PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

April 1, 2020

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

PARA

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FAST LINKS

ULTRASOUND FOR CRNA

Q. The CRNAs are asking for an answer on this ASAP. They are holding bills on cases where they used the ultrasound. They also would like to know if it is chargeable, is a hard copy or electronic copy of the ultrasound picture required to charge?

A. **Answer:** Yes, the CRNAs may report CPT® 76937 when using ultrasound to guide the placement of a peripheral IV catheter, provided that the medical documentation meets all of the requirements of that code – the requirements are contained in the code description:

76937 - ULTRASOUND GUIDANCE FOR VASCULAR ACCESS REQUIRING ULTRASOUND EVALUATION OF POTENTIAL ACCESS SITES, DOCUMENTATION OF SELECTED VESSEL PATENCY, CONCURRENT REAL TIME ULTRASOUND VISUALIZATION OF VASCULAR NEEDLE ENTRY, WITH PERMANENT RECORDING AND REPORTING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE).

Picking apart that code description, the documentation should include the following elements:

- A statement why a US evaluation is required
- Identification of the selected vessel, describing its patency
- Evidence that the visualization was real time (e.g. a statement that was used in real time), and permanent record of the image used maintained in the patient medical record. This could be electronic, for examle a PACS system or a hard-copy paper.

On the facility fee side:

Medicare reimbursement on 76937 is "packaged" to other payable lines – since it is an add-on code, there must be another HCPCS on the same claim that will be acceptable as primary. For that reason, I'm not sure it's a good idea to charge a facility fee. You might find it causes claim edits that generate more work without additional reimbursement.

On the professional fee claim:

The CRNA could report 76937 and be reimbursed, but only when billed together with a primary code, such as 36410. Since the CRNAs would be billing for the professional component only, they should append modifier 26 to 76937 on the professional fee claim:

2020 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **36410,76937** for selected Provider:
Results returned(below): 2
AWI: **0.9062**, DME: **NC**, Clinical Lab Fee Schedule: **NC**, Physician Fee Schedule:

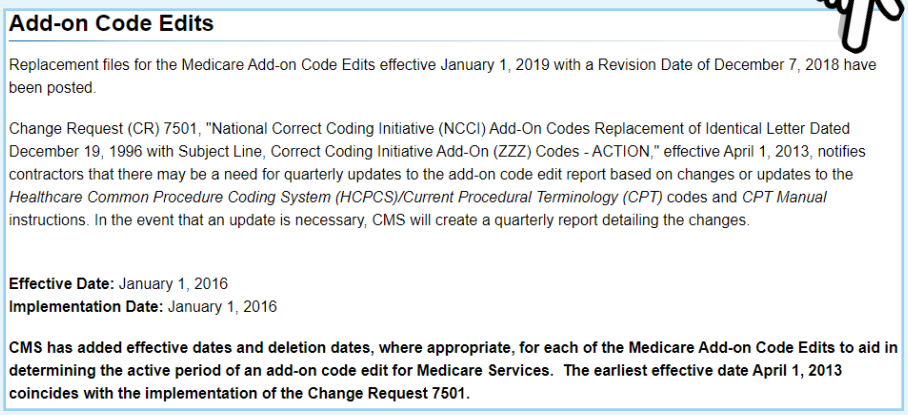
Export to PDF | Export to Excel | Physi

Current Descriptor	Fee Schedule		Initial APC	Payment
36410 - venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture) **N - Payment is packaged into payment for other services.**	GB (Physician Facility):	$9.39		
	GB (Physician Non-Facility):	$16.78		
76937 - ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure) **N - Payment is packaged into payment for other services.**	GB (Physician Facility):	$35.20		
	GB (Physician Non-Facility):	$35.20		
	26 (Physician Facility):	$14.39		
	26 (Physician Non-Facility):	$14.39		
	TC (Physician Facility):	$20.81		
	TC (Physician Non-Facility):	$20.81		

ULTRASOUND FOR CRNA

Primary to the Add-On code --The CRNA must report a primary code along with 76937. It would be inappropriate for the CRNA to report one of the the infusion codes (i.e. 96365 or 96413) in the facility setting – those are not split-billable codes. Medicare allows the individual contractors to determine which primary codes are acceptable for 76937 – I would expect (but cannot affirm) that 36410 would work (36410 - Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture.)

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits



Add-on Code Edits

Replacement files for the Medicare Add-on Code Edits effective January 1, 2019 with a Revision Date of December 7, 2018 have been posted.

Change Request (CR) 7501, "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes - ACTION," effective April 1, 2013, notifies contractors that there may be a need for quarterly updates to the add-on code edit report based on changes or updates to the *Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT)* codes and *CPT Manual* instructions. In the event that an update is necessary, CMS will create a quarterly report detailing the changes.

Effective Date: January 1, 2016
Implementation Date: January 1, 2016

CMS has added effective dates and deletion dates, where appropriate, for each of the Medicare Add-on Code Edits to aid in determining the active period of an add-on code edit for Medicare Services. The earliest effective date April 1, 2013 coincides with the implementation of the Change Request 7501.

Here is an excerpt from the AMA publication CPT® Assistant that pertains to 76937:

CPT® Assistant, September 2013:

"Question:*The physician presents to a 5 year old patient's bedside with the intent to perform an insertion of a peripherally inserted central venous catheter (PICC line) to administer medications and intravenous fluids. Upon the physician's discussion with the patient and her parents, the patient was unable to move from the chair to the bed for the procedure due to bilateral knee and diffuse joint pain. An IV line was placed using ultrasound guidance by the physician. May this be reported with code 36569, Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older, with modifier 52, Reduced services, appended? Also, may E/M code 99231, Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity, be reported in addition?*

"Answer*: No. It would not be appropriate to report code 36569 with the modifier 52 appended for this scenario. However, it would be appropriate to report code 36410, Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture), for the venipuncture, and code 76937, Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure), for the ultrasound guidance, provided that all of the requirements for reporting code 76937 are met. Unless all of the components of an evaluation and management (E/M) service are performed and documented, it should not be reported separately*

CRNA PROFESSIONAL FEES

Q. We received this email from the OR Manager this morning. Please advise.

"I am inquiring on feasibility of IV starts/lines such as Alines and Swan-Ganz charging by the CRNAs around the hospital, outside of the OR. They have created a charge sheet for their chargeable supplies and provided the following codes for ultrasound usage:

- 36410 – Guided PIV or Midline
- 36620 – Guided Aline
- 36556 – Guided CVL
- 93503 – Guided Swan-Ganz
- 76942 – Guided Block

"We would need to create a procedure charge – Level 1 – Anesthesia IV/Lines Start. These would be totally separate from the charges used for surgery and would be a way to create more income from their professional starts, if that would be appropriate legally. Would this be something **PARA** would approve for us to do?"

Later, the OR manager sent this clarification: "A point of emphasis is that many of these patients are non-surgical patients. They are patients from the floor that anesthesia is consulted to place IVs,..."

A. **Answer:** An enrolled CRNA may bill for medically necessary professional services for which there is a physician order, so long as the CRNA is acting within the state Scope of Practice regulations applicable to the CRNA licensure.

We have provided a link and an excerpt from the North Carolina CRNA Scope of Practice regulation below; it would appear that any of the vascular access codes you have inquired about would fall within the SOP–but we are not sure about the Swan-Ganz catheter or the guidance procedure 76942.

Since this is a matter of interpretation, we recommend asking the hospital risk manager to make the call. If it's legal for a CRNA to perform the procedures, then it is appropriate for the CRNA to bill and be paid for that service as an enrolled professional service provider.

