

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

- Billing and coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (DA57839)
- Billing and coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (DA57752)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11574 – Internet Only Manual Update to Pub 100-04, Chapter 16, Section 40.8 – Laboratory Date of Service Policy

  Change Request 11574 updates the Laboratory Date of Service Policy in the Medicare Claims Processing Manual, Chapter 16, Section 40.8. Make sure your billing staffs are aware of these updates.

- MM11575 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

  Change Request 11575 revises Medicare Benefit Policy, Chapter 13 RHC and FQHC Services to clarify payment and other policy information.

- MM11554 – Manual Update to Publication (Pub.) 100-04, Chapter 20, to Revise the Subsection 10 - Where to Bill Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Items and Services

  Change Request (CR) 11554 updates the Medicare Claims Processing Manual with previously published instructions from CR 5917 Claims Jurisdiction and Enrollment Procedures for Suppliers of Certain Prosthetics, Durable Medical Equipment (DME) and Replacement Parts, Accessories and Supplies (Transmittal 1603, September 26, 2008) and CR 6573 Additional Instructions on Processing Claims for DMEPOS Items Submitted Under the Guidelines Established in CR5917 (Transmittal 531, August 14, 2009). CR 11554 does not convey any Medicare policy changes.

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December 23, 2019

Special Edition – Monday, December 23, 2019

Provider Education Message:

New Medicare Card Transition Ends Next Week: Claim Reject Codes Beginning January 1

Get paid. Use Medicare Beneficiary Identifiers (MBIs) now. If you do not use MBIs on claims (with a few exceptions) after January 1, regardless of the date of service, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

How can you get the MBI? If your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in English or Spanish.
- Use your Medicare Administrative Contractor's look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. Until December 31, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN).

See the MLN Matters Article to learn how to get and use MBIs.

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Provider enrollment application fee amount for CY 2020

On November 12, CMS issued a notice: Provider enrollment application fee amount for calendar year 2020 [CMS–6089–N (https://go.usa.gov/xppFM)]. Effective January 1, 2020, the application fee is $595 for institutional providers that are:

- Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP);
- Revalidating their Medicare, Medicaid, or CHIP enrollment; or
- Adding a new Medicare practice location.

This fee is required with any enrollment application submitted from January 1 through December 31, 2020.

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December 20, 2019

New look to local coverage determinations (LCDs) and billing and coding articles

Consistent with the instruction in Change Request (CR) 10901, the Medical Policy Team has been working to relocate all coding information from our local coverage determinations (LCDs) into related billing and coding articles. This project was completed on November 21, 2019. Therefore, you will now find all coding information in billing and coding articles. In order to better assist you in finding the related billing and coding article, a link has been placed at the bottom of the LCDs.

The Novitas Solutions Medical Policy team has evaluated all active local coverage articles for any impact in response to the 2020 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.

- A56530 - Billing and coding: Anorectal Manometry, Anal Electromyography, and Biofeedback Training for Perineal Muscles and Anorectal or Urethral Sphincters
- A54117 - Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds

- A56589 - Billing and coding: Barium Swallow Studies, Modified
- A52986 - Billing and coding: Biomarkers for Oncology
- A56602 - Billing and coding: Cardiac Rhythm Device Evaluation
- A56615 - Billing and coding: Cataract Extraction (including Complex Cataract Surgery)
- A56587 - Billing and coding: Cosmetic and Reconstructive Surgery
- A53124 - Billing and coding: Endovascular Repair of Aortic and/or Iliac Aneurysms
- A53252 - Billing and coding: Independent Diagnostic Testing Facility (IDTF)
- A53134 - Billing and coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions
- A52993 - Billing and coding: Non-Invasive Peripheral Venous Studies
- A57320 - Billing and coding: Pulmonary Function Testing
- A56967 - Billing and coding: Services That Are Not Reasonable and Necessary
- A54111 - Billing and coding: Speech-Language Pathology (SLP) Services: Communication Disorders
- A57703 - Billing and coding: Therapy and Rehabilitation Services (PT, OT)
- A53001 - Billing and coding: Wound Care

.

December 19, 2019

CMS Provider Education Message:

MAC Operations: Provide Feedback at a Listening Session

MLN Connects® for Thursday, December 19, 2019

View this edition as a PDF

News

- DMEPOS: Changes to Conditions of Payment Reduce Burden
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Mohs Microsurgery: Comparative Billing Report in December
- Hospice Provider Preview Reports: Review Your Data by January 15
- Hospice Providers: Volunteer for Alpha Testing of HOPE Assessment Instrument
- LTCH Compare Refresh
- IRF Compare Refresh
- 2020 Eligible Clinician Electronic Clinical Quality Measure Flows
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments: Updated

Events

- Mohs Microsurgery: Comparative Billing Report Webinar — January 7
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14
- Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 15, 22, or 29

MLN Matters® Articles

- Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2020
- Update Inpatient Prospective Payment System (IPPS) Pricer and Related Claims Reprocessing
- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS — Revised
- Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment — Revised
- Looking for an MLN Matters Article?

Publications

- Hospital Quality Reporting: QRDA I Conformance Statement Resource

Multimedia

- Ambulance Services Call: Audio Recording and Transcript

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11598 – Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  Change Request 11598 provides instructions for the CY 2020 CLFS, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

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December 17, 2019

Provider Education Message:

Special Edition – Tuesday, December 17, 2019

Provider Education Message:

New Medicare Card Transition Ends in 2 Weeks: Use MBIs Now to Get Paid January 1

The 21 month Medicare Beneficiary identifier (MBI) transition period ends in two weeks. Update your patients' records and use MBIs now. Starting January 1, you must use MBIs to bill Medicare regardless of the date of service:

- We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few exceptions
- We will reject all eligibility transactions submitted with HICNs

Need the MBI?

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in English (PDF) or Spanish (PDF).
- Use your Medicare Administrative Contractor's look-up tool. Sign up (PDF) for the Portal to use the tool.
- Check the remittance advice. Until December 31, we return the MBI on the remittance advice for every claim with a valid and active HICN.

MBI on a Patient's Card Doesn't work?

Medicare beneficiaries, their authorized representatives, or CMS can ask to change MBIs; for example, if the number is compromised. It is possible your patient will seek care before getting a new card with the new MBI.

If you get an eligibility transaction error code (AAA 72) of "invalid member ID," your patient's MBI may have changed.

- Do a historic eligibility search to get the termination date of the old MBI.
- Get the new MBI from your Medicare Administrative Contractor's secure look-up tool. Sign up (PDF) for the Portal to use the tool.

See the MLN Matters Article (PDF) for answers to your questions on using MBIs.

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Part A Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part A Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for November 2019. New questions / answers have been added to the Eligibility/Entitlement category. Please take time to review these and other FAQs for answers to your questions.

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December 16, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11583 – Update Inpatient Prospective Payment System (IPPS) Pricer and Related Claims Reprocessing

  Change Request 11583 updates the Fiscal Year 2020 IPPS Pricer with a corrected version of the wage index table and provides direction to reprocess claims affected by the incorrect version. Make sure your billing staff is aware of this change.
- MM11593 – Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2020

Change Request 11593 announces the changes that will be included in the April 2020 quarterly release of the edit module for clinical diagnostic laboratory services. Please be sure your billing staffs are aware of these updates.

Revised:

- MM11335 – Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS

  The Centers for Medicare & Medicaid Services (CMS) revised this article on December 13, 2019, due to an updated Change Request (CR) that added the business requirement 11335.9 in the CR for contractor integration testing. CMS also changed the CR release date, transmittal number and link to the transmittal. All other information remains the same.

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November 2019 Part A Newsletter

The November 2018 Part A Newsletter is now available. Please take a moment to review.

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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 comment articles and finalized billing and coding articles will be related to the final LCDs when they are posted for notice.

- Biomarkers for Oncology (DL35396)
- Thrombolytic Agents (DL35428)

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December 12, 2019

CMS Provider Education Message:

Quality Payment Program: Your MIPS Eligibility Status

MLN Connects® for Thursday, December 12, 2019

View this edition as a PDF

News

- Open Payments: Review and Dispute Data by December 31
- LTCH Provider Preview Reports: Review Your Data by January 9
- IRF Provider Preview Reports: Review Your Data by January 9
- Quality Payment Program: Check Your Final 2019 MIPS Eligibility Status
- Quality Payment Program: MIPS Low-Volume Threshold Criteria for 2019
- Home Health Agencies: OASIS Considerations for PDGM Transition

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments

Events

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14

MLN Matters® Articles

- Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment
- CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Summary of Policies in the Calendar Year (CY) 2020 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
- Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements — Revised
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020 — Revised
- Looking for an MLN Matters Article?

Publications

- Opioid Treatment Programs (OTPs) Medicare Billing & Payment
- Hospice Comprehensive Assessment Measure

Multimedia

Hospital Price Transparency Call: Audio Recording and Transcript

.

December 10, 2019

CMS Provider Education Message:

Provider Education Message:

Most HICN Claims Reject – Regardless of Date Service

Use Medicare Beneficiary Identifiers (MBIs) now to avoid claim and eligibility transaction rejects. Starting January 1, 2020, regardless of the date of service on the Medicare transaction, most Social Security Number – based Health Insurance Claim Number (HICN) Medicare transactions will reject with a few exceptions.

If you do not use MBIs on claims after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

Thank you for transitioning to MBIs during the 21 month transition period, protecting your patients from identity theft.

- You are currently submitting 87% of claims with MBIs.
- If your patient doesn't have their new card, give them the Get Your New Medicare Card flyer in English or Spanish.
- Get MBIs through the MAC portals (sign up (PDF) now and after the transition period. You can also find the MBI on the remittance advice.

See the MLN Matters Article (PDF) for more information on getting and using MBIs.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM10882 – Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35

  Change Request 10882 revises the "Medicare Claims Processing Manual" Chapters 1 and 35, to add new sections on global billing and separate Technical Component and Professional Component billing instructions. Make sure your billing staffs are aware of these changes.

- MM11570 – CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  Change Request 11570 provides the Calendar Year 2020 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Revised:

- MM11268 – Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements

  Change Request (CR) 11268 informs Medicare Administrative Contractors that, effective on January 1, 2020 (the start of the AUC program Educational and Operations Testing Period); they should accept the AUC related Healthcare Common Procedure Coding System modifiers on claims. Please be sure your billing staff and vendors are aware of this update. Subsequent CRs will follow at a later date that will continue AUC program implementation.

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December 9, 2019

The comment period will close on December 15, 2019, for the following proposed local coverage determinations (LCDs):

- Biomarkers for Oncology (DL35396)
- Thrombolytic Agents (DL35428)

Submit comments

.

December 5, 2019

CMS Provider Education Message:

MLN Connects — DMEPOS Competitive Bidding Surveys: Comment by December 20

MLN Connects® for Thursday, December 5, 2019

View this edition as a PDF

News

- Direct Contracting Risk-Sharing Options: Submit Letter of Intent by December 10
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Quality Payment Program: Technical Expert Panel Nominations due December 20
- Quality Payment Program: MIPS Exception Applications due December 31
- Clinical Laboratory Fee Schedule: CY 2020 Final Payment Determinations
- Quality Payment Program: 2019 APM Incentive Payment Details
- PEPPERs for Short-term Acute Care Hospitals
- eCQM Reporting: Updated 2020 QRDA III Implementation Guide
- National Influenza Vaccination Week
- National Handwashing Awareness Week

Compliance

- Cardiac Device Credits: Medicare Billing

Claims, Pricers & Codes

- Average Sales Price Files: January 2020
- Home Health RAPs: Hold Starting January 1, 2020

Events

- Hospital Price Transparency Special Open Door Forum — December 10
- Medicare Promoting Interoperability Program 2020 Webinar — January 16

MLN Matters® Articles

- Overview of the Patient-Driven Groupings Model
- Payments and Payment Adjustments under the Patient-Driven Groupings Model
- Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2020 - Recurring File Update

Publications

- Disproportionate Share Hospital — Revised
- Federally Qualified Health Center — Revised
- Medicare Learning Network (MLN) Learning Management System (LMS) FAQs — Revised

Multimedia

- Clinical Labs Call: Audio Recording and Transcript

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11560 – Summary of Policies in the Calendar Year (CY) 2020 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

  Change Request 11560 provides a summary of the policies in the CY 2020 MPFS Final Rule announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2020. Make sure your billing staffs are aware of these updates.

Revised:

- MM11536 – Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020

  The Centers for Medicare & Medicaid Services revised this article on December 3, 2019, due to a revised Change Request (CR) which corrected the Low-Utilization Payment Adjustment add-on factors in the 2020 record layout in manual Section 70.2. The transmittal number, CR release date and link to the transmittal were also changed. All other information remains the same.

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December 3, 2019

Provider Education Message:

Special Edition – Tuesday, December 3, 2019

MBI Transition Ends This Month: Will You Be Paid On January 1?

The 21 month transition period will end on December 31; use Medicare Beneficiary identifiers (MBIs) now.

- You are currently submitting 86% of claims with MBIs.
- Get MBIs from your patients and through the MAC portals (sign up) now and after the transition period. You can also find the MBI on the remittance advice.
- Protect your patients from identity theft - use MBIs.

Starting January 1, if you do not use the MBI (regardless of the date of service) for Medicare transactions

- We will reject your claims with a few exceptions
- We will reject all eligibility transactions

See the MLN Matters Article for more information on getting and using MBIs.

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Part A Top Claims Submission / Reason Code Errors

The November 2019 Top Claim Submission / Reason Code 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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December 2, 2019

Provider Education Message:

Special Edition – Monday, December 2, 2019

HHAs: Get Help Registering for iQIES by December 23

Avoid payment delays. You need access to the upgraded Internet Quality Improvement and Evaluation System (iQIES) to submit assessment data beginning January 1. We will return claims that cannot be matched to assessments, delaying your Medicare payments. The first step is to create an account in the Healthcare Quality Information System (HCQIS) Access, Roles and Profile Management (HARP).

Learn how:

- HARP Registration Process 5 minute video
- HARP Manual Proofing 2 minute video
- How to Create an iQIES Account 1.5 minute video
- iQIES Onboarding Guide
- MLN Connects Special Edition article

Still Need Help?

- HARP registration: QTSO Helpdesk at (800) 339-9313 or help@qtso.com
- iQIES: send questions to iQIES_Broadcast@cms.hhs.gov

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The following local coverage article which was posted for notice on October 17, 2019 is now effective:

- Self-Administered Drug Exclusion List (A53127)

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November 27, 2019

CMS Provider Education Message:

Patients Over Paperwork Newsletter
MLN Connects® for Wednesday, November 27, 2019
View this edition as a PDF

News

- FY 2019 Medicare FFS Improper Payment Rate Lowest Since 2010
- Patients Over Paperwork Newsletter
- Celebration of National Rural Health Day
- November is Home Care and Hospice Month
- World AIDS Day is December 1

Compliance

- Ambulance Fee Schedule and Medicare Transports

Events

- Hospital Price Transparency Final Rule Call — December 3
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- Home Health Agencies (HHAs) Urged to Establish Access to the Internet Quality Improvement and Evaluation System (iQIES) By December 23, 2019
- Claim Status Category and Claim Status Codes Update
- 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) 2020
- 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
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020
- Updating Fiscal Intermediary Shared System (FISS) Editing for Practice Locations to Bypass Mobile Facility and/or Portable Units and Services Rendered in the Patient's Home
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020 — Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- ACOs: Beneficiary Engagement Toolkit and Case Studies

Multimedia

- Physician Fee Schedule and Hospital OPPS/ASC Call: Audio Recording and Transcript

.

November 26, 2019

Special Edition – Tuesday, November 26, 2019

Provider Education Message:

HHAs: Avoid Payment Delays, Register for iQIES by December 23

Act now. Home Health Agencies (HHAs) need access to the upgraded Internet Quality Improvement and Evaluation System (iQIES) to submit assessment data beginning January 1. We will return claims that cannot be matched to assessments, delaying your Medicare payments. See the MLN Connects Special Edition article SE 19025 for:

- Background
- Step-by-step instructions
- Training videos
- Frequently asked questions

- How to get help

.

Special Edition – Tuesday, November 26, 2019

Provider Education Message:

New Medicare Card: Claim Reject Codes After January 1

Get paid. Use Medicare Beneficiary Identifiers (MBIs) now.

If you do not use MBIs on claims (with a few exceptions) after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based numbers; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in English (PDF) or Spanish (PDF).
- Use your Medicare Administrative Contractor's look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. Until the end of December, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number.

See the MLN Matters Article to learn how to get and use MBIs.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11500 – Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2020 - Recurring File Update

  Change Request 11500 informs Medicare Administrative Contractors about updates to the PPS base payment rate and the Geographic Adjustment Factors for the FQHC Pricer. Make sure your billing staffs are aware of these changes.

Revised:

- MM11485 – Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020

  The Centers for Medicare & Medicaid Services revised this article on October 30, 2019, due to an updated Change Request (CR) 11485, which removed an invalid code for NCD 190.14. In the article, the CR Release Date, transmittal number and link to the transmittal were updated. All other information is unchanged.

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November 25, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11542 – Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020

  Change Request (CR) 11542 instructs the Medicare Administrative Contractors to update the claims processing system with the new CY 2020 Medicare rates. These updates relate to Chapter 3, sections 10.3, 20.2, and 20.6 of the Medicare General Information, Eligibility, and Entitlement Manual, which are attachments to the CR. Please make sure your billing staffs are aware of these changes.

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2020 Medicare deductibles / coinsurance / therapy thresholds are now available

The 2020 Medicare deductibles / coinsurance / therapy thresholds are now available. Please take a moment to review.

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How unsolicited/voluntary refunds are handled

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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November 22, 2019

Special Edition – Thursday, November 21, 2019

Provider Education Message:

HHAs: Avoid Payment Delays, Register for iQIES by December 23

Act now. Home Health Agencies (HHAs) need access to the upgraded Internet Quality Improvement and Evaluation System (iQIES) to submit assessment data beginning January 1. We will return claims that cannot be matched to assessments, delaying your Medicare payments. See the MLN Connects Special Edition article SE 19025 for:

- Background
- Step-by-step instructions
- Training videos
- Frequently asked questions
- How to get help

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11506 – 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) 2020

  Change Request 11506 implements the CY 2020 rate updates for the ESRD PPS and updates the payment for renal dialysis services furnished to beneficiaries with AKI in ESRD facilities. Make sure that your billing staffs are aware of these changes.

- MM11467 – Claim Status Category and Claim Status Codes Update

  Change Request 11467 updates 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 ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staff is aware of this update.

- MM11470 – Updating Fiscal Intermediary Shared System (FISS) Editing for Practice Locations to Bypass Mobile Facility and/or Portable Units and Services Rendered in the Patient's Home

  Change Request 11470 implements the newly approved National Uniform Billing Committee Condition Code “A7” and improved edit criteria in Medicare systems to bypass edits that match service facility location on certain hospital claims. Make sure billing staff know of this change.

- MM11489 – Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

  Change Request 11489 updates the RARC and CARC lists and instructs the ViPS Medicare System and Fiscal Intermediary Shared System to update the MREP and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print if they use that software.

- MM11490 – 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

  Change Request 11490 instructs Medicare Administrative Contractors and Medicare’s Shared System Maintainers to update systems based on the CORE 360 Uniform use of CARC, RARC, and CAGC rule publication. These system updates are based on the CORE Code Combination List scheduled to be published on or about February 1, 2020. Make sure your billing staffs are aware of these updates.

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November 21, 2019

CMS Provider Education Message:

MLN Connects — Hospital Price Transparency: Register for Dec 3 Call

MLN Connects® for Thursday, November 21, 2019

View this edition as a PDF

News

- Promoting Interoperability Programs: Updated list of eCQMs
- MIPS Improvement Activities Technical Expert Panel: Nominations due November 29
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Modernizing CMS: Organizational Changes Announced

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Hospital Price Transparency Final Rule Call — December 3
- Hospice Quality Reporting Program Forum Webinar — December 4
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- 2020 Annual Update to the Therapy Code List
- 2020 Annual Update of Per-Beneficiary Threshold Amounts
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions
- Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators
- Positron Emission Tomography (PET) Scan - Allow Tracer Codes Q9982 and Q9983 in the Fiscal Intermediary Shared System (FISS)
- Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2020

Publications

- Medical Privacy of Protected Health Information — Revised
- Remittance Advice Resources and FAQs — Revised

Multimedia

- Part A Cost Report Webcast: Audio Recording and Transcript
- Improving Health Care Quality for LGBTQ People Web-Based Training Course — Updated

.

The following local coverage determinations have been revised. The related billing and coding articles have also been revised or added.

- Electroretinography (ERG) (L37371)
  - Billing and coding: Electroretinography (ERG) (A56672)
- Endovenous Stenting (L37893)

    - Billing and coding: Endovenous Stenting (A56414)
- Epidural Injections for Pain Management (L36920)
    - Billing and coding: Epidural Injections for Pain Management (A56681)
- Evaluation and Management Services Provided in a Nursing Facility (L35068)
    - Billing and coding: Evaluation and Management Services Provided in a Nursing Facility (A56712)
- Facet Joint Interventions for Pain Management (L34892)
    - Billing and coding: Facet Joint Interventions for Pain Management (A56670)
- Nusinersen (Spinraza) (L37682)
    - Billing and coding: Nusinersen (Spinraza) (A56860)
- Thoracic Aortography and Carotid, Vertebral, and Subclavian Angiography (L35035)
    - Billing and coding: Thoracic Aortography and Carotid, Vertebral, and Subclavian Angiography (A56631)
- Trigger Point Injections (L35010)
    - Billing and coding: Trigger Point Injections (A57751)
- Vertebroplasty, Vertebral Augmentation (Kyphoplasty) Percutaneous (L35130)
    - Billing and coding: Vertebroplasty, Vertebral Augmentation (Kyphoplasty) Percutaneous (A57752)
- Wireless Capsule Endoscopy (L35089)
    - Billing and coding: Wireless Capsule Endoscopy (A57753)
- Wound Care (L35125)
    - Billing and coding: Wound Care (A53001)

The following LCD has been revised:

- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (L38229)

The following billing and coding articles have been revised:

- Billing and coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device) (A55240)
- Billing and coding: Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Physician Requirements (A55758)
- Billing and coding: Compounded Drugs Used in an Implantable Infusion Pump (A54100)
- Billing and coding: Endovascular Repair of Aortic and/or Iliac Aneurysms (A53124)
- Billing and coding: eVox® System and Other Electroencephalograph Testing for Memory Loss (A56440)
- Billing and coding: Isolated Ultrafiltration for Management of Fluid Overload in Cardiac Disease (A53126)
- Billing and coding: Laboratory Panels (A56473)
- Billing and coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)

- Billing and coding: NCD on Pneumatic Compression Therapy (A53133)
- Billing and coding: Ophthalmic Biometry for Intraocular Lens (IOL) Power Calculation (A53131)
- Billing and coding: Prepackaged Kits (A54515)
- Billing and coding: Prolonged Drug and Biological Infusions Started Incident To a Physician's Service Using an External Pump (A55134)
- Billing and coding: Rezum® Procedure (A55352)
- Billing and coding: Use of Vaccines or Inoculations for the Treatment of Injury or Exposure (A53130)
- Billing and coding: Ventricular Assist Device (VAD) Supply or Accessory (A54910)

The following LCD and the related billing and coding article have been retired for dates of service on and after November 21, 2019:

- Sclerotherapy and Endovenous Non-Thermal Treatment of Varicose Veins (L37796)
  - Sclerotherapy and Endovenous Non-Thermal Treatment of Varicose Veins (A56268)

.

November 19, 2019

CMS Provider Education Message:

Special Edition – Tuesday, November 19, 2019

Provider Education Message:

New Medicare Card: Get Paid January 1, 2020 – Use MBIs Now

Do not wait. Update your patients' records and use Medicare Beneficiary identifiers (MBIs) now, before you are busy with other patient insurance changes in January.

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in English (or Spanish).
- Use your Medicare Administrative Contractor's look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. Until December 2019, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN).

Starting January 1, you must use MBIs to bill Medicare regardless of the date of service:

- We will reject claims submitted with HICNs with a few exceptions
- We will reject all eligibility transactions submitted with HICNs

See the MLN Matters Article for answers to your questions on using MBIs.

.

November 15, 2019

CMS Provider Education Message:

Special Edition – Friday, November 15, 2019

Provider Education Message:

Hospital Price Transparency Requirements
CY 2020 Hospital Outpatient Prospective Payment System Policy Changes

On November 15, CMS finalized policies that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The policies in the final rule will further advance the agency's commitment to increasing price transparency. It includes requirements that would apply to each hospital operating in the United States. In response to comments, CMS is extending the effective date to January 1, 2021 to ensure hospital compliance with these regulations.

The final rule includes:

- Definitions of "hospital," "standard charges," and "items and services"
- Requirements for making public all standard charges for all items and services in a machine-readable format
- Requirements for displaying shoppable services in a consumer-friendly manner
- Monitoring and enforcement

For More Information:

- View the final rule (CMS-1717-F2): This HHS-approved document has been submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the Federal Register is the official HHS-approved document.
- Press Release
- Registration opening soon for December 3 Call

See the full text of this excerpted CMS Fact Sheet (Issued November 15).

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November 14, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: If an MBI Changes

MLN Connects® for Thursday, November 14, 2019

View this edition as a PDF

News

- New Medicare Card: If an MBI Changes
- Medicare Shared Savings Program: Application Deadlines for January 1, 2021, Start Date
- Drug Units in Excess of MUE: Comparative Billing Report in November
- Person-Centered Planning: Comment on Performance Measurement by December 2
- Emergency Preparedness Resources
- Raising Awareness of Diabetes in November
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Compliance

- Skilled Nursing Facility 3-Day Rule Billing

Claims, Pricers & Codes

- MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

Events

- Kidney Care Choices Model Webinars — November 15 and 22
- 2020 Quality Payment Program Final Rule Webinar — November 19
- Drug Units in Excess of MUE: Comparative Billing Report Webinar — December 4
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) — April 2020 Update
- Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)
- Display PARHM Claim Payment Amounts — Revised
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update — Revised

.

The following local coverage determinations (LCDs) posted for comment on June 27, 2019, have been posted for notice. The LCDs and related billing and coding articles will become effective December 30, 2019:

- 4Kscore Test Algorithm (L37792)
  - Billing and coding: 4Kscore Test Algorithm (A56653)
- 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)
- Micro-Invasive Glaucoma Surgery (MIGS) (L38223)
  - Billing and coding: Micro-Invasive Glaucoma Surgery (MIGS) (A56633)

The following response to comment articles contain summaries of all comments received and Novitas' responses:

- Response to comments: 4Kscore Test Algorithm (A57729)
- Response to comments: Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (A57732)
- Response to comments: Micro-Invasive Glaucoma Surgery (MIGS) (A57735)

The following local coverage determinations have been revised. The related billing and coding articles, if applicable, have been added or revised.

- Allergen Immunotherapy (L36240)
  - Billing and coding: Allergen Immunotherapy (A56538)
- Ambulance Services (Ground Ambulance) (L35162)
  - Billing and coding: Ambulance Services (Ground Ambulance) (A54574)
- Anorectal Manometry, Anal Electromyography, and Biofeedback Training for Perineal Muscles and Anorectal or Urethral Sphincters (L34977)
  - Billing and coding: Anorectal Manometry, Anal Electromyography, and Biofeedback Training for Perineal Muscles and Anorectal or Urethral Sphincters (A56530)
- Autonomic Function Tests (L35395)
  - Billing and coding: Autonomic Function Tests (A54954)
- Barium Swallow Studies, Modified (L35433)
  - Billing and coding: Barium Swallow Studies, Modified (A56589)
- Biomarkers for Oncology (L35396)
- Flow Cytometry (L35032)
  - Billing and coding: Flow Cytometry (A56676)
- Hemophilia Factor Products (L35111)
  - Billing and coding: Hemophilia Factor Products (A56433)
- Hyperbaric Oxygen (HBO) Therapy (L35021)
  - Billing and coding: Hyperbaric Oxygen (HBO) Therapy (A56714)
- Implantable Infusion Pump (L35112)
  - Billing and coding: Implantable Infusion Pump (A56778)
- In Vitro Chemosensitivity & Chemoresistance Assays (L36634)
  - Billing and coding: In Vitro Chemosensitivity & Chemoresistance Assays (A56710)
- Intensity Modulated Radiation Therapy (IMRT) (L36711)
  - Billing and coding: Intensity Modulated Radiation Therapy (IMRT) (A56725)
- Intraoperative Neurophysiological Testing (L35003)
  - Billing and coding: Intraoperative Neurophysiological Testing (A56722)
- Intravenous Immune Globulin (IVIG) (L35093)
  - Billing and coding: Intravenous Immune Globulin (IVIG) (A56786)
- Lacrimal Punctum Plugs (L35095)
  - Billing and coding: Lacrimal Punctum Plugs (A56780)
- Loss-of-Heterozygosity Based Topographic Genotyping with PathfinderTG ® (L34864)
  - Billing and coding: Loss-of-Heterozygosity Based Topographic Genotyping with Pathfinder TG® (A56897)
- Lower Extremity Major Joint Replacement (Hip and Knee) (L36007)
  - Billing and coding: Lower Extremity Major Joint Replacement (Hip and Knee) (A56796)
- Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (L34822)

    - Billing and coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Microvascular Therapy (L36434)
    - Billing and coding: Microvascular Therapy (MVT) (A54343)
- Mohs Micrographic Surgery (MMS) (L34961)
    - Billing and coding: Mohs Micrographic Surgery (MMS) (A53883)
- Multiple Imaging in Oncology (L35391)
    - Billing and coding: Multiple Imaging in Oncology (A56848)
- Neuromuscular Junction Testing (L34996)
    - Billing and coding: Neuromuscular Junction Testing (A56785)
- Outpatient Wireless Pulmonary Artery Pressure Monitoring for Heart Failure (L36419)
    - Billing and coding: Outpatient Wireless Pulmonary Artery Pressure Monitoring for Heart Failure (A56856)
- Surgery: Posterior Tibial Nerve Stimulation (PTNS) for Urinary Control (L35011)
    - Billing and coding: Surgery: Posterior Tibial Nerve Stimulation (PTNS) for Urinary Control (A57712)
- Therapy and Rehabilitation Services (PT, OT) (L35036)
    - Billing and coding: Therapy and Rehabilitation Services (PT, OT) (A57703)
- Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities (L34924)
    - Billing and coding: Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities (A55229)

The following billing and coding articles have been revised:

- Billing and coding: 3D Interpretation and Reporting of Imaging Studies (A56526)
- Billing and coding: Acute Care: Inpatient, Observation and Treatment Room Services (A52985)

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11536 – Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020

  Change Request (CR) 11536 updates the CY 2020 60-day and 30-day base payment rates, the national per-visit amounts, Low-Utilization Payment Adjustment add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS. In addition, this CR revises the initial payment percentage for both initial and subsequent 30-day periods of care under the split percentage payment approach for CY 2020. Make sure that your billing staffs are aware of these changes.

- MM11501 – 2020 Annual Update to the Therapy Code List

  Change Request 11501 updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the Calendar Year 2020 Current Procedural Terminology and Level II HCPCS. Make sure your billing staffs are aware of these updates.

- MM11532 – 2020 Annual Update of Per-Beneficiary Threshold Amounts

  Change Request (CR) 11532 updates the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for CY 2020. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as “therapy caps” before the Bipartisan Budget Act of 2018 was signed into law repealing the application of the caps.

  For CY 2020, the KX modifier threshold amounts are: (a) $2,080 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined, and (b) $2,080 for Occupational Therapy (OT) services. Make sure your billing staffs are aware of these updates.

- MM11453 – Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators

  Change Request (CR) 11453 informs MACs that Status Indicator Q (therapy functional information code) is no longer effective with the 2020 MPFSDB beginning January 1, 2020. Medicare no longer requires functional therapy reporting. CR 11453 makes change to the Medicare Claims Processing Manual, Chapter 23, Section 30.2.2 to reflect this change for Status Indicator Q. Make sure that your billing staffs are aware of this change.

- MM11498 – Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2020

  Change Request 11498, informs the Medicare Administrative Contractors about updates to the CY 2019 payment limit for RHCs. Make your billing staff aware of these changes.

- MM11537 – Positron Emission Tomography (PET) Scan - Allow Tracer Codes Q9982 and Q9983 in the Fiscal Intermediary Shared System (FISS)

  Change Request 11537 updates the FISS system with the additional tracer healthcare common procedure coding system (HCPCS) codes Q9982 and Q9983. Currently, the system does not recognize HCPCS Q9982 and Q9983 as valid radiopharmaceutical tracer codes and claims are incorrectly returned to the provider as unprocessed or rejected. Please make sure your billing staffs are aware of these updates.

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November 13, 2019

October 2019 Part A Newsletter

The October 2019 Part A Newsletter is now available. Please take a moment to review.

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Part A open issues log – New issue

Claims for Maryland SNFs (Type of Bill 22x and 23x) and outpatient therapy facilities (Type of bill 74x), provider numbers starting with 215xxx or 216xxx, are not receiving reimbursement on various services, primarily services that are paid at the Medicare Physician Fee Schedule, such as therapy.

CMS is actively researching this issue. The majority of the claims are suspended in status location SMQ218 with reason code 39910. Some claims have finalized without payment. Once a correction is scheduled and implemented, we will release all held claims. We will also identify all claims that incorrectly finalized without reimbursement and reprocess them.

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November 12, 2019

CMS Provider Education Message:

Special Edition – Tuesday, November 12, 2019

HICN Claims Reject

We are 50 days out from the end of the Medicare Beneficiary Identifier (MBI) transition period. Use the MBI on Medicare claims and other transactions now. Starting January 1, regardless of the date of service:

- We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few exceptions
- We will reject all eligibility transactions submitted with HICNs

See the MLN Matters Article to learn how to get and use MBIs.