HCPCS/CPT®	Status	Fee Schedule
36410 - VENIPUNCTURE, AGE 3 YEARS OR OLDER, NECESSITATING THE SKILL OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (SEPARATE PROCEDURE), FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES (NOT TO BE USED FOR ROUTINE VENIPUNCTURE)	N	GB (P-Fac):$9.39 GB (P-NonFac):$16.78
36556 - INSERTION OF NON-TUNNELED CENTRALLY INSERTED CENTRAL VENOUS CATHETER; AGE 5 YEARS OR OLDER	J1	GB (P-Fac):$85.61 GB (P-NonFac):$207.11
36620 - ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING, MONITORING OR TRANSFUSION (SEPARATE PROCEDURE); PERCUTANEOUS	N	GB (P-Fac):$44.93 GB (P-NonFac):$44.93
76942 - ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), IMAGING SUPERVISION AND INTERPRETATION	N	GB (P-Fac):$55.82 GB (P-NonFac):$55.82 26 (P-Fac):$31.71 26 (P-NonFac):$31.71 TC (P-Fac):$24.10 TC (P-NonFac):$24.10
93503 - INSERTION AND PLACEMENT OF FLOW DIRECTED CATHETER (EG, SWAN-GANZ) FOR MONITORING PURPOSES	J1	GB (P-Fac):$89.52 GB (P-NonFac):$89.52

CRNA PROFESSIONAL FEES

http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0226.html

21 NCAC 36 .0226 NURSE ANESTHESIA PRACTICE

(a) Only a registered nurse who completes a program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs, is credentialed as a certified registered nurse anesthetist by the Council on Certification of Nurse Anesthetists, and who maintains recertification through the Council on Recertification of Nurse Anesthetists, shall perform nurse anesthesia activities in collaboration with a physician, dentist, podiatrist, or other lawfully qualified health care provider. A nurse anesthetist shall not prescribe a medical treatment regimen or make a medical diagnosis except under the supervision of a licensed physician.

(b) For the purpose of this Rule, collaboration means a process by which the certified registered nurse anesthetist works with one or more qualified health care providers, each contributing his or her respective area of expertise consistent with the appropriate occupational licensure laws of the State and according to the established policies, procedures, practices, and channels of communication that lend support to nurse anesthesia services and that define the roles and responsibilities of the qualified nurse anesthetist within the practice setting. The individual nurse anesthetist shall be accountable for the outcome of his or her actions.

(c) Nurse Anesthesia activities and responsibilities that the appropriately qualified registered nurse anesthetist may safely accept shall depend upon the individual's knowledge, skills, and other variables in each practice setting as outlined in 21 NCAC 36 .0224(a), including:

(1) Preanesthesia preparation and evaluation of the client, including:
- (A) performing a pre-operative health assessment;
- (B) recommending, requesting, and evaluating pertinent diagnostic studies; and
- (C) selecting and administering preanesthetic medications.

(2) Anesthesia induction, maintenance, and emergence of the client to include:
- (A) securing, preparing, and providing safety checks on all equipment, monitors, supplies, and pharmaceutical agents used for the administration of anesthesia;
- (B) selecting, implementing, and managing general anesthesia; monitored anesthesia care; and regional anesthesia modalities, including administering anesthetic and related pharmaceutical agents, consistent with the client's needs and procedural requirements;
- (C) performing tracheal intubation, extubation, and providing mechanical ventilation;
- (D) providing perianesthetic invasive and non-invasive monitoring, recognizing abnormal findings, implementing corrective action, and requesting consultation with appropriately qualified health care providers as necessary;
- (E) managing the client's fluid, blood, electrolyte, and acid-base balance; and
- (F) evaluating the client's response during emergence from anesthesia and implementing pharmaceutical and supportive treatment to ensure the adequacy of client recovery from anesthesia.

(3) Postanesthesia Care of the client, including:
- (A) providing postanesthesia follow-up care, including evaluating the client's response to anesthesia, recognizing potential anesthetic complications, implementing corrective actions, and requesting consultation with appropriately qualified health care professionals as necessary;
- (B) initiating and administering respiratory support to ensure adequate ventilation and oxygenation in the immediate postanesthesia period;
- (C) initiating and administering pharmacological or fluid support of the cardiovascular system during the immediate postanesthesia period;
- (D) documenting all aspects of nurse anesthesia care and reporting the client's status, perianesthetic course, and anticipated problems to an appropriately qualified postanesthetic health care provider who assumes the client's care following anesthesia, consistent with 21 NCAC 36 .0224(f); and
- (E) releasing clients from the postanesthesia care or surgical setting in compliance with established agency policy.

(d) Other clinical activities for which the qualified registered nurse anesthetist may accept responsibility shall include:
- (1) inserting central vascular access catheters and epidural catheters;
- (2) identifying, responding to, and managing emergency situations, including initiating and participating in cardiopulmonary resuscitation;
- (3) providing consultation related to respiratory and ventilatory care and implementing such care according to established policies within the practice setting; and
- (4) initiating and managing pain relief therapy using pharmaceutical agents, regional anesthetic techniques, and other accepted pain relief modalities according to established policies and protocols within the practice setting.

History Note: *Authority G.S. 90-171.20(4); 90-171.20(7); 90-171.21; 90-171.23; 90-171.42(b);*
Eff. July 1, 1993;
Temporary Amendment Eff. July 25, 1994 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. December 1, 2010; December 1, 1994;
Readopted Eff. January 1, 2019.

...

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(A) securing, preparing, and providing safety checks on all equipment, monitors, supplies, and pharmaceutical agents used for the administration of anesthesia;

(B) selecting, implementing, and managing general anesthesia; monitored anesthesia care; and regional anesthesia modalities, including administering anesthetic and related pharmaceutical agents, consistent with the client's needs and procedural requirements;

(C) performing tracheal intubation, extubation, and providing mechanical ventilation;

(D) providing perianesthetic invasive and non-invasive monitoring, recognizing abnormal findings, implementing corrective action, and requesting consultation with appropriately qualified health care providers as necessary;

(E) managing the client's fluid, blood, electrolyte, and acid-base balance; and

(F) evaluating the client's response during emergence from anesthesia and implementing pharmaceutical and supportive treatment to ensure the adequacy of client recovery from anesthesia.

(3) Postanesthesia Care of the client, including:

CRNA PROFESSIONAL FEES

(A) providing postanesthesia follow-up care, including evaluating the client's response to anesthesia, recognizing potential anesthetic complications, implementing corrective actions, and requesting consultation with appropriately qualified health care professionals as necessary;

(B) initiating and administering respiratory support to ensure adequate ventilation and oxygenation in the immediate postanesthesia period;

(C) initiating and administering pharmacological or fluid support of the cardiovascular system during the immediate postanesthesia period;

(D) documenting all aspects of nurse anesthesia care and reporting the client's status, perianesthetic course, and anticipated problems to an appropriately qualified postanesthetic health care provider who assumes the client's care following anesthesia, consistent with 21 NCAC 36 .0224(f); and

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(2) identifying, responding to, and managing emergency situations, including initiating and participating in cardiopulmonary resuscitation;

(3) providing consultation related to respiratory and ventilatory care and implementing such care according to established policies within the practice setting; and(4) initiating and managing pain relief therapy using pharmaceutical agents, regional anesthetic techniques, and other accepted pain relief modalities according to established policies and protocols within the practice setting

BLOOD TRANSFUSION SERVICES

Q. I have questions regarding blood administration. I'll give an example. Patient came into ED. 2/17 Blood (fresh frozen plasma) was given from 10:50-12:50-infusing on transfer to floor. RBC Blood given as an IP: 2/17 14:07-16:45 217 22:33-01:23 2/18 01:50-04:27 How does this get charged out? If administered by nursing, can we charge as an IP? This is how we have it right now but not sure if it is right.

Can we charge for the administration of it as an IP on med/surg or only the ED administration? Blood Storage and Processing Qty 5 (1 frozen and 4 red blood) Blood Storage and Processing Blood Administration CPT 36430 Qty 1 Thanks.

A. **Answer:** There is no regulation which specifies whether blood transfusion administration (CPT® 36430) can or should be charged on an inpatient unit. While the regulations are silent, **PARA** holds to the principle that all services performed for inpatients by regularly assigned unit nursing personnel should be considered covered in the room rate.

We have attached our paper on "Bedside Procedures" which reiterates this point.

For outpatients, including observation patients, the hospital may charge only one unit of blood administration 36430 per day.

Here's an excerpt from the Medicare Claims Processing Manual that addresses that point:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

231.8 - Billing for Transfusion Services
(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

To report charges for transfusion services, OPPS providers should bill the appropriate CPT code for the specific transfusion service provided under Revenue Code 391 (Blood Administration). Transfusion services codes are billed on a per service basis, and not by the number of units of blood product transfused. For payment, a blood product HCPCS code is required when billing a transfusion service code. A transfusion APC will be paid to the OPPS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused.

The MUE for 36430 is 1, and the MUE Adjudication indicator is 2, which means that as a matter of policy, Medicare will only pay up to the MUE and will not entertain appeals or exceptions to that rule.

CODING SEGMENTS

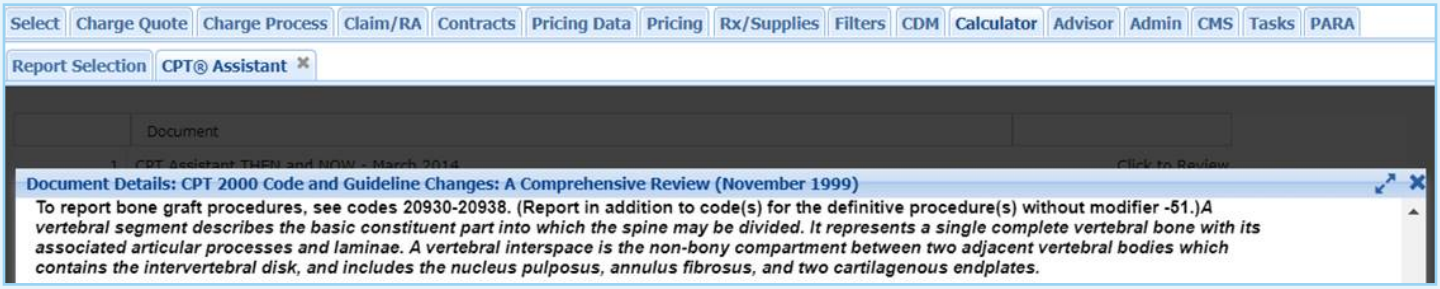
Q. The coding team is trying to determine how many segments to code.

Basically should 63408 be billed once or twice?

A. **Answer:** The documentation supports three vertebral segments; therefore CPT® code 63408 would be reported twice with the primary code (63045) reported once. CPT® code 63408 describes each additional segment, cervical, thoracic, or lumbar. Please refer to the **PARA Data Editor** reference AMA CPT® Assistant, November 1999 Page: 11.

The article states, "A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae."

In this case, C3, C4, and C5 each represent a segment.



PARA
HealthCare Analytics

HEALTHCARE
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COVID-19

april first, twenty-twenty

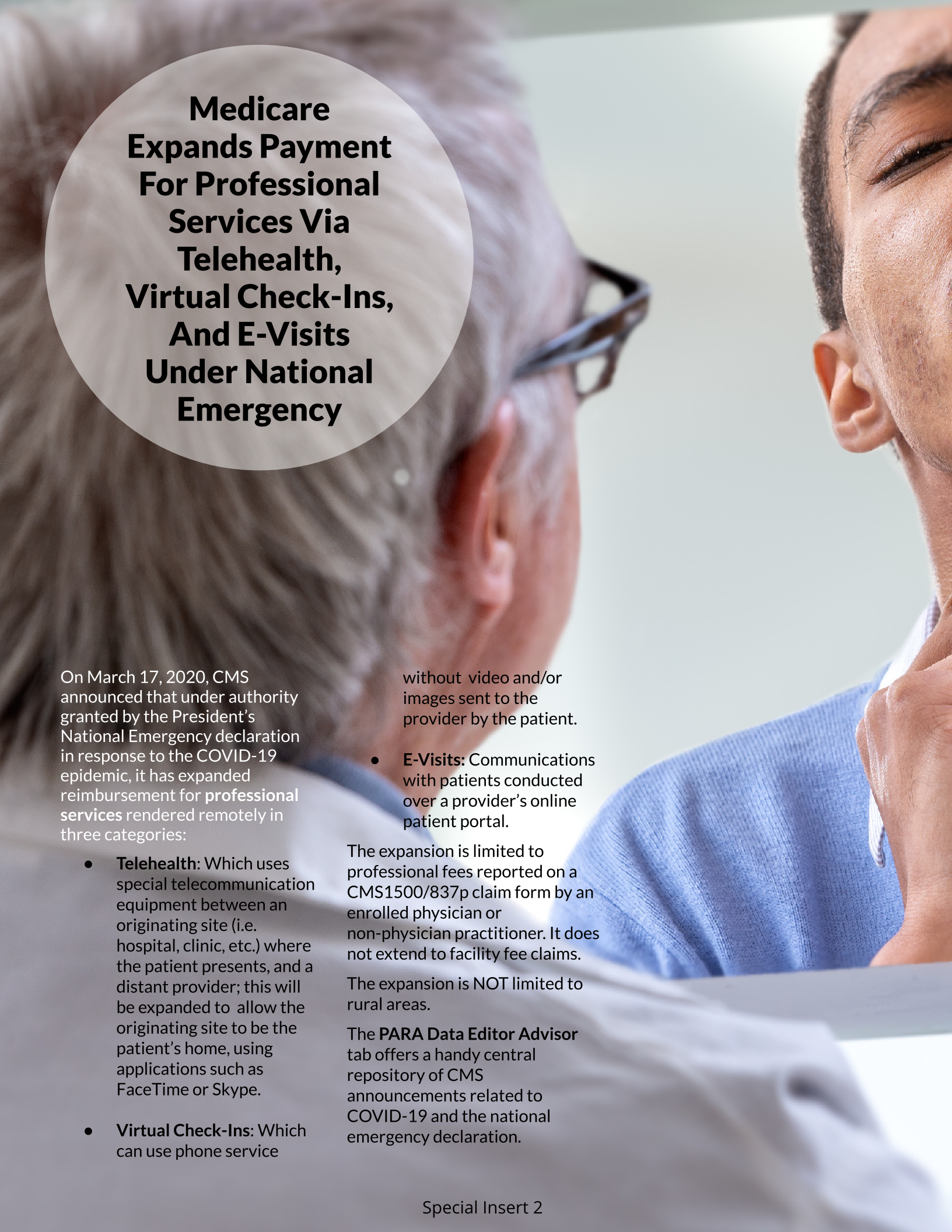
Special
publication

Questions about how to manage the COVID-19 Coronavirus are multiplying almost as fast as the virus itself.