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November 8, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11513 – Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

  Change Request 11513 contains updates to handle Veterans Administration demonstration claims under the SNF PDPM. Make sure your billing staffs are aware of these changes.

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November 7, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: HICN Claims Reject January 1, 2020

MLN Connects® for Thursday, November 7, 2019

View this edition as a PDF

News

- New Medicare Card: HICN Claims Reject January 1, 2020
- IRF/LTCH/SNF Quality Reporting Program: Submission Deadline Extended to November 18
- MIPS Heart Failure Measure: Call for Public Comment Closes November 27
- CAHs: Hardship Exception Application Deadline December 2
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- MIPS: Virtual Group Election Period Open Through December 31
- Medicare Ground Ambulance Data Collection System: Starts January 1, 2020
- Home Health Agency: Final OASIS D-1 Data Submission Specifications
- MACRA Patient Relationship Categories and Codes: Learn More
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Compliance

- Bill Correctly for Medicare Telehealth Services

Claims, Pricers & Codes

- Skilled Nursing Facility Claims Hold

Events

- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- Addition of Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy
- Health Professional Shortage Area (HPSA) Bonus Payments for All Mental Health Specialties
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.0, Effective January 1, 2020
- April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised

Publications

- Opioid Treatment Programs (OTPs) Medicare Enrollment
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Revised

Multimedia

- Medicare Telehealth Services Video

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11491 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) -- April 2020 Update

  Change Request 11491 constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Make sure that your billing staffs are aware of these changes.

Revised:

- MM11422 – Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update

  The Centers for Medicare & Medicaid Services revised this article on November 5, 2019, to reflect the revised CR11422 issued on November 4, 2019. In the article, CMS added HCPCS code J0642 and revised the CR release date, transmittal number, and the web address. All other information remains the same.

- MM11355 – Display PARHM Claim Payment Amounts

  The Centers for Medicare & Medicaid Services (CMS) revised this article on November 5, 2019, to reflect the revised CR11355 issued on November 4. The last sentence of the first paragraph of the Background section of this article reflects the revised CR language. Also, CMS revised the CR release date, transmittal number, and the web address. All other information remains the same.

- MM11451 – October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  The Centers for Medicare & Medicaid Services revised this article on November 5, 2019, to clarify that the providers affected are institutional providers. All other information remains the same.

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The following local coverage determinations (LCDs) and related billing and coding articles have been revised.

- Biomarkers Overview (L35062)
  - Billing and coding: Biomarkers Overview (A56541)
- Blood Glucose Monitoring in a Skilled Nursing Facility (SNF) (L34834)
  - Billing and coding: Blood Glucose Monitoring in a Skilled Nursing Facility (SNF) (A56591)
- BRCA1 and BRCA2 Genetic Testing (L36715)
  - Billing and coding: BRCA1 and BRCA2 Genetic Testing (A56542)
- Cataract Extraction (including Complex Cataract Surgery) (L35091)
  - Billing and coding: Cataract Extraction (including Complex Cataract Surgery) (A56615)
- Chiropractic Services (L35424)
  - Billing and coding: Chiropractic Services (A52987)
- Co-Management of Surgical Procedures (L34862)
  - Billing and coding: Co-Management of Surgical Procedures (A52989)
- Corus® CAD Test (L36713)
  - Billing and coding: Corus® CAD Test (A56608)
- Cosmetic and Reconstructive Surgery (L35090)
  - Billing and coding: Cosmetic and Reconstructive Surgery (A56587)
- C-Reactive Protein High Sensitivity Testing (hsCRP) (L34856)
  - Billing and coding: C-Reactive Protein High Sensitivity Testing (hsCRP) (A56643)
- Diagnostic Abdominal Aortography and Renal Angiography (L35092)
  - Billing and coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Frequency of Laboratory Tests (L35099)
  - Billing and coding: Frequency of Laboratory Tests (A56420)

The following billing and coding article has been revised.

- Billing and Coding: Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents (A53049)

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Part A open issues log

It has come to the attention of CMS that CWF SNF CB edit 7275 is denying Part B ambulance claims inappropriately with date of service on/after, April 1, 2019. This is occurring when the beneficiary is in a covered Part A SNF stay but requires a Part B covered transport for emergency services and when the transport claim is billed with Healthcare Common Procedure Coding System (HCPCS) code A0427, A0429, or A0433.

A correction is tentatively scheduled for January 1, 2020. Claims will be suspended and the error 7275 will be manually overridden until the correction is installed. Any claims with HCPCS A0427, A0429, or A0433, with dates of service on/after April 1, 2019, that have rejected with reason code C7275, can be resubmitted or can be brought to our attention to be reprocessed.

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November 6, 2019

Part A Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part A Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for October 2019. New questions / answers have been added to the Eligibility/Entitlement and Return to Provider categories. Please take time to review these and other FAQs for answers to your questions.

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Part A Top Claims Submission / Reason Code Errors

The October 2019 Top Claim Submission / Reason Code 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.

.

November 5, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11508 – Addition of Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy

  Change Request 11508 adds MS-DRGs 319 and 320 (Other Endovascular Cardiac Valve Procedures with and without major complications and comorbidities (MCC), respectively) to the list of MS-DRGs subject to the policy for replaced devices offered without cost or with a credit.

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November 4, 2019

Physician Fee Schedule and OPPS/ASC Final Rules Call — November 6

Please join the Centers for Medicare & Medicaid Services on Wednesday, November 6 from 2:15 to 3:45 pm Eastern Time for the Physician Fee Schedule and Outpatient Prospective Payment System

(OPPS)/Ambulatory Surgical Center (ASC) Final Rules Call. For details and registration, please read this article.

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Special Edition – Monday, November 4, 2019

Provider Education Message:

Physician Fee Schedule and OPPS/ASC Final Rules Call — November 6

Wednesday, November 6 from 2:15 to 3:45 pm ET

Register for Medicare Learning Network events.

During this call, learn about the provisions in two CMS CY 2020 final rules:

- Physician Fee Schedule and Quality Payment Program: Final Rule, Press Release, Physician Fee Schedule Fact Sheet, and Quality Payment Program Fact Sheet
- Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems: Final Rule and Fact Sheet

Changes to the Physician Fee Schedule are aimed at reducing burden, recognizing clinicians for the time they spend taking care of patients, removing unnecessary measures, and making it easier for clinicians to be on the path towards value-based care. Topics include:

- Payment and supervision policy updates
- Merit-based Incentive Payment System Value Pathways: Streamlining the Quality Payment Program to reduce clinician burden
- Creating the new Opioid Treatment Program benefit in response to the opioid epidemic

In addition, updates and policy changes under the Medicare OPPS and ASC payment systems lay the foundation for a patient-driven health care system.

A question-and-answer session follows the presentation. We encourage you to review the final rules prior to the call.

Target Audience: Medicare Part B fee-for-service clinicians; office managers and administrators; state and national associations that represent health care providers; all hospitals operating in the United States; and other stakeholders.

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11003 – Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System

  The Centers for Medicare & Medicaid Services revised this article on November 1, 2019, to update and clarify information regarding the eMDR registration/enrollment to indicate the provider and the Health Information Handler roles with more detail. All other information is unchanged.

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November 1, 2019

Special Edition – Friday, November 1, 2019

Provider Education Message:

Physician Fee Schedule, Hospital OPPS, and ASC Final Rules

Physician Fee Schedule: Finalized Policy, Payment, and Quality Provisions for CY 2020

Medicare Hospital OPPS and ASC Payment System Final Rule for CY 2020

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Physician Fee Schedule: Finalized Policy, Payment, and Quality Provisions for CY 2020

On November 1, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) effective on or after January 1, 2020.

Payment Provisions:

- Rate-setting and conversion factor
- Medicare telehealth services
- Evaluation and management services
- Physician supervision requirements for physician assistants
- Review and verification of medical record documentation
- Care management services
- Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs
- Bundled payments under the PFS for opioid use disorders
- Therapy services

Other Provisions:

- Quality Payment Program
- Ambulance services
- Ground ambulance data collection system
- Open Payments Program
- Medicare Shared Savings Program

For More Information:

- Final Rule
- Press Release
- Press Release – Treatment for Opioid Use Disorder
- Quality Payment Program Fact Sheet
- Register for November 6 Call

See the full text of this excerpted CMS Fact Sheet (Issued November 1).

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Medicare Hospital OPPS and ASC Payment System Final Rule for CY 2020

On November 1, CMS finalized policies that aim to increase choices, encourage medical innovation, empower patients, and eliminate waste, fraud, and abuse to protect seniors and taxpayers. The changes build on existing efforts to increase patient choice by making Medicare payment available for more services in different sites of services and adopting policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

In accordance with Medicare law, CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent. This update is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for Multi-Factor Productivity (MFP).

Using the hospital market basket, CMS is finalizing an update to the ASC rates for CY 2020 equal to 2.6 percent. The update applies to ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for MFP. This change will also help to promote site-neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

The final rule with comment period includes:

- Increasing choices and encouraging site neutrality
- Method to control for unnecessary increases in utilization of outpatient services
- Changes to the inpatient only list
- ASC covered procedures list
- Payment for procedures involving skin substitutes
- Rethinking rural health
- Changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals
- Addressing wage index disparities
- Unleashing innovation
- Device pass-through applications
- Protecting taxpayer dollars
- Meaningful Measures/Patients Over Paperwork
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- OPPS payment methodology for 340B purchased drugs
- Partial Hospitalization Program (PHP) rate setting
- Update to PHP per diem rates

Revision to the organ procurement organization conditions for certification

For More Information:

- Final Rule
- Register for November 6 Call

See the full text of this excerpted CMS Fact Sheet (Issued November 1).

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October 31, 2019

Special Edition – Thursday, October 31, 2019

Provider Education Message:

Final Payment Rules for HH, ESRD, and DMEPOS

- HHAs: CY 2020 Payment and Policy Changes and CY 2021 Home Infusion Therapy Benefit
- ESRD and DMEPOS CY 2020 Final Rule

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HHAs: CY 2020 Payment and Policy Changes and CY 2021 Home Infusion Therapy Benefit

CMS issued a final rule with comment period that finalizes routine updates to the home health payment rates for CY 2020, in accordance with existing statutory and regulatory requirements. This rule with comment period includes:

- Modification to the payment regulations pertaining to the content of the home health plan of care
- Allows therapist assistants to furnish maintenance therapy
- Finalizes policies related to the split percentage payment approach under the Home Health Prospective Payment System (HH PPS)
- Final policies related to the implementation of the permanent home infusion therapy benefit in CY 2021, including payment categories, amounts, and required and optional adjustments, and solicits comments on options to enhance future efforts to improve policies related to coverage of eligible drugs for home infusion therapy
- Implementation of the Patient-Driven Groupings Model (PDGM), an alternate case-mix adjustment methodology with a 30-day unit of payment, mandated by the Bipartisan Budget Act of 2018 (BBA of 2018)

CMS projects that aggregate Medicare payments to Home Health Agencies (HHAs) in CY 2020 will increase by 1.3 percent, or $250 million. This increase reflects the effects of the 1.5 percent home health payment update percentage ($290 million increase), mandated by the BBA of 2018; and a 0.2 percent aggregate decrease (-$40 million) in payments to HHAs due to the changes in the rural add-on percentages, also mandated by the BBA of 2018. The rate updates also include a budget-neutral adjustment to the CY 2020 30-day payment amount to offset anticipated provider behavior changes upon implementation of the PDGM; the use of updated wage index data for the home health wage index; and updates to the fixed-dollar loss ratio to determine outlier payments. Given the scale of the PDGM payment system changes for CY 2020, it may take HHAs more time before they fully implement the behavior assumed by CMS; therefore, we applied the three previously outlined behavior change assumptions to half of the 30-day periods in our analytic file, resulting in a smaller adjustment to the 30-day payment amount needed to maintain budget neutrality, as required by law. CMS is finalizing a CY 2020 30-day payment amount (for those HHAs that report the required quality data) of $1,864.03.

The final rule also includes:

- Enhance and modernize program integrity while reducing regulatory burden
- Paraprofessional roles – Improving access to care
- Home Health Quality Reporting Program
- Home Health Value-Based Purchasing (HHVBP) Model

For More Information:

- Final Rule
- Press Release
- HH PPS website
- HHA Center website
- PDGM webpage
- Home Infusion Therapy Services website
- Home Health Quality Reporting Requirements webpage
- HHVBP Model webpage

See the full text of this excerpted CMS Fact Sheet (Issued October 31).

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ESRD and DMEPOS CY 2020 Final Rule

On October 31, CMS issued a final rule that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2020. This rule also updates the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI and finalizes changes to the ESRD Quality Incentive Program.

In addition, this rule includes:

Methodology for calculating fee schedule payment amounts for new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items and services and making adjustments to the fee schedule amounts established using supplier or commercial prices if such prices decrease within five years of establishing the initial fee schedule amounts

Revises existing policies related to the competitive bidding program for DMEPOS

Streamlines the requirements for ordering DMEPOS items and creates one Master List of DMEPOS items that could potentially be subject to face-to-face encounter and written order prior to delivery and/or prior authorization requirements

Summaries of responses to requests for information on data collection resulting from the ESRD PPS technical expert panel, possible updates and improvements to the ESRD PPS wage index, and new rules for the competitive bidding of diabetic testing strips

CMS projects that the updates for CY 2020 will increase the total payments to all ESRD facilities by 1.6 percent compared with CY 2019. For hospital-based ESRD facilities, CMS projects an increase in total payments of 2.1 percent, while for freestanding facilities, the projected increase in total payments is 1.6 percent.

The final rule also includes:

- Update to the outlier policy
- Eligibility criteria for the Transitional Drug Add-on Payment Adjustment (TDAPA)
- Basis of payment for the TDAPA for calcimimetics
- Average sales price conditional policy for the application of the TDAPA
- New and innovative renal dialysis equipment and supplies
- Discontinuing the erythropoiesis-stimulating agent monitoring policy

- Requests for Information

For More Information:

- Final Rule
- Press Release

See the full text of this excerpted CMS Fact Sheet (Issued October 31).

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CMS Provider Education Message:

MLN Connects — Influenza Vaccine: Payment & Resources

MLN Connects® for Thursday, October 31, 2019

View this edition as a PDF

News

- Protect Your Patients' Identities: Use the MBI Now
- Hospital Value-Based Purchasing Program Results for FY 2020
- IRF/LTCH/SNF Quality Reporting Program Submission Deadline: November 15
- Nursing Home Compare Refresh
- Influenza Vaccination: Protect Your Patients this Season

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Claims, Pricers & Codes

- Liver Transplant Claims: Possible Overpayment

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14
- Success with the Hospice Quality Reporting Program Webinar — November 14

MLN Matters® Articles

- Billing Instructions for Beneficiaries Enrolled in Medicare Advantage (MA) Plans for Services Covered by Decision Memo CAG-00451N
- Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model — Revised
- What New Home Health Agencies (HHAs) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight — Revised

Multimedia

- Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course
- Quality Payment Program: MIPS 2019 Web-Based Training Courses

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The following local coverage determinations (LCDs) have been revised in response to reconsideration requests and are now posted as proposed LCDs. The proposed LCDs are

open for comments related to the current revisions only. Please refer to the synopsis of changes, summary of evidence and analysis of evidence sections for information pertinent to the revisions that are open for comment. The comment period will end on December 15, 2019.

- Biomarkers for Oncology (DL35396)
- Thrombolytic Agents (DL35428)

  Submit comments

The following draft billing and coding articles are related to the above proposed LCDs. The articles contain the applicable CPT/HCPCS codes, ICD-10 Codes and billing and coding information.

- Billing and coding: Biomarkers for Oncology (DA52986)
- Billing and coding: Thrombolytic Agents (DA55237)

The following local coverage determinations (LCDs) have been revised. The related billing and coding articles for these LCDs have been added or revised.

- 3D Interpretation and Reporting of Imaging Studies (L35408)
  - Billing and coding: 3D Interpretation and Reporting of Imaging Studies (A56526)
- 4Kscore Test Algorithm (L37792)
  - Billing and coding: Coding for 4Kscore Test Algorithm (A56281)
- Hyaluronan Acid Therapies for Osteoarthritis of the Knee (L35427)
  - Billing and coding: Hyaluronan Acid Therapies for Osteoarthritis of the Knee (A55036)
- Nerve Conduction Studies and Electromyography (L35081)
  - Billing and coding: Nerve Conduction Studies and Electromyography (A54095)
- Sacral Nerve Stimulation (L35449)
  - Billing and coding: Sacral Nerve Stimulation (A57617)
- Scanning Computerized Ophthalmic Diagnostic Imaging (L35038)
  - Billing and coding: Scanning Computerized Ophthalmic Diagnostic Imaging (A57600)
- Speech-Language Pathology (SLP) Services: Communication Disorders (L35070)
  - Billing and coding: Speech-Language Pathology (SLP) Services: Communication Disorders (A54111)
- Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy (L34891)
  - Billing and coding: Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy (A57656)
- Surgery: Blepharoplasty (L35004)
  - Billing and coding: Surgery: Blepharoplasty (A57618)

The following billing and coding article has been revised.

- Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11216 – April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  The Centers for Medicare & Medicaid Services revised this article on October 29, 2019, to add a reference to a related article, SE19009 which replaces Section 6 - Chimeric Antigen Receptor (CAR) T- Cell Therapy - instructions on pages 5-7 of this article. All other information is unchanged.

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Online registration available for November 15, 2019, Open meeting and proposed LCDs now posted

Online registration for the November 15, 2019, Open meeting is now available and will close at 3:00 PM Eastern Time (ET) on Tuesday, November 12, 2019, or before November 12th if room capacity is filled. The Novitas Solutions proposed LCDs are now posted. **Important:** The open meeting will be held at Novitas Solutions, 2020 Technology Parkway, Suite 100, Mechanicsburg, PA 17050 at 10:00 AM ET. Due to limited room capacity, registered presenters will be given priority for seating and registered observers will be accepted until remaining seats are filled.

Open meetings are for the specific purpose of discussing the proposed LCDs. Anyone is welcome to present information related to the proposed LCDs that are in the 45-day draft 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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October 28, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

SE19024 – Billing Instructions for Beneficiaries Enrolled in Medicare Advantage (MA) Plans for Services Covered by Decision Memo CAG-00451N

This article conveys information on the National Coverage Determination requiring coverage of Chimeric Antigen Receptor (CAR) T-cell therapy for cancer. For more information on the National Coverage Determination, see the decision memorandum.

The Centers for Medicare & Medicaid Services is providing this information for hospitals providing CAR T-cell therapy to beneficiaries enrolled in MA plans. Make sure your billing staff is aware of these instructions.

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October 24, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: Claim Reject Codes After January 1

MLN Connects® for Thursday, October 24, 2019

View this edition as a PDF

News

- New Medicare Card: Claim Reject Codes After January 1
- Take Medicare Fraud, Waste and Abuse Fighting Further, Through Innovation
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing

Claims, Pricers & Codes

- ICD-10 Vaping Coding Guidance

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14

MLN Matters® Articles

- Updating Calendar Year (CY) 2020 Medicare Diabetes Prevention Program (MDPP) Payment Rates

Multimedia

- CDC Opioids Training Module for Nurses
- Quality Payment Program: APMs Web-Based Training

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Changes to amount in controversy (AIC) for appeals in 2020

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2019, is $160.This amount will increase to $170 for ALJ hearing requests filed on or after January 1, 2020. The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2019, is $1,630. This amount will increase to $1,670 for appeals to Federal District Court filed on or after January 1, 2020.

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October 17, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: MBI Transition Ends in Less Than 10 Weeks

MLN Connects® for Thursday, October 17, 2019

View this edition as a PDF

News

- New Medicare Card: MBI Transition Ends in Less Than 10 Weeks
- Guide for Appropriate Tapering or Discontinuation of Long-Term Opioid Use
- ICD-10 Coordination and Maintenance: Deadline for Comments November 8
- CMS Health Equity Award: Submit Nomination by November 15
- Quality Payment Program: Participation Status Tool Includes Second Snapshot of Data
- Atherectomy: Comparative Billing Report in October
- Protect Your Patients from Influenza this Season

Compliance

- Cardiac Device Credits: Medicare Billing

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5
- Atherectomy: Comparative Billing Report Webinar — November 6
- Provider Compliance Focus Group Meeting — November 12

MLN Matters® Articles

- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS
- Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes
- Home Health Orders for Nurse Practitioners under the Maryland Total Cost of Care (TCOC) Model
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised
- October 2019 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- Roster Billing for Mass Immunizers — Revised
- Acute Care Inpatient Hospital Prospective Payment System — Reminder
- Hospice Payment System— Reminder
- Hospital Outpatient Prospective Payment System— Reminder
- Inpatient Psychiatric Facility Prospective Payment System— Reminder
- Inpatient Rehabilitation Facility Prospective Payment System— Reminder
- Long-Term Care Hospital Prospective Payment System— Reminder
- Telehealth Services — Reminder

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In response to the annual ICD-10 code update, the following billing and coding articles have been added or revised. The related local coverage determinations (LCDs) have been revised to remove the codes and place them into the billing and coding articles.

- Billing and coding: Monitored Anesthesia Care (A57361)
  - Monitored Anesthesia Care (L35049)
- Billing and coding: Oximetry Services (A57205)
  - Oximetry Services (L35434)
- Billing and coding: Pulmonary Function Testing (A57320)

- Pulmonary Function Testing (L35360)
- Billing and coding: Real-Time, Outpatient Cardiac Telemetry (A52995)
  - Real-Time, Outpatient Cardiac Telemetry (L34997)
- Billing and coding: Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) (A57414)
  - Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) (L35350)
- Billing and coding: Vestibular and Audiologic Function Studies (A57434)
  - Vestibular and Audiologic Function Studies (L35007)

In response to the 2020 annual ICD-10 code update, the following billing and coding articles have been revised. Related LCDs, as applicable, have undergone a system change to remove the coding sections.

- Billing and coding: Allergy Testing (A56558)
  - Allergy Testing (L36241)
- Billing and coding: Assays for Vitamins and Metabolic Function (A56416)
  - Assays for Vitamins and Metabolic Function (L34914)
- Billing and coding: Bariatric Surgical Management of Morbid Obesity (A56422)
  - Bariatric Surgical Management of Morbid Obesity (L35022)
- Billing and coding: Cardiac Event Detection Monitoring (A56600)
  - Cardiac Event Detection Monitoring (L34953)
- Billing and coding: Cardiac Rhythm Device Evaluation (A56602)
  - Cardiac Rhythm Device Evaluation (L34833)
- Billing and coding: Cardiovascular Nuclear Medicine (A56423)
  - Cardiovascular Nuclear Medicine (L35083)
- Billing and coding: Controlled Substance Monitoring and Drugs of Abuse Testing (A56645)
  - Controlled Substance Monitoring and Drugs of Abuse Testing (L35006)
- Billing and coding: Implantable Automatic Defibrillators (A56355)
- Billing and coding: Magnetic Resonance Angiography (MRA) (A56805)
  - Magnetic Resonance Angiography (MRA)(L34865)
- Billing and coding: Molecular Diagnostics: Genitourinary Infectious Disease Testing (A56791)
  - Molecular Diagnostics: Genitourinary Infectious Disease Testing (L35015)
- Billing and coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions (A53134)
- Billing and coding: Neurophysiology Evoked Potentials (NEPs) (A56773)
  - Neurophysiology Evoked Potentials (NEPs) (L34975)
- Billing and coding: Non-Coronary Vascular Stents (A56365)
  - Non-Coronary Vascular Stents (L35084)
- Billing and coding: Non-Invasive Peripheral Venous Studies (A52993)
  - Non-Invasive Peripheral Venous Studies (L35451)

- Billing and coding: Non-Vascular Extremity Ultrasound (A55037)
  - Non-Vascular Extremity Ultrasound (L35409)
- Billing and coding: Routine Foot Care (A52996)
  - Routine Foot Care (L35138)
- Billing and coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers (A54982)
- Billing and coding: Strapping (A56804)
  - Strapping (L36423)
- Billing and coding: Thrombolytic Agents (A55237)
  - Thrombolytic Agents (L35428)
- Billing and coding: Transesophageal Echocardiography (TEE) (A56505)
  - Transesophageal Echocardiography (TEE) (L35016)

The following billing and coding articles have been revised. The related LCDs have been revised to remove the coding sections.

- Billing and coding: Hydration Therapy (A56634)
  - Hydration Therapy (L34960)
- Billing and coding: Non-Invasive Cerebrovascular Arterial Studies (A52992)
  - Non-Invasive Cerebrovascular Arterial Studies (L35397)

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The Self-Administered Drug Exclusion List, A53127 **has been revised and is posted for notice. The article will become effective December 2, 2019**

Modifier JB Use for Drugs/Biologicals included on the Self-Administered Drug Exclusion List

Several drugs/biologicals that are considered self-administered and included on the Novitas Self-Administered Drug (SAD) Exclusion List may be administered intravenously or subcutaneously. Effective with claims submitted for dates of service on or after December 2, 2019, Novitas will require the use of the Healthcare Common Procedure Coding System (HCPCS) modifier when reporting subcutaneous administration of a drug/biological that is included on the Novitas Self-Administered Drug (SAD) Exclusion List.

Further information regarding Self-Administered Drugs is found on the Medical Policy Drugs & Biologicals: Self-Administered Drug Exclusions page.

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Part A open issues log: Update to U5200 issue

The error that caused claims to reject with U5200 or U5210 has been corrected. The missing beneficiary entitlement data has been updated. All claims that were held have been released for processing. Any claims that were incorrectly rejected should be resubmitted for processing.

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October 16, 2019

Part A Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part A Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for September 2019. New questions / answers have been added to the General Information and Return to Provider categories. Please take time to review these and other FAQs for answers to your questions.

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October 14, 2019

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

- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (DL38385)

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11335 – Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS

  Change Request (CR) 11335 instructs Medicare's Common Working File (CWF) to send the Date of Service (DOS) for both PPV HCPCS codes (90670 and 90732) to the Medicare Beneficiary Database (MBD). This will allow other systems to know whether the DOS was for the initial vaccine or the second vaccine. Once the CR is implemented, providers will receive more detail in reply to eligibility transactions on whether their beneficiaries have received one or both PPV vaccines.

Revised:

- MM11152 – Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

  The Centers for Medicare & Medicaid Services (CMS) revised this article on October 11, 2019, to show that CMS rescinded the changes made by the revised CR 11152 issued on October 4. This is the May 6, 2019 version of the article that we are re-posting to correspond to the CR11152 version that CMS issued on May 3.

.

October 11, 2019

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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Medicare Secondary Payer (MSP): MSP billing webinars

Join us as we discuss Medicare as a secondary payer (MSP) and the fundamentals of this cost-saving program. During our upcoming webcasts, we will provide an overview of the different Medicare secondary payer billing options for Medicare Part A on November 5, 2019, and Medicare Part B on November 6, 2019.

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October 10, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: 80% of Claims Submitted with MBI

MLN Connects® for Thursday, October 10, 2019

View this edition as a PDF

News

- New Medicare Card: 80% of Claims Submitted with MBI
- Nursing Homes: Enhancing Transparency about Abuse and Neglect
- Quality Payment Program: MIPS Dates and Deadlines
- October is National Breast Cancer Awareness Month

Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

Claims, Pricers & Codes

- FY 2020 IPPS and LTCH PPS Claims Hold

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5

MLN Matters® Articles

- Ambulance Inflation Factor for Calendar Year (CY) 2020 and Productivity Adjustment
- Provider Enrollment Rebuttal Process
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update — Revised
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020 — Revised

Publications

- Medicare Preventive Services — Revised
- Medicare Enrollment for Providers Who Solely Order or Certify — Reminder
- Medicare Fraud & Abuse Poster — Reminder
- Medicare Fraud & Abuse: Prevent, Detect, Report — Reminder
- Medicare Overpayments — Reminder
- PECOS for DMEPOS Suppliers — Reminder

- PECOS for Physicians and NPPs — Reminder
- PECOS for Provider and Supplier Organizations — Reminder

Multimedia

- Opioid Treatment Program Listening Session: Audio Recording and Transcript

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The following draft articles have replaced the future effective articles and have been related to the proposed LCDs:

- Billing and coding: 4Kscore Test Algorithm (DA56653)
  - 4Kscore Test Algorithm (DL37792)
- Billing and coding: Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (DA56642)
  - Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATs) (DL38229)
- Billing and coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (DA56938)
  - Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (DL38385)
- Billing and coding: Micro-Invasive Glaucoma Surgery (MIGS) (DA56633)
  - Micro-Invasive Glaucoma Surgery (MIGS) (DL38223)

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Part A open issues — New issue: U5200 - U5210

Entitlement dates are missing from some beneficiary files. This is causing claims to reject incorrectly with either reason code U5200 or U5210.

The Shared System Maintainers are still working on a resolution. We are holding claims in status location:SMQ217until the entitlement data is corrected. Any claims that were rejected in error may be resubmitted to be held. Once the files are correct, claims will automatically be released for processing.

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September 2019 Part A Newsletter

The September 2019 Part A Newsletter is now available. Please take a moment to review.

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October 9, 2019

Special Edition – Wednesday, October 9, 2019

Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule

On October 9, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the “Stark Law”), which has not been significantly updated since it was enacted in 1989. The proposed rule supports the CMS “Patients over Paperwork” initiative by reducing unnecessary regulatory burden on physicians and other health care providers while reinforcing the Stark Law’s goal of protecting patients from unnecessary services and

being steered to less convenient, lower quality, or more expensive services because of a physician's financial self-interest. Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other health care providers to coordinate the care of the patients they serve – allowing providers across different health care settings to work together to ensure patients receive the highest quality of care.

For More information:

- Proposed Rule: Public comments due by December 31
- Press Release

See the full text of this excerpted CMS Fact Sheet (Issued October 9).

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11361 – Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

  Change Request 11361 provides the Fiscal Year 2020 update to the IPPS and LTCH PPS. Please make sure your billing staffs are aware of these updates.

Revised:

- MM11451 – October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  The Centers for Medicare & Medicaid Services (CMS) revised this article on October 7, 2019, to reflect the revised Change Request (CR) 11451, issued on October 4, 2019. CMS revised the CR to correct Table 7 to reinstate C9043 rather than delete it effective October 1, 2019. CR 11451 also added a new HCPCS code J0642, which is effective October 1, 2019, and revised the descriptor for J0641. The CR release date, transmittal number, and the web address are changed. All other information remains the same.

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October 8, 2019

The comment period will close on October 13, 2019, for the following proposed local coverage determination (LCD):

- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (DL38385)

Submit comments

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October 7, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11497 – Ambulance Inflation Factor for Calendar Year (CY) 2020 and Productivity Adjustment

Change Request 11497 furnishes the Calendar Year (CY) 2020 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2020 is 0.9 percent. Make sure that your billing staffs are aware of this change.

Revised:

- MM11152 – Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

  The Centers for Medicare & Medicaid Services (CMS) revised this article on October 4, 2019, to reflect a revised Change Request (CR) 11152 that CMS issued on October 4. CMS revised the CR to attach a new Health Insurance Prospective Payment System codes file attachment. CMS revised the CR release date, transmittal number, and the web address. All other information remains the same.

.

October 3, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: Do You Refer Patients?

MLN Connects® for Thursday, October 3, 2019

View this edition as a PDF

News

- New Medicare Card: Do You Refer Patients?
- Opioid Treatment Programs: Get Ready to Participate in the New Benefit
- Home Health Preview Reports for January 2020 Refresh
- LTCH Provider Preview Reports: Review Your Data by October 11
- IRF Provider Preview Reports: Review Your Data by October 11
- Hospice Provider Preview Reports: Review Your Data by October 11
- CLFS CY 2020 Preliminary Payment Determinations: Comment by October 27
- MIPS: Virtual Group Election Period Open Through December 31
- LTCH Compare Refresh
- IRF Compare Refresh
- Qualified Medicare Beneficiary Billing Requirements
- Ostomies are Life-Savers
- Looking for Educational Materials?

Compliance

- Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020
- January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2020 Update — Revised

Publications

- Quality Payment Program: 2019 APM Incentive Payment Fact Sheet
- Billing Information for Rural Providers and Suppliers — Revised

Multimedia

- Reducing Opioid Misuse Listening Session: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos

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Part A Top Claims Submission / Reason Code Errors

The September 2019 Top Claim Submission / Reason Code 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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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11420 – Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020

  The Centers for Medicare & Medicaid Services (CMS) revised this article on October 2, 2019, to reflect the revised Change Request (CR) 11420 issued on October 1. The revised CR did not impact the substance of the article. In the article, CMS revised the CR release date, transmittal number, and the web address. All other information remains the same.

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October 2, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM10978 – Provider Enrollment Rebuttal Process

  Change Request (CR) 10978 puts into operation the provision under 42 C.F.R. Section 424.545(b), which permits providers/suppliers whose Medicare billing privileges are deactivated to file a rebuttal. CR 10978 provides instructions for Medicare Administrative Contractors to advise providers/suppliers of their rebuttal rights, as well as for receiving and processing rebuttals.

  A copy of the rebuttal submission form can be viewed in Attachment 2 of CR 10978. Make sure your billing staffs are aware of these instructions.

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October 1, 2019

October is national breast cancer awareness month

Breast cancer is the second most common cancer in women. Medicare covers a screening mammography for eligible women. This article provides information on coverage you can share with your patients.

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Provider Education Message:

New HCPCS Code J0642 for Levoleucovorin Injection

For dates of service on or after October 1, use HCPCS code J0642 for levoleucovorin injection products marketed under the brand name of Khapzory.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11485 – Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020

  Change Request 11485 announces changes to be included in the January 2020 quarterly release of the edit module for clinical diagnostic laboratory services. Please make sure your billing staffs are aware of these changes.

- MM11495 – January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  Change Request 11495 informs Medicare Administrative Contractors (MAC) about new and revised ASP and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) will make files available for download on or after December 16, 2019. CMS gives MACs the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor through separate instructions available in Chapter 4, Section 50 of the Medicare Claims Processing Manual Make sure that your billing staffs are aware of these changes.

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September 27, 2019

Local coverage determination (LCD) and article update history for Jurisdiction L

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 2020 annual ICD-10 code update. On this page is a list of the impacted LCDs and 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.

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September 26, 2019

Special Edition – Thursday, September 26, 2019

Provider Education Message:

- Omnibus Burden Reduction (Conditions of Participation) Final Rule

- Discharge Planning Rule Supports Interoperability and Patient Preferences

Omnibus Burden Reduction (Conditions of Participation) Final Rule

On September 26, CMS took action at President Trump's direction to "cut the red tape," by reducing unnecessary burden for American's health care providers allowing them to focus on their priority – patients. The Omnibus Burden Reduction (Conditions of Participation) Final Rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers to reduce inefficiencies and moves the nation closer to a health care system that delivers value, high quality care and better outcomes for patients at the lowest possible cost.

This rule advances the Patients over Paperwork initiative by saving providers an estimated 4.4 million hours of time previously spent on paperwork with an overall total projected savings to providers of $800 million annually.

This rule finalizes the provisions of three proposed rules

- Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction ("Omnibus Burden reduction"), published September 20, 2018
- Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, published June 16, 2016
- Fire Safety Requirements for Certain Dialysis Facilities, published November 4, 2016.

For More Information:

- Final Rule
- Press Release

Press release See the full text of this excerpted CMS Fact Sheet (Issued September 26).

Discharge Planning Rule Supports Interoperability and Patient Preferences

On September 26, CMS issued a final rule that empowers patients preparing to move from acute care into Post-Acute Care (PAC), a process called discharge planning. The rule puts patients in the driver's seat of their care transitions and improves quality by requiring hospitals to provide patients access to information about PAC provider choices, including performance on important quality measures and resource-use measures, including:

- Number of pressure ulcers
- Proportion of falls that lead to injury
- Number of readmissions back to the hospital

The rule also:

- Advances CMS's interoperability efforts by requiring the seamless exchange of patient information between health care settings, and ensuring that a patient's health care information follows them after discharge from a hospital or PAC provider.
- Revises the discharge planning requirements that hospitals (including long-term care hospitals, Critical Access Hospitals (CAHs) psychiatric hospitals, children's hospitals, and cancer hospitals), inpatient rehabilitation facilities, and home health agencies must meet to participate in Medicare and Medicaid programs. It requires the discharge planning process to focus on a patient's goals and treatment preferences. Hospitals are mandated to ensure each patient's right to access their medical records in an electronic format.
- Implements requirements from the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) that includes how facilities will account for and document a patient's goals of care and treatment preferences.

Hospitals and CAHs are already conducting most of the revised discharge planning requirements, with the exception of the discharge planning requirements of the IMPACT Act.

For More Information:

- Fact Sheet
- Final Rule

See the full text of this excerpted CMS Press Release (Issued September 26).

.

CMS Provider Education Message:

MLN Connects — More Questions About Using the MBI?

MLN Connects® for Thursday, September 26, 2019

View this edition as a PDF

News

- New Medicare Card: More Questions about Using the MBI?
- Quality Payment Program: Submit Comments on 2020 Proposed Rule by September 27
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- 2019 QRDA I Implementation Guide and Sample File for Hospital Quality Reporting: Updated
- Post-Acute Care and Hospice Utilization and Payment Public Use Files
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Hospice Quality Reporting Program Quarterly Updates
- National Cholesterol Education Month and World Heart Day

Compliance

- DME Proof of Delivery Documentation Requirements

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- IRF/LTCH: Reporting Health Care Personnel Influenza Vaccination Data Webinars — October 1, 3, or 9

MLN Matters® Articles

- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2020
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – October 2019 Update — Revised

Publications

- Quality Payment Program: Resources for Clinicians New to the Program in 2019

- Medicare Enrollment for Physicians and Other Part B Suppliers — Reminder
- Medicare Preventive Services Poster — Reminder
- Safeguard Your Identity and Privacy Using PECOS — Reminder

Multimedia

- Quality Payment Program: All-Payer Combination Option in 2019 Web-Based Training Course
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category in 2019 Web-Based Training Course
- Dementia Care Call: Audio Recording and Transcript
- Quality Payment Program for Advanced APMs in 2019 Web-Based Training Course — Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Participation in 2019 Web-Based Training Course — Revised
- Transitioning to an Advanced APM: 2019 Update Web-Based Training Course — Revised

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Local coverage determination (LCD) and article update history

The following local coverage determinations (LCDs) have been revised. The related billing and coding articles for these LCDs have been added or revised.

- Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (L35041)
  - Billing and coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (A54117)
- Frequency of Hemodialysis (L35014)
  - Billing and coding: Frequency of Hemodialysis (A55723)
- Independent Diagnostic Testing Facility (IDTF) (L35448)
  - Billing and coding: Independent Diagnostic Testing Facility (IDTF) (A53252)
- Prostate Mapping Biopsy (L35009)
  - Billing and coding: Prostate Mapping Biopsy (A56966)
- Psychiatric Codes (L35101)
  - Billing and coding: Psychiatric Codes (A57130)
- Removal of Benign Skin Lesions (L34938)
  - Billing and coding: Removal of Benign Skin Lesions (A57113)
- Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder (L34998)
  - Billing and coding: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder (A57072)
- Spinal Cord Stimulation (Dorsal Column Stimulation) (L35450)
  - Billing and coding: Spinal Cord Stimulation (Dorsal Column Stimulation) (A57023)
- Surgical Treatment of Nails (L34887)

- Billing and coding: Surgical Treatment of Nails (A52998)

.

September 25, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11392 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update

  The Centers for Medicare and Medicaid Services revised this article on September 23, 2019, due the release of an updated Change Request (CR).The update added to the CR:

  - A revised spreadsheet for NCD110.23, requirement 3
  - FISS responsibility and new verbiage to NCD150.3, requirement 4 and associated spreadsheet
  - Revised verbiage to NCD110.21, requirement 11

  All other information remains the same.

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September 24, 2019

Limited systems availability — Friday, October 4, 2019 - Sunday, October 6, 2019

There will be Common Working File (CWF) "Dark" days from Friday, October 4, 2019 - Sunday, October 6, 2019, due to the October release upgrades. The interactive voice response (IVR) unit and our customer service representatives will have limited availability. Customer service representatives will not be able to assist providers with eligibility inquiries, claim status inquiries relating to eligibility or claim denial inquiries relating to eligibility.

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September 19, 2019

CMS Provider Education Message:

MLN Connects — Why Use the MBI?

MLN Connects® for Thursday, September 19, 2019

View this edition as a PDF

News

- New Medicare Card: Why Use the MBI?
- Proposed Opioid Treatment Program Policies: Comment Deadline September 27
- Quality Payment Program: MIPS Targeted Review Request Deadline September 30
- SNF PPS Patient Driven Payment Model Resources: Get Ready for October 1
- Emergency Triage, Treat, and Transport Model: Apply by October 5
- LTCH Provider Preview Reports: Review Your Data by October 11

- IRF Provider Preview Reports: Review Your Data by October 11
- Hospice Provider Preview Reports: Review Your Data by October 11
- Prostate Cancer Awareness Month

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

MLN Matters® Articles

- 2019-2020 Influenza (Flu) Resources for Health Care Professionals
- Billing for Hospital Part B Inpatient Services

Publications

- Medicare Enrollment for Institutional Providers — Reminder
- Medicare Enrollment Resources Educational Tool — Reminder
- PECOS FAQs Booklet — Reminder
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder

.

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11343 – October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  The Centers for Medicare and Medicaid Services (CMS) revised this article on September 16, 2019, to reflect the revised Change Request (CR) 11343 issued on September 13. The CR revision had no impact on the substance of the article. CMS did update the release date, transmittal number, and the web address of the CR. All other information remains the same.

- MM11422 – Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – October 2019 Update

  The Centers for Medicare and Medicaid Services (CMS) revised this article on September 18, 2019, to reflect the revised Change Request (CR) 11422 issued on September 17. The revised CR did not impact the content of the article. In the article, CMS revised the release date, transmittal number, and the web address of the CR. All other information remains the same.

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September 16, 2019

Part A Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part A Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for August 2019. New questions / answers have been added to the following categories:

- Appeals
- Claim Denials
- Eligibility/Entitlement

Please take time to review these and other FAQs for answers to your questions.

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11413 – Billing for Hospital Part B Inpatient Services

  Change Request 11413 reminds Medicare Administrative Contractors of the policy regarding billing instructions for hospital Part B inpatient service claims, including the allowance of Revenue Code 0240 on 012x Type of Bills. No policy is being updated. Be sure your billing staffs are aware of this billing instruction.

.

September 13, 2019

Diabetes Prevention Program (MDPP) Specialty Page

We are pleased to announce the addition of Medicare Diabetes prevention Program (MDPP) to the Provider Specialties / Services page of our website.

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September 12, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card Transition Period Ends in Less Than 4 Months

MLN Connects® for Thursday, September 12, 2019

View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 4 Months
- New Enforcement Authorities to Reduce Criminal Behavior in Medicare, Medicaid, and CHIP
- Different-Day Upper and Lower Endoscopy: Comparative Billing Report in September
- Hospices: Call for Panel on Assessment Instrument and Quality Measures — Nominations due September 30
- Local Coverage Determination Meetings
- Pain Management: CDC Conversation Starters for Patients and Their Doctors
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- Average Sales Price Files: October 2019

Events

- Opioids: What's an "Outlier Prescriber"? Listening Session — September 17

- Different-Day Upper and Lower Endoscopy: Comparative Billing Report Webinar — September 24

MLN Matters® Articles

- Hurricane Dorian and Medicare Disaster Related State of North Carolina Claims
- Additional Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and Earlier, or SSI Ratios for Hospital Cost-Reporting Periods for Patient Discharges Occurring Before October 1, 2004
- October 2019 Update of the Ambulatory Surgical Center (ACS) Payment System
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update — Revised
- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System — Revised
- 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments — Revised

Publications

- Medicare Part A Cost Report Electronic Filing
- Quality Payment Program: 2019 MIPS Resources
- Advance Care Planning — Revised
- Medicare Billing: CMS Form CMS-1500 and the 837 Professional — Revised
- Medicare Secondary Payer— Revised
- Roadmap to Behavioral Health — Updated

Multimedia

- Home Health Call: Audio Recording and Transcript
- Radiation Oncology Listening Session: Audio Recording and Transcript
- SNF Value-Based Purchasing Call: Audio Recording and Transcript
- Medicare Secondary Payer Provisions Web-Based Training Course — Revised
- Quality Payment Program for Merit-based Incentive Payment System (MIPS) APMs in 2019 Web-Based Training Course — Revised
- SNF PPS: Patient Driven Payment Model Videos

.

The following local coverage determinations (LCDs) have been revised. The related billing and coding articles for these LCDs have been added or revised:

- Debridement of Mycotic Nails (L35013)
  - Billing and coding: Debridement of Mycotic Nails (A56640)
- Outpatient Sleep Studies (L35050)
  - Billing and coding: Outpatient Sleep Studies (A56923)
- Reflectance Confocal Microscopy (L37375)
  - Billing and coding: Reflectance Confocal Microscopy (A56969)

- Services That Are Not Reasonable and Necessary (L35094)
  - Billing and coding: Services That Are Not Reasonable and Necessary (A56967)

The following billing and coding articles have been revised:

- Billing and coding: Biomarkers for Oncology (A52986)
- Billing and coding: Implantable Automatic Defibrillators (A56355)
- 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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September 11, 2019

August 2019 Part A Newsletter

The August 2019 Part A Newsletter is now available. Please take a moment to review.

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September 10, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE19022 – 2019-2020 Influenza (Flu) Resources for Health Care Professionals

  Special Edition (SE) MLN Matters article SE19022 provides information about influenza (flu) resources for health care professionals and providers relevant to the 2019-2020 flu season. Health care professionals should:

  - Keep this article and refer to it throughout the 2019-2020 flu season.
  - Take advantage of each office visit as an opportunity to encourage patients to protect themselves from the flu and serious complications by getting a flu shot.
  - Continue to provide the flu shot if you have vaccine available, even after the New Year.
  - Remember to immunize yourself and your staff.

.

September 9, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM10484 – Additional Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and Earlier, or SSI Ratios for Hospital Cost-Reporting Periods for Patient Discharges Occurring Before October 1, 2004

  Change Request 10484 directs Medicare Administrative Contractors to inform hospitals of the additional instructions for making an election for a particular fiscal period covered by the

Centers for Medicare & Medicaid Services' (CMS) Ruling 1498-R (as modified by CMS Ruling 1498-R2). Please make sure your cost report staffs are aware of these instructions.

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New look coming to local coverage determinations and billing and coding articles

Consistent with the instruction in Change Request (CR) 10901, our local coverage determinations (LCDs) and billing and coding articles will undergo further changes beginning on September 12, 2019.

Due to recent system changes, the entire Coding Information section will no longer appear in proposed LCDs, Future effective LCDs, and revised LCDs. Additionally, all new articles and revised articles will have a new look. The coding section will be rearranged with new fields for CPT/HCPCS modifiers and other coding information that may be utilized.

All LCDs and articles will be in the new format by the end of the year.

September 6, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE19020 – Hurricane Dorian and Medicare Disaster Related State of North Carolina Claims

  The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the State of North Carolina on September 4, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 1, 2019, and are in effect for 90 days.

  The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

  More Information:

  - Current Emergencies webpage
  - Instructions to request an individual waiver if there is no blanket waiver

- SE19019 – Hurricane Dorian and Medicare Disaster Related States of Georgia and South Carolina Claims

  The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the States of Georgia and South Carolina on September 2, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 29, 2019, for Georgia, and retroactive to August 31, 2019, for South Carolina. The PHE is in effect for 90 days.

  The Centers for Medicare & Medicaid Services is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

  More Information:

  - Current Emergencies webpage

- Instructions to request an individual waiver if there is no blanket waiver

Revised:

- SE19007 – Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update

  The Centers for Medicare & Medicaid Services revised this article on September 5, 2019, to announce a delay of full implementation until April 2020.

.

September 5, 2019

CMS Provider Education Message:

MLN Connects — September is Pain Awareness Month - Learn Pain Management Options

MLN Connects® for Thursday, September 5, 2019

View this edition as a PDF

News

- New Medicare Card: Do You Refer Patients?
- IRF Appeals Settlement Option: Deadline September 17
- Quality Payment Program: MIPS Targeted Review Request Deadline September 30
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- PEPPERs for Short-term Acute Care Hospitals
- DME QIC Contract Award
- Health Care Supply Chain, Provider Self-Care, and Emergency Preparedness Resources
- September is Pain Awareness Month

Compliance

- Chiropractic Services: Comply with Medicare Billing Requirements

Events

- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10
- Health Coaching and Wellness Planning for Self-Management Webinar — September 10
- New Medicare Card: Open Door Forum — September 11
- Developing a Hospice Patient Assessment Tool Special Open Door Forum — September 12
- Opioids: What's an "Outlier Prescriber"? Listening Session — September 17
- CMS Public Meeting: Action Plan to Prevent and Manage Opioid Use Disorder and Substance Use Disorder and Address Pain Management — September 20

MLN Matters® Articles

- Hurricane Dorian and Medicare Disaster Related State of Florida Claims
- Hurricane Dorian and Medicare Disaster Related States of Georgia and South Carolina Claims
- Hurricane Dorian and Medicare Disaster Related Commonwealth of Puerto Rico Claims
- 2020 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

- Annual Clotting Factor Furnishing Fee Update 2020
- Influenza Vaccine Payment Allowances - Annual Update for 2019-2020 Season
- October 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.3
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- October Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Multimedia

- CMS: Beyond the Policy Podcast: Dispatches from the Blue Button Developers Conference

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11437– 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

  The Centers for Medicare & Medicaid Services revised this article on September 4, 2019, to add: “MACs will continue to accept the AQ modifier on claims for services furnished in a geographic HPSA that is not on the list of ZIP codes for automated payments” (page 2). All other information is unchanged.

.

September 4, 2019

Part A Top Claims Submission / Reason Code Errors

The August 2019 Top Claim Submission / Reason Code 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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2019-2020 Flu, pneumococcal, and hepatitis B vaccine reimbursement

The influenza vaccine payment allowances annual update for the 2019-2020 season is available on the Fee Schedule page of our website.

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Medicare secondary payer: Gathering MSP information (A/B) October 8, 2019

Join us as we discuss Medicare as a secondary payer (MSP) and the fundamentals of this cost-saving program. During this webcast, we will discuss gathering information in relation to Medicare as the secondary payer.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE19017 – Hurricane Dorian and Medicare Disaster Related Commonwealth of Puerto Rico Claims

The Secretary of the Department of Health & Human Services declared a Public Health Emergency in the Commonwealth of Puerto Rico on August 28, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 26, 2019, and are in effect for 90 days.