In this Special Publication from **PARA HealthCare Analytics** and **Healthcare Financial Resources (HFRI)**, the experts answer coding and financial questions.

The responses to Coronavirus are rapidly changing. That's why we've brought together a compilation of informative articles to simplify and clarify issues.

Medicare Expands Payment For Professional Services Via Telehealth, Virtual Check-Ins, And E-Visits Under National Emergency



On March 17, 2020, CMS announced that under authority granted by the President's National Emergency declaration in response to the COVID-19 epidemic, it has expanded reimbursement for **professional services** rendered remotely in three categories:

- **Telehealth**: Which uses special telecommunication equipment between an originating site (i.e. hospital, clinic, etc.) where the patient presents, and a distant provider; this will be expanded to allow the originating site to be the patient's home, using applications such as FaceTime or Skype.

- **Virtual Check-Ins**: Which can use phone service without video and/or images sent to the provider by the patient.

- **E-Visits:** Communications with patients conducted over a provider's online patient portal.

The expansion is limited to professional fees reported on a CMS1500/837p claim form by an enrolled physician or non-physician practitioner. It does not extend to facility fee claims.

The expansion is NOT limited to rural areas.

The **PARA Data Editor Advisor** tab offers a handy central repository of CMS announcements related to COVID-19 and the national emergency declaration.

CMS issued a separate press release which explains that, under the emergency expansion, "…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. …"

CMS addresses HIPAA concerns both within the Fact Sheet (link here) https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet) which specifically mentions the use of telecommunications that will serve the patient in the home, such as FaceTime or Skype:

> *HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.*

For more information:
https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Links to additional CMS and HHS announcements relating to providers and the national emergency declaration are provided below:

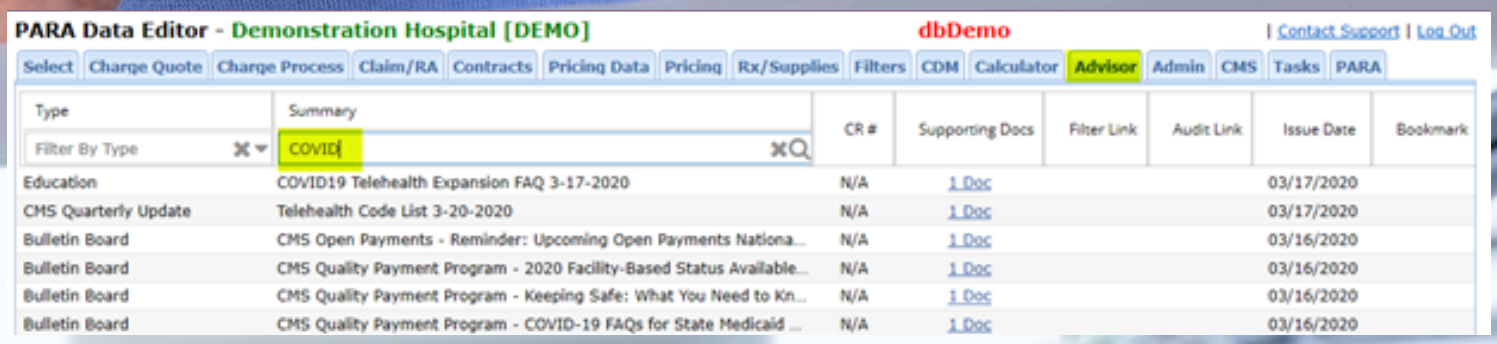
https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

https://apps.para-hcfs.com/para/Documents/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf

According to an FAQ published by Medicare, telehealth, e-visits, and virtual check-in services are billable by professionals only – they are not payable to facilities:

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf



Con't.

Medicare Expands Payment For Professional Services Via Telehealth, Virtual Check-Ins, And E-Visits Under National Emergency Authority

Medicare Telehealth Frequently Asked Questions (FAQs)
March 17, 2020

13. Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.

2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)

Facility-based providers, such as PT, OT, and Speech Pathology therapists who have not been enrolled as independent billing professionals may enroll with Medicare in order to be eligible for reimbursement for services delivered via telemedicine. CMS has offered expedited enrollment for billing professionals to help meet the needs of the COVID-19 emergency.

MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET

Mar 17, 2020 | Telehealth

Share

Medicare coverage and payment of virtual services

INTRODUCTION:

Under President Trump's leadership, the Centers for Medicare & Medicaid Services (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. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The 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.

Modifiers --The expansion of telemedicine, e-visits, and virtual check-in services to non-rural areas, and to communication channels such as Skype and Facetime, was implements under an 1135 waiver of the ordinary Medicare coverage requirements, as explained in the Medicare telemedicine Fact Sheet published at the link below:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Since 2009, services which are performed subject to a waiver should be reported with modifier CR:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6451.pdf

The CR Modifier:Both the short and long descriptors of the CR modifier are "catastrophe/disaster related."The CR modifier is used in relation to Part B items and services for both institutional and non-institutional billing.Non-institutional billing, i.e., claims submitted by "physicians and other suppliers", are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format.In previous emergencies, use of the CR modifier was entirely discretionary with the billing provider or supplier.

It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned directly or indirectly on the presence of a "formal waiver."

However, we have found no specific instruction from CMS to append modifier CR to telehealth claims under the current COVID-19 National Emergency.

Although Method II Critical Access Hospitals must report modifier GT on professional fees submitted to Medicare on a UB04/837i outpatient claim, Medicare has no other requirement for a modifier on telehealth under normal telehealth circumstances.

Professional fee claims to Medicare for telemedicine must be reported with POS 02.The use of modifier GT was discontinued for non-CAH claims in 2018.

Private payers may require either modifier GT or 95 – as found in the following excerpt from Anthem of Wisconsin's provider bulletin:

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

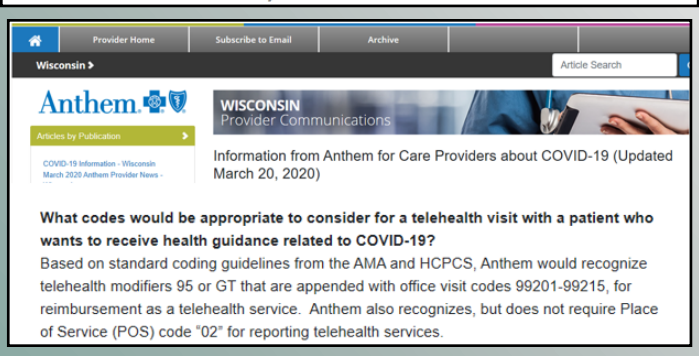
Notification of Enforcement Discretion for telehealth remote communications during the COVID-19 nationwide public health emergency

We are empowering medical providers to serve patients wherever they are during this national public health emergency. We are especially concerned about reaching those most at risk, including older persons and persons with disabilities. – Roger Severino, OCR Director.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.



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Professional fee claims to Medicare for telemedicine must be reported with POS 02.The use of modifier GT was discontinued for non-CAH claims in 2018.

Private payers may require either modifier GT or 95 – as found in the following excerpt from Anthem of Wisconsin's provider bulletin:

https://providernews.anthem.com/wisconsin/article/information-from-anthem-for-care-providers-about-covid-19-updated-march-19-2020-7

Other Important Links And Announcement:

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

https://apps.para-hcfs.com/para/Documents/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf

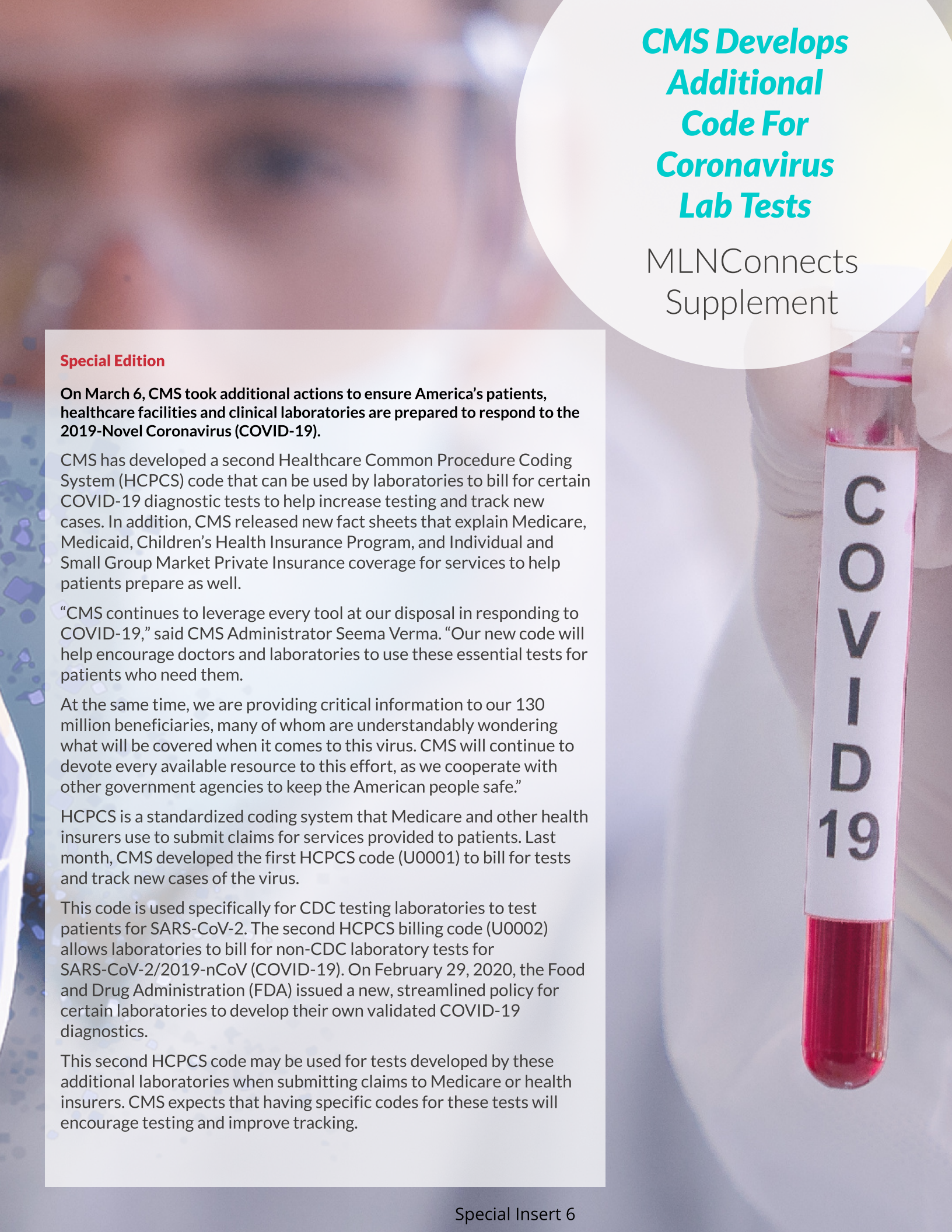
https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

https://www.hhs.gov/hipaa/for-professionals/faq/1068/is-hipaa-suspended-during-a-national-or-public-health-emergency/index.html

CMS Develops Additional Code For Coronavirus Lab Tests

MLNConnects Supplement



Special Edition

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.

Other Important Links:

Medicare Fact Sheet Highlights(PDF): 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(PDF): 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.

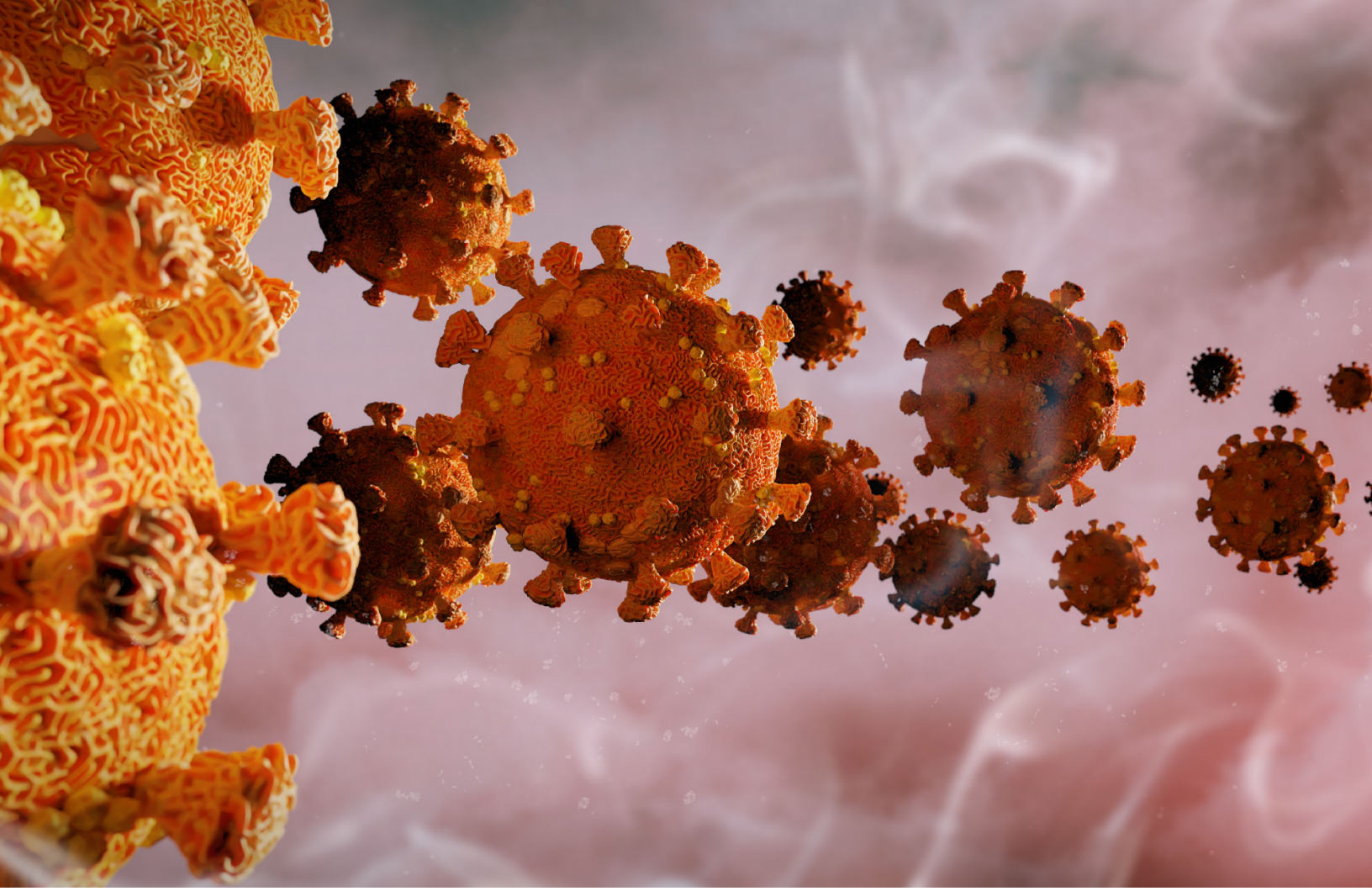
Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage(PDF):

CMS Announces Actions to Address Spread of Coronavirus.

Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

View this edition as PDF (PDF)



Coding changes are evolving rapidly in response to the national COVID-19 emergency.

New codes have been released for the COVID-19 testing and are listed here:

Question: When should CPT® code 87635 be used versus the HCPCS codes established by CMS?

Answer: Code selection is based on the payer.

For Medicare patients, report the HCPCS Level II codes (U0002).

The CPT® and HCPCS level II codes should not be reported on the same claim.

Contact your local third-party payer directly to determine their specific reporting guidelines.

Medicare will accept claims billed with HCPCS code U0002 beginning on April 1, 2020 for dates of service starting February 4, 2020.

AMA Current Procedural Terminology (CPT®) Editorial Panel approved a new, specific CPT code to describe laboratory testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).	
87635	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
Medicare Claims: HCPCS codes established by the Centers for Medicare & Medicaid Services (CMS) for Coronavirus testing	
U0001	Specifically, for CDC testing laboratories to test patients for SARS-CoV-2 and to track new cases of the virus
U0002	Intended for laboratories to report non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

Coronavirus Update

As Of March 23, 2020

What is the Coronavirus?

Coronaviruses are classified as a large family of viruses that cause infection in the sinuses, nose and upper throat. Some coronaviruses cause illness in people, and others circulate among animals, including camels, cats and bats.

The 2019 Novel Coronavirus is a new form of coronavirus first identified in Wuhan, Hubei Province, China.

This virus is officially named "SARS-CoV2" which is a betacoronavirus.The disease it causes is now referred to as COVID-19 (previously referred to as 2019-nCoV).

The COVID-19 outbreak has been detected in 50 locations internationally, including multiple confirmed cases in the United States.The Centers for Disease Control (CDC) confirmed that the disease caused illness, including illness resulting in death and sustained person to person spread.Individual risk is dependent on exposusure.

Symptoms of the COVID-19 can include fever, cough and shortness of breath.

However, some patients with confirmed COVID-19 have developed little to no symptoms depending on the incubation period.

The CDC reported, "Symptoms may appear in as few as 2 days or as long as 14 after exposure ".

The CDC has developed a real-time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens.

ICD-10 CM: Coding COVID-19

As new clinical information becomes available, detail in coding selection may be revised.

The ICD-10-CM codes provided in this reference are intended to provide information on the coding of encounters related to coronavirus.

All coding selections should be supported by documentation.

Respiratory conditions such as Pneumonia, Bronchitis, Respiratory Infection and Acute Respiratory Distress Syndrome (ARDS) have been identified in patients with confirmed COVID-19 diagnosis.

Con't. Coronavirus Upda

Confirmed Cases:

New code available 4-1-20: For confirmed cases of COVID-19 report ICD-10 CM code U07.1,2019-nCoV acute respiratory disease.

On Wednesday, March 18, 2020, the Centers for Disease Control (CDC) announced that the ICD-10-CM diagnosis code, previously slated to be effective October 1, 2020, will now be effective April 1, 2020.

This code should only be reported for confirmed COVID-19 cases.

When one of the following conditions is confirmed as due to the COVID-19, both the respiratory condition and ICD-10-CM code B97.29 should be coded.Refer to the **PARA Data Editor** code selection following:

- **Pneumonia** confirmed as due to the COVID-19 - assign codes J12.89, Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J1289	Other viral pneumonia
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Acute bronchitis** confirmed as due to COVID-19, assign codes J20.8, Acute bronchitis due to other specified organisms, and B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J208	Acute bronchitis due to other specified organisms
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Bronchitis Not Otherwise Specified (NOS)** due to the COVID-19, assign codes J40, Bronchitis, not specified as acute or chronic; and B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J40	Bronchitis, not specified as acute or chronic
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Acute respiratory infection, NOS or Lower respiratory infection NOS**, assign ICD-10 CM codes code J22, Unspecified acute lower respiratory infection, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J22	Unspecified acute lower respiratory infection
B9729	Other coronavirus as the cause of diseases classified elsewhere

ate

As Of March 23, 2020

- **Respiratory infection, NOS**, assign ICD-10 CM code J98.8, Other specified respiratory disorders, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J988	Other specified respiratory disorders
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Acute respiratory distress syndrome (ARDS)**, assign ICD-10 CM codesJ80, Acute respiratory distress syndrome, and B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J80	Acute respiratory distress syndrome
B9729	Other coronavirus as the cause of diseases classified elsewhere

Concern for or Exposure to COVID-19

In some cases, the patient may be evaluated for exposure or possible exposure to the COVID-19; however, after the evaluation the condition may be ruled out.In those cases, it would not be appropriate to report a code for the actual virus.

Please refer to the **PARA Data Editor** code descriptions for exposure without symptoms.

- **Actual Exposure to** COVID-19 without symptoms, assign ICD-10 CM code Z20.828, contact with and (suspected) exposure to other viral communicable diseases

- **The concern of possible exposure** without symptoms, assign ICD-10 CM code Z03.818, Encounter of observation for suspected exposure of other biological agents ruled out

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
Z20828	Contact with and (suspected) exposure to other viral communicable diseases
Z03818	Encounter for observation for suspected exposure to other biological agents ruled out

When documenting signs and symptoms, the coder should report that symptom rather than a code for exposure or possible exposure. Please refer to the **PARA Data Editor** for symptom code descriptions.