The Centers for Medicare & Medicaid Services is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

More Information:

- Current Emergencies webpage
- Instructions to request an individual waiver if there is no blanket waiver

- SE19018 – Hurricane Dorian and Medicare Disaster Related State of Florida Claims

  The Secretary of the Department of Health & Human Services declared a Public Health Emergency in the State of Florida on August 30, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 28, 2019, and are in effect for 90 days.

  The Centers for Medicare & Medicaid Services is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

  More Information:

  - Current Emergencies webpage
  - Instructions to request an individual waiver if there is no blanket waiver

- MM11441 – 2020 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

  Change Request 11441 makes changes to HCPCS codes and Medicare Physician Fee Schedule (MPFS) designations that will be used to revise Medicare's Common Working File edits to allow Medicare Administrative Contractors to make appropriate payments in accordance with policy for SNF Consolidated Billing (CB) in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

- MM11435 – Annual Clotting Factor Furnishing Fee Update 2020

  Change Request 11435 announces that the clotting factor furnishing fee for 2020 is $0.226 per unit. Make sure your billing staffs are aware of the update to the annual clotting factor furnishing fee for 2020.

- MM11428 – Influenza Vaccine Payment Allowances - Annual Update for 2019-2020 Season

  Change Request 11428 informs Medicare Administrative Contractors about payment allowances for influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services will post the payment allowances for influenza vaccines that are approved after the release of CR 11428 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Make sure your billing staffs are aware of the payment allowances for the 2019-2020 season.

- MM11412 – October 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.3

- Change Request 11412 provides the I/OCE instructions and specifications for the Medicare Integrated OCE version 20.3 used as follows:
- Under the Outpatient Prospective Payment System (OPPS)
- For Non-OPPS hospital outpatient departments, community mental health centers and all non-OPPS providers
- For limited services when provided in a Home Health Agency not under the Home Health Prospective Payment System
- For a hospice patient for the treatment of a non-terminal illness

Make sure your billing staffs are aware of these changes.

- MM11451 – October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

  Change Request 11451 describes changes to and billing instructions for various payment policies that Medicare is implementing in the October 2019 OPPS update. Make sure your billing staffs are aware of these changes.

- MM11433 – October Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

  Change Request 11433 informs Durable Medical Equipment Medicare Administrative Contractors about the changes to the DMEPOS fee schedule that Medicare updates on a quarterly basis when necessary to implement fee schedule amounts for new codes. In addition, the update corrects any fee schedule amounts for existing codes and updates to the DMEPOS Rural ZIP code file. Make sure your billing staffs are aware of these changes.

.

September 3, 2019

September is prostate cancer awareness month

Prostate cancer is the most common nonskin cancer among men in the United States. Prostate cancer is treatable and has a very strong possibility of cure if it is caught early. September is a good time with this focus to speak to your patients, remind them of the concern of prostate cancer, and recommend that they pursue this annual screening service to help them to identify a potential health issue.

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August 30, 2019

The Centers for Medicare & Medicaid Services updated the following inpatient rehabilitation facility (IRF) resources:

- Inpatient rehabilitation facility prospective payment system booklet
- Inpatient rehabilitation facilities (IRFs): Improving documentation positively impacts CERT webinar (**Note**: You will need a login and password to access the MLN Learning Management System.)

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August 29, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: Open Door Forum — September 11

MLN Connects® for Thursday, August 29, 2019

View this edition as a PDF

News

- Promoting Interoperability: 2019 PDMP Bonus Measure
- Beneficiary Notices Initiative Mailbox Portal
- Promoting Interoperability: 2020 Eligible Hospital eCQM Flows
- DMEPOS: Nationwide Expansion of Required PA of Pressure Reducing Support Surfaces

Compliance

- IRF Services: Follow Medicare Billing Requirements

Events

- MIPS Value Pathways RFI Webinar — September 4
- Venipuncture: Comparative Billing Report Webinar — September 5
- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10
- New Medicare Card: Open Door Forum— September 11
- Hospice Outcomes & Patient Evaluation Tool ODF – September 12
- Opioids: What's an "Outlier Prescriber"? Listening Session — September 17
- Overall Hospital Star Ratings Listening Session - September 19

MLN Matters® Articles

- New Documentation Requirements for Filing Medicare Cost Reports
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2020
- Claim Status Category and Claim Status Codes Update
- 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
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions
- 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code set Update
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised

Publications

- Inpatient Rehabilitation Facility Prospective Payment System Booklet — Revised

Multimedia

- Physician Fee Schedule Listening Session: Audio Recording and Transcript
- IRF Appeals Settlement Call: Audio Recording and Transcript
- OPPS and ASC Listening Session: Audio Recording and Transcript
- ESRD QIP Call: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos
- Inpatient Rehabilitation Facilities (IRFs): Improving Documentation Positively Impacts CERT Web-Based Training Course — Revised

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The following proposed local coverage determination (LCD) has been posted for comment. The comment period will end on October 13, 2019:

- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (DL38385)

Submit Comments

The following future effective related billing and coding article has been added:

- Billing and Coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (A56938)

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Online registration available for September 13, 2019, Open meeting and proposed LCD now posted

Online registration for the September 13, 2019, Open meeting is now available and will close at 12:00 PM (Noon) Eastern Time (ET) on Wednesday, September 11, 2019, or before September 11th if room capacity is filled. The Novitas Solutions' proposed LCD for one of the June 2019 CAC meeting topics is now posted. **Important**: The Open meeting will be held at Novitas Solutions, 2020 Technology Parkway, Suite 100, Mechanicsburg, PA 17050 at 10:00 AM ET. Due to limited room capacity, registered presenters will be given priority for seating and registered observers will be accepted until remaining seats are filled.

Open meetings are for the specific purpose of discussing the proposed LCDs. Anyone is welcome to present information related to the proposed LCDs that are in the 45-day draft 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 28, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11003 – Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System

  The Centers for Medicare & Medicaid Services revised this article on August 26, 2019, to reflect changes made to the eMDR registration screens within the National Plan and Provider Enumeration System (NPPES).The article includes illustrations of the new screens that

providers will have to complete in order to register to receive the eMDRs. In particular, the steps and screens relating to “Create new Endpoint Information in NPPES” and “Delete an existing Endpoint Information in NPPES” have been revised or added. A section discussing “Who should register the endpoint information in NPPES” was also added. The NPPES updates result in no changes to the Change Request. All other information is unchanged. Please make sure your billing staffs are aware of these changes.

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August 26, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11393 – Claim Status Category and Claim Status Codes Update

  Change Request 11393 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 ASC X12 277 Health Care Claim Acknowledgement transactions. Make sure your billing staffs are aware of these updates.

- MM11394 – 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

  Change Request 11394 instructs Medicare Administrative Contractors and Medicare's Shared System Maintainers to update systems based on the CORE 360 Uniform use of CARC, RARC and CAGC rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2019. Make sure that your billing staffs are aware of these changes.

- MM11437 – 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

  Change Request 11437 provides files for the automated payments of HPSA bonuses for dates of service January 1, 2020, through December 31, 2020. Please make sure your billing staffs are aware of these updates.

- MM11418 – Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code set Update

  Change Request 11418 advises the Medicare Administrative Contractors to obtain the most recent HPTCs code set and use it to update their internal HPTC tables and, or reference files. Please make sure your billing staffs are aware of these changes.

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August 23, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE19015 – New Documentation Requirements for Filing Medicare Cost Reports

  Special Edition 19015 reminds providers of the new documentation requirements for filing Medicare Cost Reports that were published in the Fiscal Year 2019 Inpatient Perspective Payment System Final Rule.

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August 22, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: Read the Updated MLN Matters Article

MLN Connects® for Thursday, August 22, 2019

View this edition as a PDF

News

- Overall Hospital Quality Star Ratings: Upcoming Enhancement
- Pneumococcal Vaccine Eligibility Data Issue
- Venipuncture: Comparative Billing Report in August
- SNF Provider Preview Reports: Review Your Data by September 16
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- Promoting Interoperability: 2019 Program Requirements for Hospitals
- Quality Payment Program Exception Applications
- Hospice Compare Refresh
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- CBRs: We Want Your Feedback

Compliance

- Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

- MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

Events

- Understanding Your SNF VBP Program Performance Score Report Call — August 27
- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10

MLN Matters® Articles

- New Medicare Beneficiary Identifier (MBI) Get It, Use It — Reissued
- Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2019 Update
- Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020 — Revised

Publications

- MLN Catalog September 2019 Edition
- Ambulance Fee Schedule and Medicare Transports
- QPP: New Resources
- Getting Started with Hospice CASPER Review and Correct Reports
- Behavioral Health Integration — Revised
- Critical Access Hospital — Revised
- Swing Bed Services — Revised
- Screening Pap Tests and Pelvic Examinations Booklet — Revised
- Hospices: CASPER QM Fact Sheet — Updated

.

The following local coverage determinations (LCDs) have been revised. The related billing and coding articles for these LCDs have been added or revised:

- Intravenous Immune Globulin (IVIG) (L35093)
  - Billing and coding: Intravenous Immune Globulin (IVIG) (A56786)
- Loss-of-Heterozygosity Based Topographic Genotyping with PathfinderTG ® (L34864)
  - Billing and coding: Loss-of-Heterozygosity Based Topographic Genotyping with Pathfinder TG® (A56897)
- Microvascular Therapy (L36434)
  - Billing and coding: Microvascular Therapy (MVT) (A54343)
- Multiple Imaging in Oncology (L35391)
  - Billing and coding: Multiple Imaging in Oncology (A56848)
- Non-Vascular Extremity Ultrasound (L35409)
  - Billing and coding: Non-Vascular Extremity Ultrasound (A55037)
- Nusinersen (Spinraza) (L37682)
  - Billing and coding: Nusinersen (Spinraza) (A56860)
- Outpatient Wireless Pulmonary Artery Pressure Monitoring for Heart Failure (L36419)
  - Billing and coding: Outpatient Wireless Pulmonary Artery Pressure Monitoring for Heart Failure (A56856)
- Strapping (L36423)
  - Billing and coding: Strapping (A56804)

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 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: Implantable Automatic Defibrillators (A56355)

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August 21, 2019

Provider Specialty: Ambulance

The Ambulance Specialty page has been updated to add the Centers for Medicare & Medicaid Services new booklet on Ambulance Fee Schedule and Medicare Transports.

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Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE19008 – Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management

  Given the issues associated with using opioids for acute and chronic pain, this article summarizes some other treatment options to consider when you treat Medicare patients for chronic pain. This article is informational only and does not convey any new or revised Medicare policies.

Revised:

- SE18006 – New Medicare Beneficiary Identifier (MBI) Get It, Use It

  The Centers for Medicare & Medicaid Services reissued this article on August 19, 2019, to show that all new Medicare cards have been mailed. CMS encourages providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a health insurance claim number after January 1, 2020.

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August 20, 2019

Electronic submission of medical documentation system (esMD) split indicators

Novitas Solutions is experiencing a large number of esMD submissions for Appeals Content Type 9 and Medical Review Content Type 1 medical records. We are observing situations where the records are submitted for one case in separate submissions without a split indicator.

Starting September 1, 2019, the split indicator will be required. In this situation, if documentation is submitted without the split indicator, we will be rejecting the transmission and these records will not be reviewed.

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August 19, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11402 – Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2019 Update

  Change Request (CR) 11402 informs providers that the Centers for Medicare & Medicaid Services issued payment files to the MACs based on the 2019 Medicare Physician Fee

Schedule Final Rule. CR 11402 amends those payment files. Please make sure your billing staffs are aware of these changes.

- MM11403 – Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual

  Change Request 11403 updates the language in sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual to add a link to the current influenza codes and payment rates. Make sure your billing staffs are aware of these updates. For the Medicare-covered codes for the influenza vaccines approved by Food and Drug Administration for the current influenza vaccine season, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html.

- MM11422 – Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update

  Change Request 11422 updates the HCPCS code set for codes related to drugs and biologicals. Make sure your billing staffs are aware of these updates.

Revised:

- MM11345 – Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020 – Revised

  The Centers for Medicare & Medicaid Services (CMS) revised this article on August 16, 2019, to reflect a revised Change Request (CR) 11345 issued on August 15. CMS revised the CR to replace the Health Insurance Prospective Payment System Case Mix Group Codes spreadsheet with a corrected version. In this article, the CR release date, transmittal number and the web address of the CR was also revised. All other information remains the same.

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July 2019 Part A Newsletter

The July 2019 Part A Newsletter is now available. Please take a moment to review.

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August 15, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: Transition Period Ends in Less Than 5 Months

MLN Connects® for Thursday, August 15, 2019

View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 5 Months
- CAR T-Cell Cancer Therapy Available to Medicare Beneficiaries Nationwide
- DMEPOS Competitive Bidding: Round 2021 Deadlines
- MACRA Patient Relationship Categories and Codes: Learn More

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Events

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call — August 20
- IPPS/LTCH PPS FY 2020 Final Rule Special Open Door Forum — August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21
- Self-Direction for Dually Eligible Individuals Utilizing LTSS Webinar — August 21
- Radiation Oncology Model Listening Session — August 22
- Understanding Your SNF VBP Program Performance Score Report Call — August 27
- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10

MLN Matters® Articles

- Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services
- Display PARHM Claim Payment Amounts
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update

Publications

- Chronic Care Management Services — Revised
- ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets — Revised

Multimedia

- I&A Enrollment Webcast: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos

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High dollar reimbursement claims: Reason codes 7TOLR, 37577, 37551

The high dollar reimbursement claims article has been revised to include detailed instructions relating to reason codes 7TOLR, 37557, and 37551. Please make sure your billing staff are aware of these changes.

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August 14, 2019

Part A Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part A Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for July 2019. New questions / answers have been added to the following categories:

- Claim denials
- Return to provider
- Eligibility

Please take time to review these and other FAQs for answers to your questions.

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August 12, 2019

The comment period is now closed for the following proposed local coverage determinations (LCDs). Comments received will be reviewed by our contractor medical directors and response to comments articles will be posted to our website and related to the LCDs when they are posted for notice.

- 4Kscore Test Algorithm (DL37792)
- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATS) (DL38229)
- Micro-Invasive Glaucoma Surgery (MIGS) (DL38223)

.

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11420 – Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020

  Change Request 11420 identifies changes that the Centers for Medicare & Medicaid Services must make as part of the annual IPF PPS update established in the Medicare Program; FY 2020 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year (FY) Beginning October 1, 2019 (FY 2020) Final Rule. These changes are applicable to discharges occurring from October 1, 2019, through September 30, 2020 (FY 2020). Make sure your billing staffs are aware of these changes.

- MM11392 – International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update

  Change Request 11392 constitutes a maintenance update of International Classification of Diseases (ICD)-10 conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these updates..

- MM11312 – Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services

  Change Request 11312 directs Medicare Administrative Contractors (MACs) to implement logic that ensures they bypass payment window edits (3-days and 1-day) when processing claims for donor post-kidney transplant complications services. MACs will hold certain claims, as noted below, until Medicare's Common Working File system edits these claims correctly. Please be sure your billing staffs are aware of these changes.

- MM11355 – Display PARHM Claim Payment Amounts

  Change Request 11355 announces creation of a protected line level field to house the line level payment amount for the Pennsylvania Rural Health Model (PARHM). This field will represent the actual amount Medicare paid for the line. Make sure your billing staffs are aware of these changes.

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August 8, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: Will Your Claims Reject?