PARA - Healthcare Financial Services
ICD10 Codes

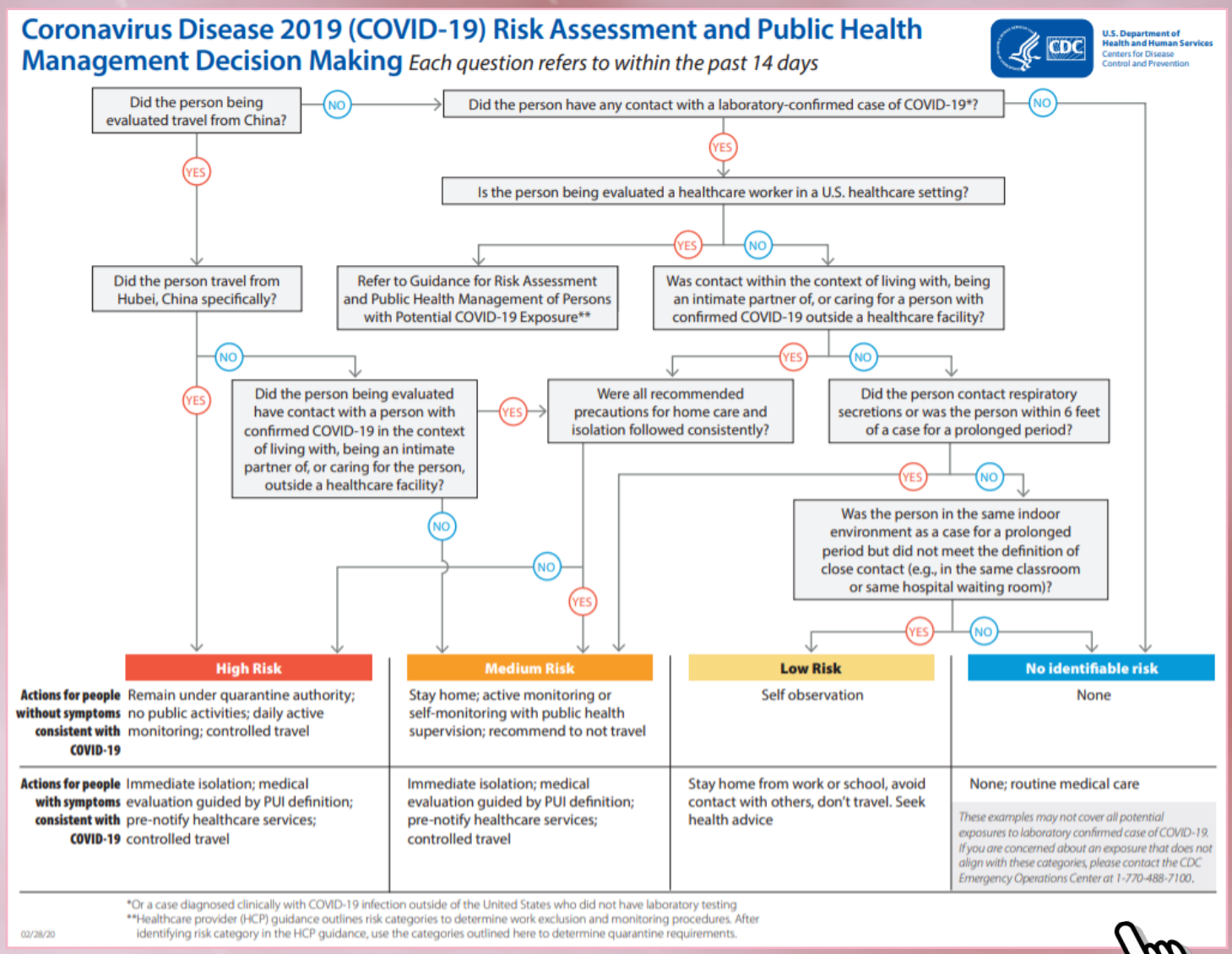
ICD10 Code	Description
R05	Cough
R0602	Shortness of breath
R509	Fever, unspecified

Con't. Coronavirus Update

Risk Assessment

Please refer to the Risk Assessment reference from the CDC. The CDC continues to monitor and provide updates of the virus.

https://www.cdc.gov/coronavirus/2019-ncov/downloads/public-health-management-decision-making.pdf



The CDC reported that the COVID-19 is likely spread person to person via respiratory droplets when the infected person coughs or sneezes.There is much more to learn about the transmissibility, severity, and other features associated with COVID-19 and investigations are ongoing.

https://www.cdc.gov/coronavirus/2019-ncov/index.html

PARA
HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

An Open Letter To HealthCare Providers

With all of the recent restrictions for the crisis, we are reaching out to all of our clients and prospects that we have had conversations with to assist them if their internal insurance follow up teams are unable to work or will be experiencing shortages.

PARA HealthCare Analytics and **Healthcare Financial Resources (HFRI)**, is now operating remotely 100% and have the capacity to help out with any hospital systems that are experiencing any pain.

If any of this is of interest to you please let us know. We are here to help.

Justin Orsini
Director of Business Development
Healthcare Financial Resources (HFRI)
c:623-332-3963
e:jorsini@hfri.net
www.hfri.net
2500 Westfield Drive, Suite 2-300
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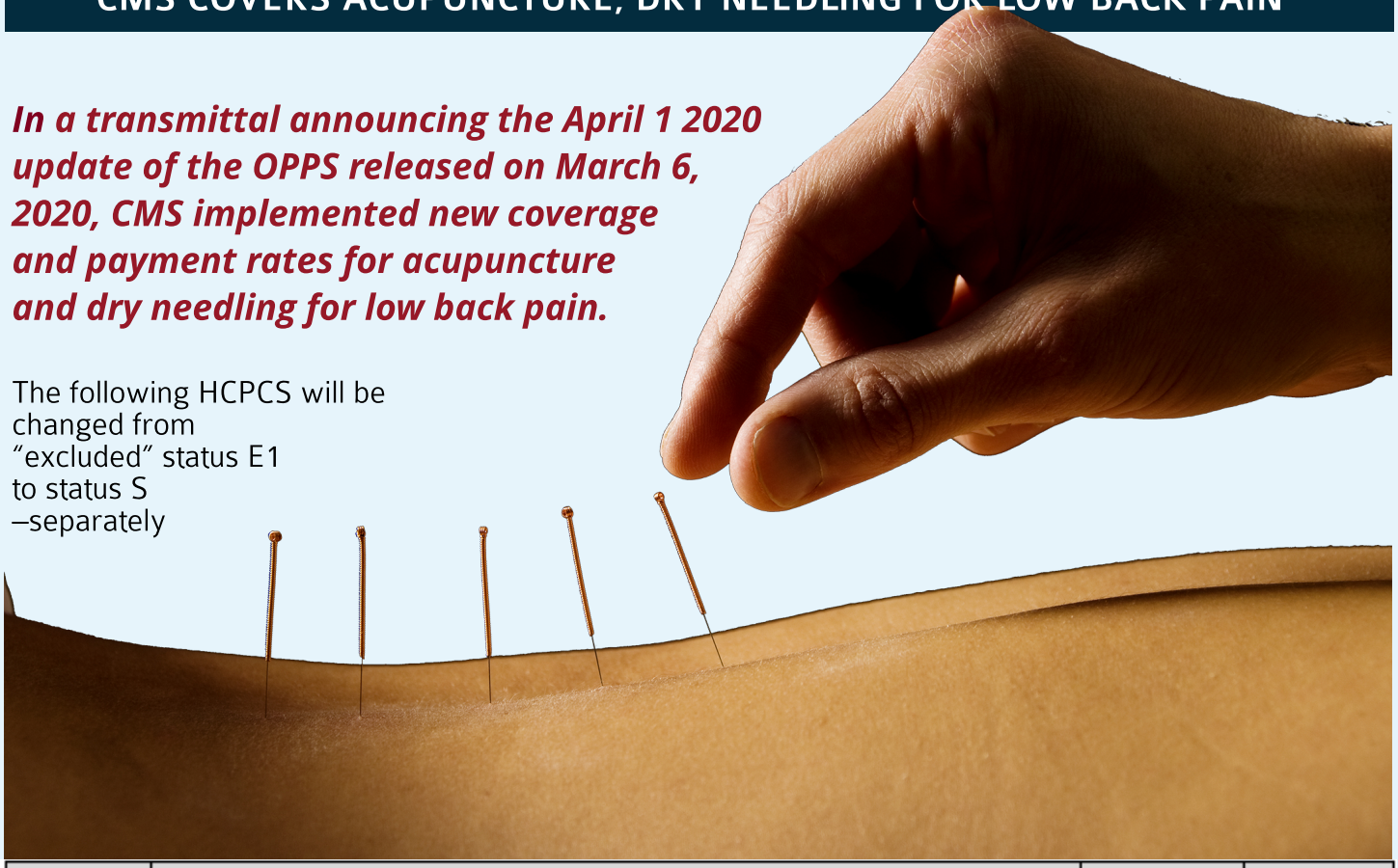
CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN

In a transmittal announcing the April 1 2020 update of the OPPS released on March 6, 2020, CMS implemented new coverage and payment rates for acupuncture and dry needling for low back pain.