MLN Connects® for Thursday, August 8, 2019

View this edition as a PDF

News

- New Medicare Card: Will Your Claims Reject?
- Securing Access to Life-Saving Antimicrobial Drugs for American Seniors
- IRF/LTCH/SNF Quality Reporting Programs: Submission Deadline August 15
- Hospice Patient Assessment Instrument Focus Groups: Respond by August 26
- Emergency Triage, Treat, and Transport Model: Apply by September 19
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- 2019 QRDA III Implementation Guide: Updated Addendum
- Quality Payment Program: Reporting Patient Relationship Categories

Compliance

- Skilled Nursing Facility 3-Day Rule Billing

Events

- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12
- IRF Appeals Settlement Initiative Call — August 13
- OPPS and ASC Proposed Rule Listening Session — August 14
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call — August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21
- Radiation Oncology Model Listening Session — August 22
- Understanding Your SNF VBP Program Performance Score Report Call — August 27

MLN Matters® Articles

- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020
- Instructions for Use of Informational Remittance Advice Remark Code Alert on Laboratory Service Remittance Advices
- Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates' Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims
- Modification to the National Coordination of Benefits Agreement (COBA) Crossover Process
- October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
- Oxygen Policy Update
- Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Multimedia

- CMS: Beyond the Policy Podcast: Nursing Home Strategy Part 1 – Strengthening Oversight

- CLFS Public Meetings: Videos

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The following local coverage determinations (LCDs) have been revised. The related billing and coding articles for these LCDs have been added:

- Implantable Infusion Pump (L35112)
  - Billing and coding: Implantable Infusion Pump (A56778)
- Intravenous Immune Globulin (IVIG) (L35093)
  - Billing and coding: Intravenous Immune Globulin (IVIG) (A56786)
- Lacrimal Punctum Plugs (L35095)
  - Billing and coding: Lacrimal Punctum Plugs (A56780)
- Lower Extremity Major Joint Replacement (Hip and Knee) (L36007)
  - Billing and coding: Lower Extremity Major Joint Replacement (Hip and Knee) (A56796)
- Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (L34822)
  - Billing and coding: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs (A56776)
- Magnetic Resonance Angiography (MRA) (L34865)
  - Billing and coding: Magnetic Resonance Angiography (MRA) (A56805)
- Molecular Diagnostics: Genitourinary Infectious Disease Testing (L35015)
  - Billing and coding: Molecular Diagnostics: Genitourinary Infectious Disease Testing (A56791)
- Neuromuscular Junction Testing (L34996)
  - Billing and coding: Neuromuscular Junction Testing (A56785)
- Neurophysiology Evoked Potentials (NEPs) (L34975)
  - Billing and coding: Neurophysiology Evoked Potentials (NEPs) (A56773)

The following billing and coding article has been revised:

- Billing and Coding: Cardiovascular Nuclear Medicine (A56423)

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August 7, 2019

CMS Provider Education Message:

Special Edition – Wednesday, August 7, 2019

- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12
- OPPS and ASC Proposed Rule Listening Session — August 14

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Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12

Monday, August 12 from 1-2:30 pm ET

Register for Medicare Learning Network events.

Proposed changes to the CY 2020 Physician Fee Schedule are aimed at reducing burden, recognizing clinicians for the time they spend taking care of patients, removing unnecessary measures, and making it easier for clinicians to be on the path towards value-based care. During this listening session, CMS experts briefly cover three provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission:

- Increasing value of Evaluation and Management (E/M) payments
- Continuing to improve the Quality Payment Program by streamlining the program's requirement's in order to reduce clinician burden
- Creating the new Opioid Treatment Program benefit in response to the opioid epidemic

We encourage you to review the following materials prior to the call:

- Proposed rule
- Press release
- Physician Fee Schedule proposed rule fact sheet
- Quality Payment Program proposed rule fact sheet

Note: Feedback received during this listening session is not a substitute for your formal comments on the rule. See the proposed rule for information on submitting these comments by September 27.

Target Audience: Medicare Part B fee-for-service clinicians; office managers and administrators; state and national associations that represent health care providers; and other stakeholders.

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OPPS and ASC Proposed Rule Listening Session — August 14

Wednesday, August 14 from 2:30 to 4 pm ET

Register for Medicare Learning Network events.

CMS proposed updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems, including price and quality transparency that lay the foundation for a patient-driven health care system. During this listening session, CMS experts briefly cover provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission. Topics include:

- Price transparency: Requirements for all United States hospitals to make their standard charges public
- Increasing choices and encouraging site neutrality, including payments for clinic visits

We encourage you to review the proposed rule, press release, and fact sheet prior to the call. Note: Feedback received during this listening session is not a substitute for your formal comments on the rule. See the proposed rule for information on submitting these comments by September 27.

Target Audience: All hospitals operating in the United States and other stakeholders.

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August 5, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11406 – Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  Change Request 11406 provides instructions for the quarterly update to the Clinical Laboratory Fee Schedule. Make sure your billing staffs are aware of these updates.

- MM11307 – Modification to the National Coordination of Benefits Agreement (COBA) Crossover Process

  Change Request 11307 explains actions the Centers for Medicare & Medicaid Services is taking to ensure that the MACs handle certain Medicare Fee-For-Service inpatient claims submitted without a required diagnosis code or incorrect Claim Adjustment Group Code, as included on submissions for incoming Medicare Secondary Payer claims, in a standard manner. Make sure your billing staffs are aware of this information.

- MM11381 – October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

  Change Request (CR) 11381 provides updates to the lists of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS).

  CR11381 alerts providers of incorrectly categorized CPT codes 29580, 29581, and 29584. CR 11381 provides instructions to categorize these codes correctly on the SNF CB files.

  Section 1888 of the Social Security Act codifies SNF PPS and Consolidated Billing (CB). The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services are in place because of these routine updates; that is, the new updates occur because of changes to the coding system, not because of redefined services subject to SNF CB. There are no other regulatory changes beyond code list updates.

  Make sure your billing staffs are aware of these changes.

- MM11345 – Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020

  Change Request 11345 notifies MACs that a new IRF Pricer software package will be released prior to October 1, 2019, which will contain the updated rates that are effective for claims with discharges that fall within October 1, 2019, through September 30, 2020. MACs will install and pay IRF claims with the FY 2020 IRF PPS Pricer for discharges on or after October 1, 2019. Make sure your billing staffs are aware of these changes.

- MM11369 – Instructions for Use of Informational Remittance Advice Remark Code Alert on Laboratory Service Remittance Advices

  Change Request 11369 states, effective January 1, 2020, MACs will include a revised informational Remittance Advice Remark Code Alert Code N817 on all Remittance Advices returned from processed claims containing a laboratory service. Make sure your billing staffs are aware of these changes.

- MM11290 – Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates' Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims

  Change Request 11290 requires SNF affiliates of Accountable Care Organizations (ACOs) participating in the Shared Savings Program to include demonstration code 77 in the treatment authorization field on claims when the SNF affiliate intends for the claim to be subject to the SNF 3-day rule waiver. Beginning with admissions on or after January 1, 2020, ACO SNF affiliates need to submit demonstration code 77 on claims in the treatment authorization field to serve as the SNF affiliate's attestation that the eligibility requirements for using a SNF 3-Day Rule Waiver have been met. Should Medicare systems determine the beneficiary is deemed

ineligible for services under the demonstration code 77, MACs will reject the claim with the following messages:

- Claim Adjustment Reason Code 272: Coverage/program guidelines were not met.
- Remittance Advice Remark Code N564: Patient did not meet the inclusion criteria for the demonstration project or pilot program.

This waiver is only available to ACOs that are eligible and approved to use the SNF 3-day rule waiver. Make sure your SNF billing staffs are aware of the requirement to include demonstration code 77 in the treatment authorization field.

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Part A Top Claims Submission / Reason Code Errors

The July 2019 Top Claim Submission / Reason Code 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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August 2, 2019

CMS Provider Education Message:

Special Edition – Friday, August 2, 2019

- IPPS/LTCH: FY 2020 PPS Final Rule
- IRF: FY 2020 Payment and Policy Changes
- Hospice: FY 2020 Hospice Payment Rate Final Rule

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IPPS/LTCH: FY 2020 PPS Final Rule

On August 2, CMS finalized policy changes to spur competition and innovation that will help deliver improved care and outcomes at a better value to patients. The final rule updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for FY 2020 and advances two key CMS priorities—“Rethinking Rural Health” and “Unleashing Innovation” by making historic changes to how Medicare pays hospitals. This final rule:

- Increases the wage index for certain low-wage index hospitals, including many rural hospitals
- Increases Medicare add-on payments for high cost eligible new technologies from 50-65%
- Clarifies policies on “substantial clinical improvement” to qualify for new technology add on payments
- Provides an alternative pathway where Breakthrough Devices are no longer required to demonstrate evidence of “substantial clinical improvement” to qualify for new technology add-on payments
- Provides an alternative pathway where Qualified Infectious Disease Products are no longer required to meet the “substantial clinical improvement” criteria for technology add-on payments, which are increased from 50 to 75%

For More Information:

- Final Rule
- Fact Sheet

Press release See the full text of this excerpted CMS Press Release (Issued August 2).

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IRF: FY 2020 Payment and Policy Changes

On July 31, CMS issued a final rule that updates Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program for FY 2020. We are continuing our efforts towards the eventual transition to a unified post-acute care system through updates to the data used for IRF payments, including revising the Case-Mix Groups (CMGs), updating the CMG relative weights and average length of stay values, and using concurrent inpatient prospective payment system wage index data for the IRF PPS to align wage index data across settings of care.

For FY 2020, CMS is finalizing updates to the IRF PPS payment rates using the most recent data to reflect an estimated 2.5 percent increase factor (reflecting an IRF-specific market basket increase factor of 2.9 percent, reduced by a 0.4 percentage point multifactor productivity adjustment). CMS projects that IRF payments will increase by 2.5 percent (or $210 million) for FY 2020, relative to payments in FY 2019.

This Rule Finalizes:

- Rebase and revise the IRF market basket
- Clarification of “rehabilitation physician”
- Two new quality measures

See the full text of this excerpted CMS Fact Sheet (Issued July 31).

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Hospice: FY 2020 Hospice Payment Rate Final Rule

On July 31, CMS issued a final rule that demonstrates continued commitment to strengthening Medicare by better aligning the hospice payment rates with the costs of providing care and increasing transparency so patients can make more informed choices. For FY 2020, hospice payment rates are updated by 2.6 percent ($520 million increase in their payments). The final hospice cap amount for the FY 2020 cap year will be $29,964.78, which is equal to the FY 2019 cap amount ($29,205.44) updated by the final FY 2020 hospice payment update percentage of 2.6 percent. The aggregate cap limits the overall payments per patient made to a hospice annually.

This Rule Finalizes:

- Rebasing to more accurately align Medicare payments with the costs of providing care
- Modifications to the election statement beginning in FY 2021, increasing coverage transparency for beneficiaries under a hospice election
- Hospice Quality Reporting Program updates, including developing a hospice assessment tool for real-time patient assessments

For More Information:

- Final Rule
- Hospice Center webpage
- Hospice Quality Reporting webpage

See the full text of this excerpted CMS Fact Sheet (Issued July 31).

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The comment period will close on August 11, 2019, for the following proposed local coverage determinations (LCDs):

- 4Kscore Test Algorithm (DL37792)
- Gastrointestinal Pathogen (GIP) Panels Utilizing Multiplex Nucleic Acid Amplification Techniques (NAATS) (DL38229)
- Micro-Invasive Glaucoma Surgery (MIGS) (DL38223)

Submit comments

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August 1, 2019

CMS Provider Education Message:

MLN Connects — Protect Your Patients' Identities: Use the MBI Now

MLN Connects® for Thursday, August 1, 2019

View this edition as a PDF

News

- SNF: FY 2020 Payment and Policy Changes
- IPF: FY 2020 Payment and Quality Reporting Updates
- Protect Your Patients' Identities: Use the MBI Now
- CMS Advances MyHealthEData with New Pilot to Support Clinicians
- Reducing Administrative Burden: Comment by August 12
- Medicare Coverage for Treatment Services Furnished by Opioid Treatment Programs
- Open Payments Program Expansion
- Improve Accessibility of Care for People with Disabilities: New Resources
- Part A Providers: Formal Telephone Discussion Demonstration
- July – September Quarterly Provider Update
- Disaster Preparedness Resources
- Vaccines Are Not Just for Kids

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Events

- Emergency Triage, Treat, and Transport Model Application Tutorial Webinar — August 8

- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12
- IRF Appeals Settlement Initiative Call — August 13
- OPPS and ASC Proposed Rule Listening Session — August 14
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call — August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21
- Understanding Your SNF VBP Program Performance Score Report Call — August 27

MLN Matters® Articles

- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period – Claims Processing Requirements
- New Waived Tests
- Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment — Revised

Publications

- Skilled Nursing Facility 3-Day Rule Billing
- Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies — Revised

Multimedia

- Quality Payment Program Merit-based Incentive Payment System (MIPS): Cost Performance Category in 2019 Web-Based Training Course — Revised
- Quality Payment Program 2019 Overview Web-Based Training Course — Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019 Web-Based Training Course — Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Improvement Activities in 2019 Web-Based Training Course — Revised

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July 29, 2019

CMS Provider Education Message:

Special Edition – Monday, July 29, 2019

- PFS: Proposed Policy, Payment, and Quality Provisions Changes for CY 2020
- Medicare OPPS and ASC Payment System CY 2020 Proposed Rule
- ESRD and DMEPOS CY 2020 Proposed Rule

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PFS: Proposed Policy, Payment, and Quality Provisions Changes for CY 2020

On July 29, CMS issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2020. This proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better accessibility, quality, affordability, empowerment, and innovation. It also includes proposals to streamline the Quality

Payment Program with the goal of reducing clinician burden. This includes a new, simple way for clinicians to participate in our pay-for-performance program, the Merit-based Incentive Payment System (MIPS), called the MIPS Value Pathways.

The proposed rule also includes:

- CY 2020 PFS rate setting and conversion factor
- Medicare telehealth services
- Payment for evaluation and management services
- Physician supervision requirements for physician assistants
- Review and verification of medical record documentation
- Care management services
- Comment solicitation on opportunities for bundled payments
- Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs
- Bundled payments for substance use disorders
- Therapy services
- Ambulance services
- Ground ambulance data collection system
- Open Payments Program
- Medicare Shared Savings Program
- Stark advisory opinion process

For More information:

- Proposed Rule: Public comments due by September 27
- Press Release
- PFS Proposed Rule Fact Sheet
- Quality Payment Program Proposed Rule Fact Sheet

See the full text of this excerpted Fact Sheet (Issued July 29).

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Medicare OPPS and ASC Payment System CY 2020 Proposed Rule

On July 29, CMS proposed policies that follow directives in President Trump's Executive Order, entitled "Improving Price and Quality Transparency in American Health Care to Put Patients First," that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The proposed changes also encourage site-neutral payment between certain Medicare sites of services. Finally, the proposed rule proposes updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed polices in the CY 2020 OPPS/ASC Payment System proposed rule would further advance the agency's commitment to increasing price transparency, (including proposals for requirements that would apply to each hospital operating in the United States),

strengthening Medicare, rethinking rural health, unleashing innovation, reducing provider burden, and strengthening program integrity so that hospitals and ambulatory surgical centers can operate with better flexibility and patients have what they need to become active health care consumers.

In accordance with Medicare law, CMS is proposing to update OPPS payment rates by 2.7 percent. This update is based on the projected hospital market basket increase of 3.2 percent minus a 0.5 percentage point adjustment for Multi-Factor Productivity (MFP).

In the CY 2019 OPPS/ASC final rule with comment period, we finalized our proposal to apply the hospital market basket update to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023). CMS is not proposing any changes to its policy to use the hospital market basket update for ASC payment rates for CY 2020-2023. Using the hospital market basket, CMS proposes to update ASC rates for CY 2020 by 2.7 percent for ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 3.2 percent minus a 0.5 percentage point adjustment for MFP. This change will also help to promote site neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

The proposed rule also includes:

- Proposed definition of ‘hospital,’ ‘standard charges,’ and ‘items and services’
- Proposed requirements for making public all standard charges for all items and services
- Proposed requirements for making public consumer-friendly standard charges for a limited set of ‘shoppable services’
- Proposals for monitoring and enforcement
- Method to control for unnecessary increases in utilization of outpatient services
- Changes to the Inpatient Only list
- ASC covered procedures list
- High-cost/low-cost threshold for packaged skin substitutes
- Device pass-through applications
- Addressing wage index disparities
- Changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- CY 2020 OPPS payment methodology for 340B purchased drugs
- Partial Hospitalization Program rate setting and update to per diem rates
- Revision to the organ procurement organization conditions for certification
- Potential changes to the organ procurement organization and transplant center regulations: Request for Information

For More Information:

- Proposed Rule: Public comments due by September 27
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued July 29).

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ESRD and DMEPOS CY 2020 Proposed Rule

On July 29, CMS issued a proposed rule that proposes to update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2020. This rule also:

- Proposes updates to the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI
- Proposes changes to the ESRD Quality Incentive Program
- Includes requests for information on data collection resulting from the ESRD PPS technical expert panel, on possible updates and improvements to the ESRD PPS wage index, and on new rules for the competitive bidding of diabetic testing strips.

In addition, this rule proposes a methodology for calculating fee schedule payment amounts for new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items and services and making adjustments to the fee schedule amounts established using supplier or commercial prices if such prices decrease within five years of establishing the initial fee schedule amounts. This rule would also:

- Make amendments to revise existing policies related to the competitive bidding program for DMEPOS
- Streamline the requirements for ordering DMEPOS items, and create one Master List of DMEPOS items that could potentially be subject to face-to-face encounter and written order prior to delivery and/or prior authorization requirements

The proposed CY 2020 ESRD PPS base rate is $240.27, an increase of $5.00 to the current base rate of $235.27. This proposed amount reflects a reduced market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.7 percent) and application of the wage index budget-neutrality adjustment factor (1.004180).
The proposed rule also includes:

- Annual update to the wage index
- Update to the outlier policy
- Eligibility criteria for the Transitional Drug Add-on Payment Adjustment (TDAPA)
- Basis of Payment for the TDAPA for calcimimetics
- Average sales price conditional policy for the application of the TDAPA:
- New and innovative renal dialysis equipment and supplies
- Discontinuing the application of the erythropoiesis-stimulating agent monitoring policy
- Impact analysis:

For More Information:

- Proposed Rule: Public comments due by September 27
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued July 29).

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August is national immunization awareness month

Help protect your Medicare patients from vaccine-preventable diseases by encouraging utilization of Medicare-covered immunizations and ensuring those immunizations are up-to-date.

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July 26, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11268 – Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period – Claims Processing Requirements

  Change Request (CR) 11268 informs the Medicare Administrative Contractors (MACs) that effective January 1, 2020 (the start of the AUC program Educational and Operations Testing Period), MACs should accept the Appropriate Use Criteria (AUC) related HCPCS modifiers on claims. Please be sure your billing staff and vendors are aware of this update. Subsequent CRs will follow at a later date that will continue AUC program implementation.

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July 25, 2019

CMS Provider Education Message:

MLN Connects — Questions about Using the MBI?

MLN Connects® for Thursday, July 25, 2019

View this edition as a PDF

News

- New Medicare Card: Questions about Using the MBI?
- 2020 QRDA III Implementation Guide, Schematron, and Sample Files
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Compliance

- Importance of Proper Documentation: Provider Minute Video

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30
- Diagnosing and Treating Dementia: Current Best Practices Webinar — July 30
- Quality Payment Program Performance Information on Physician Compare Webinar — July 30/Aug 1
- Disability-Competent Care Conversation on Access Webinar — July 31
- RF Appeals Settlement Initiative Call — August 13
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21

MLN Matters® Articles

- Medicare Plans to Modernize Payment Grouping and Code Editor Software

Publications

- Medicare DMEPOS Improper Inpatient Payments
- Medicare Part D Vaccines — Revised
- Provider Compliance Tips for Enteral Nutrition Pumps — Revised

Multimedia

- Hospital Listening Session: Audio Recording and Transcript
- Hospice Quality Reporting Program Web-Based Courses

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The following local coverage determinations (LCDs) have been revised. The related billing and coding articles for these LCDs have been added:

- Evaluation and Management Services Provided in a Nursing Facility (L35068)
  - Billing and coding: Evaluation and Management Services Provided in a Nursing Facility (A56712)
- Flow Cytometry (L35032)
  - Billing and coding: Flow Cytometry (A56676)
- Hyperbaric Oxygen (HBO) Therapy (L35021)
  - Billing and coding: Hyperbaric Oxygen (HBO) Therapy (A56714)
- Intensity Modulated Radiation Therapy (IMRT) (L36711)
  - Billing and coding: Intensity Modulated Radiation Therapy (IMRT) (A56725)
- Intraoperative Neurophysiological Testing (L35003)
  - Billing and coding: Intraoperative Neurophysiological Testing (A56722)
- In Vitro Chemosensitivity & Chemoresistance Assays (L36634)
  - Billing and coding: In Vitro Chemosensitivity & Chemoresistance Assays (A56710)

The following local coverage determination (LCD) has been revised

- Services That Are Not Reasonable and Necessary (L35094)

The following local coverage article has been revised:

- Billing and Coding: Hemophilia Factor Products (A56433)

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Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11273 – Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment

  Change Request 11273 removes the requirement that the medical record show a home visit was medically necessary instead of an office or outpatient visit. Also, the Centers for Medicare & Medicaid Services added a new section to chapter 12 of the Medicare Claims Processing Manual regarding Evaluation and Management codes that you may bill with superficial radiation treatment. Make your billing staff aware of these changes.

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July 23, 2019

Hospital off-campus outpatient department reporting requirements

Changes to editing for appropriate reporting of off-campus outpatient department locations will impact all providers. Payment impacts related to this reporting will only impact those providers paid under the outpatient prospective payment system (OPPS). For more information view the entire article.

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July 18, 2019

CMS Provider Education Message:

MLN Connects — DMEPOS Competitive Bidding: Round 2021 Bid Window is Open

MLN Connects® for Thursday, July 18, 2019

View this edition as a PDF

News

- Is Your Vendor/Clearinghouse Submitting Your Claims with the MBI?
- DMEPOS Competitive Bidding: Round 2021 Bid Window is Open
- Nursing Homes: Updating Requirements for Arbitration Agreements and New Regulations
- CMS Proposes to Cover Acupuncture for Chronic Low Back Pain for Medicare Beneficiaries Enrolled in Approved Studies
- Quality Payment Program: 2018 MIPS Performance Feedback and Final Score
- Quality Payment Program Participation: Preliminary Data on 2018
- Physician Compare: 2017 Quality Payment Program Performance Information
- PEPPERs for HHAs, PHPs
- 2017 Physician and Other Supplier PUF
- 2017 Referring Provider DMEPOS PUF
- Qualified Medicare Beneficiary Billing Requirements
- Mass Casualty Triage White Paper and June Express
- Looking for Educational Materials?

Compliance

- Cardiac Device Credits: Medicare Billing

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30
- IRF Appeals Settlement Initiative Call — August 13

MLN Matters® Articles

- Tropical Storm Barry and Medicare Disaster Related Louisiana Claims

- Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines
- Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program
- Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infant Protection Act
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2019
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2019
- Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home
- July 2019 Update of the Ambulatory Surgical Center (ASC) Payment System
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations — Revised

Publications

- Provider Compliance Tips for Respiratory Assistive Devices — Revised
- Provider Compliance Tips for Enteral Nutrition — Revised

Multimedia

- Post-Acute Care Call: Audio Recording and Transcript

.

July 17, 2019

Part A Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part A Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for June 2019. New questions / answers have been added to the following categories:

- Appeals
- Claim denials
- General information

Please take time to review these and other FAQs for answers to your questions.

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July 16, 2019

Provider Enrollment alert - Issues resulting from recent Provider Enrollment, Chain and Ownership System (PECOS) release

On June 30, 2019, PECOS Release 7.37 was implemented. This release was prescheduled and designed to bring efficiencies to Medicare administrative contractors (MACs) and providers who use

PECOS. While many aspects of the release were successful, a small component associated to changes made to existing and new group reassignments, was found to be problematic post-implementation. As a result, data flows from PECOS to the Multi-Carrier System (MCS) for these changes have been delayed for all MACs to proactively correct the identified issue.

The Centers for Medicare & Medicaid Services has assembled a team with accountability for resolving this issue. The team is working tirelessly to resolve the issue(s). While some records are expected to be corrected by Tuesday, July 16, 2019, problems persist for other records. Please be assured that the team is working aggressively for a resolution. Click here for potential questions and answers that you may have.

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July 15, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE19014 – Tropical Storm Barry and Medicare Disaster Related Louisiana Claims

  The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the state of Louisiana on July 12, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to July 10, 2019, and are in effect for 90 days.

  The Centers for Medicare & Medicaid Services is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

  More Information:

  - Current Emergencies webpage
  - Instructio3 ns to request an individual waiver if there is no blanket waiver

- MM11295 – Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

  Change Request 11295 informs MACs about changes which update the list of International Classification of Diseases, Tenth Revision, Clinical Modification codes for the coverage of Intravenous Immune Globin for treatment of Primary Immune Deficiency Diseases in the home. Make sure that your billing staffs are aware of these changes.

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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 12, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11344 – Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2019

Change Request 11344 announces changes that will be in the October 2019 quarterly release of the edit module for clinical diagnostic laboratory services. Please make sure your billing staffs are aware of these changes.

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July 11, 2019

CMS Provider Education Message:

MLN Connects — New Medicare Card: Transition Period Ends in Less Than 6 Months

MLN Connects® for Thursday, July 11, 2019

View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 6 Months
- HHS To Transform Care Delivery for Patients with Chronic Kidney Disease
- CMS Expands Coverage of Ambulatory Blood Pressure Monitoring
- Open Payments: Program Year 2018 Data
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30

MLN Matters® Articles

- Medicare Plans to Modernize Payment Grouping and Code Editor Software
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2020
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program — Revised
- July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2 — Revised
- July Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications

- Get Your New Medicare Card
- Medicare Documentation Job Aid for Doctors of Chiropractic
- Medicare Preventive Services — Revised

Multimedia

- CMS: Beyond the Policy Podcast: Throwback to HIMSS Conference

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CMS Provider Education Message: Home Health Payment and Policy Changes

Special Edition – Thursday, July 11, 2019

HHAs: CY 2020 and 2021 New Home Infusion Therapy Benefit and Payment and Policy Changes

On July 11, CMS issued a proposed rule [CMS-1711-P] that proposes routine updates to the home health payment rates for CY 2020, in accordance with existing statutory and regulatory requirements. This rule will also include:

- Proposal to modify the payment regulations pertaining to the content of the home health plan of care
- Proposal to allow therapist assistants to furnish maintenance therapy
- Proposal related to the split percentage payment approach under the Home Health Prospective Payment System (PPS)
- Proposals related to the implementation of the permanent home infusion therapy benefit in 2021

This proposed rule sets forth implementation of the Patient-Driven Groupings Model (PDGM), an alternate case-mix adjustment methodology, and a 30-day unit of payment as mandated by the Bipartisan Budget Act of 2018 (BBA of 2018). CMS projects that Medicare payments to Home Health Agencies (HHAs) in CY 2020 will increase in aggregate by 1.3 percent, or $250 million, based on proposed policies. The increase reflects the effects of the 1.5 percent home health payment update percentage ($290 million increase) mandated by BBA of 2018. It also reflects a 0.2 percent decrease in aggregate payments due to reductions made by the new rural add-on policy mandated by the BBA of 2018 for CY 2020 (i.e., an estimated $40 million decrease in rural add-on payments). The rate updates also include adjustments for anticipated changes with implementation of the PDGM and a change to a 30-day unit of payment, the use of updated wage index data for the home health wage index, and updates to the fixed-dollar loss ratio to determine outlier payments.

In addition, the proposed rule includes:

- Proposed payment rate changes for home infusion therapy temporary transitional payments for CY 2020
- Payment proposals for new home infusion therapy benefit for CY 2021
- Regulatory burden reduction – Patients over paperwork and enhance and modernize program integrity
- Paraprofessional roles – Improving access to care
- Home Health Quality Reporting Program – Support MyHealthEData Initiative
- Home Health Value-Based Purchasing model

For More Information:

- Proposed Rule
- Press Release
- Home Health PPS website
- Home Health Quality Reporting Requirements webpage
- Home Health Value-Based Purchasing Model webpage

See the full text of this excerpted CMS Fact Sheet (issued July 11).

The following local coverage determinations (LCDs) have been revised. The related billing and coding articles for these LCDs have been added:

- Debridement of Mycotic Nails (L35013)
  - Billing and coding: Debridement of Mycotic Nails (A56640)
- Diagnostic Abdominal Aortography and Renal Angiography (L35092)
  - Billing and coding: Diagnostic Abdominal Aortography and Renal Angiography (A56682)
- Electroretinography (ERG) (L37371)
  - Billing and coding: Electroretinography (ERG) (A56672)
- Epidural Injections for Pain Management (L36920)
  - Billing and coding: Epidural Injections for Pain Management (A56681)
- Facet Joint Interventions for Pain Management (L34892)
  - Billing and coding: Facet Joint Interventions for Pain Management (A56670)
- Hydration Therapy (L34960)
  - Billing and coding: Hydration Therapy (A56634)

The following Local Coverage Article has been revised:

- Independent Diagnostic Testing Facility (IDTF) (A53252)

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Medicare secondary payer: Non-group health plans (NGHP) (A/B) September 17, 2019

Join us as we discuss Medicare as a secondary payer (MSP) and the fundamentals of this cost-saving program. During this webcast, we will provide information regarding non-group health plans in relation to Medicare as the secondary payer.

Medicare secondary payer (MSP) is a term used when Medicare is not the beneficiary's primary health insurance coverage. Providers are responsible to determine whether Medicare is the primary payer or not, as well as billing for the services and/or supplies provided to Medicare beneficiaries. One of the top inquiries we receive every month is regarding a patient's eligibility and MSP. This event is the third in a series of webcasts designed in collaboration with the A/B Medicare administrative contractors (MAC) to educate Medicare providers on the fundamentals of the MSP program.

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June 2019 Part A Newsletter

The June 2019 Part A Newsletter is now available. Please take a moment to review.

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July 10, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- SE19001 – Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program

This article is for providers who may refer Medicare patients to the Medicare Diabetes Prevention Program (MDPP) for services to reduce diabetes risk.

- SE19011 – Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines

  This article is for physicians, non-physician practitioners (NPPs), other prescribers, and pharmacists who prescribe or dispense opioids and benzodiazepines (BZDs).

- SE19012: Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infant Protection Act

  EMTALA requires Medicare participating hospitals (including critical access hospitals) to perform the following:

  - Provide medical screening examinations to every individual, including women in labor, their unborn child(ren), and newly born infants protected by the Born-Alive Infant Protection Act when they present for care to dedicated emergency departments, which includes labor and delivery departments, or other locations on the hospital campus;
  - Provide stabilizing treatment within the hospital's capabilities to any individual, including a born-alive infant, with an emergency medical condition;
  - If unable to stabilize the emergency medical condition, arrange for an appropriate transfer to another hospital with specialized services for the necessary stabilizing treatment; and,
  - Accept appropriate transfers of patients with unstable emergency medical conditions if the hospital has the capabilities and capacity to provide necessary stabilizing treatment.

  EMTALA protections start for an infant at time of birth. A newly born infant is presumed to be presenting with an emergency medical condition and requires a medical screening examination to determine necessary stabilizing treatment. EMTALA requires physicians and other qualified practitioners to provide care within nationally accepted standards of practice.

- SE19013 – Medicare Plans to Modernize Payment Grouping and Code Editor Software

  The Centers for Medicare & Medicaid Services is modernizing its grouping and code editor software. Medicare processes all Original Medicare institutional claims through one of three sub-systems within the Fiscal Intermediary Shared System:

  - The Medicare Code Editor
  - The Inpatient Grouper
  - The Integrated Outpatient Code Editor

  These sub-systems are built with an antiquated programming language (Assembler) that is difficult to extend, maintain, support and test. Modernizing these programs will protect CMS from future quality and integration risks.

Revised:

- SE19007 – Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

  The Centers for Medicare & Medicaid Services revised this article on June 28, 2019, to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019.

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July 9, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11343 – October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

  Change Request 11343 informs MACs about new and revised ASP and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) will make files available for download on or after September 13, 2019.

  CMS gives Medicare Administrative Contractors the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System are incorporated into the Outpatient Code Editor through separate instructions available in Chapter 4, Section 50 of the Medicare Claims Processing Manual. Make sure that your billing staffs are aware of these changes

Revised:

- MM11230 – Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program

  The Centers for Medicare & Medicaid Services (CMS) revised this article on July 9, 2019, to reflect the revised Change Request (CR) 11230 issued on July 3. In the article, CMS deleted a reference to the Fiscal Intermediary Standard System rejections that was on page 3. They also revised the release date, transmittal number, and the web address of the CR. All other information remains the same.

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July 5, 2019

Local coverage determination (LCD) and article update history

The following local coverage determination (LCD) has been revised. The related billing and coding article has also been revised:

- Frequency of Hemodialysis (L35014)
  - Billing and coding: Frequency of Hemodialysis (A55723)

July 3, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11280 – Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

  The Centers for Medicare & Medicaid Services (CMS) revised this article on July 3, 2019, to reflect a revised Change Request (CR) that they posted on June 28. In the article, a section was added on page 5 regarding Advanced Diagnostic Laboratory Tests. CMS also revised the CR release date, transmittal number, and the web address. All other information remains the same.

- MM11298 – July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2

  The Centers for Medicare & Medicaid Services (CMS) revised this article on July 3, 2019, to reflect the revised Change Request (CR) 11298 that they issued on June 28. In the article,

CMS revised the CR release date, transmittal number, and the Web address. All other information remains the same.

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July 2, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

New:

- MM11347 – Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2020

  Change Request 11347 provides information on the Fiscal Year (FY) 2020 updates to the SNF PPS payment rates, as required by statute. Make sure your billing staffs are aware of these updates.

Revised:

- MM11334 – July Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

  The Centers for Medicare & Medicaid Services (CMS) revised this article on July 2, 2019, to reflect the revised Change Request (CR) 11334 issued on June 28. CMS revised the CR to include a correction to the fee schedule amounts for HCPCS codes E1353 and E1355. The article includes this correction information on page 4. CMS also revised the CR release date, transmittal number, and the web address. All other information remains the same.

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Part A Top Claims Submission / Reason Code Errors

The June 2019 Top Claim Submission / Reason Code 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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July 1, 2019

Medicare Learning Network® MLN Matters® Articles from CMS

Revised:

- MM11296 – Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – July 2019 Update

  The Centers for Medicare & Medicaid Services (CMS) revised this article on June 19, 2019 to reflect the revised Change Request (CR) 11296 issued on June 12. CMS revised the CR to update the short and long descriptors of Q5115 and revised the article accordingly. The CR release date, transmittal number, and the web address have also been revised. All other information remains the same.

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