The following HCPCS will be changed from "excluded" status E1 to status S –separately

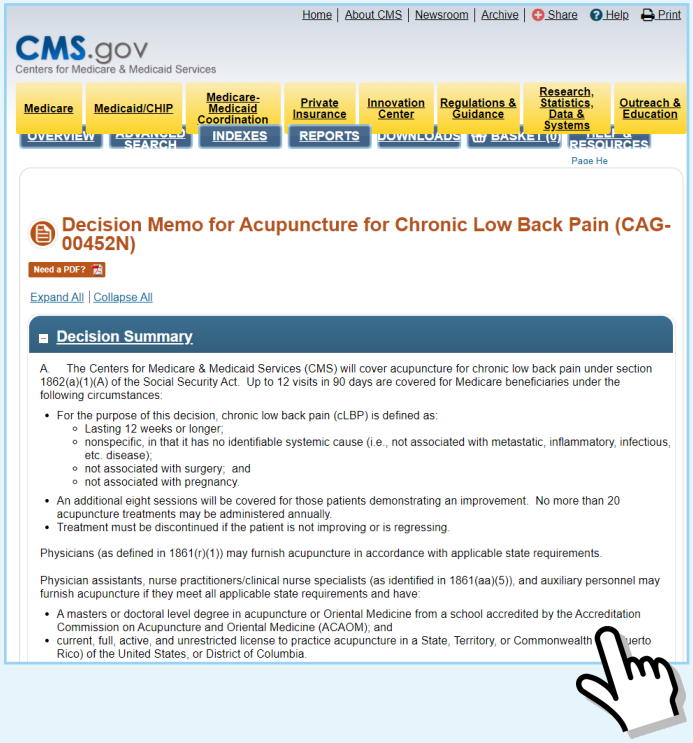


CPT®	Long Description	OPPS Status Indicator	OPPS APC
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	S	5731
20561	Needle insertion(s) without injection(s); 3 or more muscles	S	5731
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	S	5731
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)	N	N/A
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	S	5731
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)	N	N/A

CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN

Excerpts from the Decision Memo appear here:

https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=295



Decision Memo for Acupuncture for Chronic Low Back Pain (CAG-00452N)

A. The Centers for Medicare & Medicaid Services (CMS) will cover acupuncture for chronic low back pain under section 1862(a)(1)(A) of the Social Security Act.Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

- For the purpose of this decision, chronic low back pain (cLBP) is defined as:
  - -Lasting 12 weeks or longer;
  - -nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
  - -not associated with surgery;and
  - -not associated with pregnancy
- An additional eight sessions will be covered for those patients demonstrating an improvement.No more than 20 acupuncture treatments may be administered annually
- Treatment must be discontinued if the patient is not improving or is regressing

Physicians (as defined in 1861(r)(1)) may furnish acupuncture in accordance with applicable state requirements.

Physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

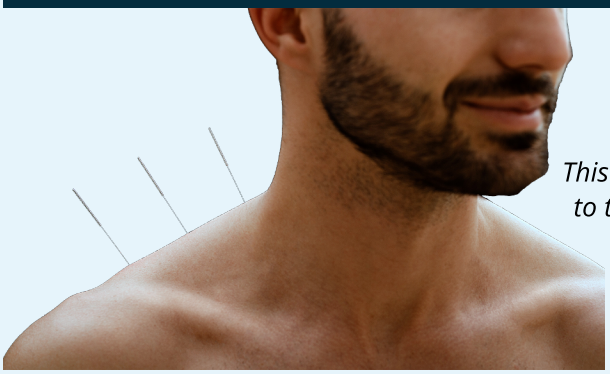
Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist required by our regulations at 42 CFR §§ 410.26 and 410.27.

...

The decision memo is lengthy, and includes an appendix which provides language in red text which will be added to the National Coverage Determination manual for these services.

That appendix appears on the next page.

CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN



APPENDIX B
Medicare National Coverage Determinations Manual

This draft NCD is subject to formal revisions and formatting changes prior to the release of the final NCD contractor instructions and publication in the Medicare National Coverage Determinations Manual.

Table of Contents
(Rev.)

30.3.3 - ACUPUNCTURE

The Centers for Medicare & Medicaid Services (CMS) is finalizing changes to its acupuncture National Coverage Determination (NCD) policy that will expand Medicare coverage. The scope of this review is limited to acupuncture for chronic low back pain (cLBP) and will be manualized under NCD 30.3.3, Acupuncture for cLBP. However, any corresponding policy changes that appear in the final decision memorandum will also be manualized in changes to NCD 30.3, Acupuncture. In addition, clarifying changes would be necessary in NCD 30.3.1, Acupuncture for Fibromyalgia and NCD 30.3.2, Acupuncture for Osteoarthritis.

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications

Effective for services performed on or after January 21, 2020 CMS will cover acupuncture for Medicare patients

with chronic low back pain. Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

- *For the purpose of this decision, chronic low back pain (cLBP) is defined as:*
  - *Lasting 12 weeks or longer;*
  - *nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);*
  - *not associated with surgery; and*
  - *not associated with pregnancy*

- *An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.*

- *Treatment must be discontinued if the patient is not improving or is regressing.*

  Physicians (as defined in 1861(r)(1)) may furnish acupuncture in accordance with applicable state requirements.

  Physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- *A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,*

- *Current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.*

Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist required by our regulations at 42 CFR §§ 410.26 and 410.27. ***C. Nationally Non-Covered Indications***

All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare.

D. Other *N/A*

CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN

30.3 - ACUPUNCTURE

A. General

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications

Effective for claims with dates of service on and after January 21, 2020, acupuncture is only covered for chronic low back pain under section 1862(a)(1)(A) of the Social Security Act (the Act). See National Coverage Determination section 30.3.3 for specific coverage criteria.

C. Nationally Non-Covered Indications

Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic or for other therapeuticpurposes, may not be made unless the specific indication is excepted. Accordingly, acupuncture is not considered reasonable and necessary within the meaning of §1862(a)(1)(A) of the Act. All indications for acupuncture outsided of NCD section 30.3.3 remain non-covered.

D. Other *N/A*

30.3.1 – ACUPUNCTURE FOR FIBROMYALGIA

A. General

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications *N/A for acupuncture for fibromyalgia.*

C. Nationally Non-Covered Indications

Effective for claims with dates of service on and after April 16, 2004, after careful reconsideration of its initial non-coverage determination for acupuncture, the Centers for Medicare & Medicaid Services (CMS) concludes that there is no convincing evidence for the use of acupuncture for pain relief in patients with fibromyalgia. Study design flaws presently prohibit assessing acupuncture's utility for improving health outcomes. Accordingly, CMS determines that acupuncture is not considered reasonable and necessary for the treatment of fibromyalgia within the meaning of §1862(a)(1) of the Social Security Act, and the national non-coverage determination for acupuncture for fibromyalgia continues.

D. Other *N/A (This NCD last reviewed April 2004.)*

30.3.2 – ACUPUNCTURE FOR OSTEOARTHRITIS

A. General

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications

N/A for acupuncture for osteoarthritis.

C. Nationally Non-Covered Indications

Effective for claims with dates of service on and after April 16, 2004, after careful reconsideration of its initial non-coverage determination for acupuncture, the Centers for Medicare & Medicaid Services (CMS) concludes that there is no convincing evidence for the use of acupuncture for pain relief in patients with osteoarthritis. Study design flaws presently prohibit assessing acupuncture's utility for improving health outcomes. Accordingly, CMS determines that acupuncture is not considered reasonable and necessary for the treatment of osteoarthritis within the meaning of §1862(a)(1) of the Social Security Act, and the national non-coverage determination for acupuncture for osteoarthritis continues.

D. Other *N/A (This NCD last reviewed April 2004.)*

REVISED MOON FORM REQUIRED APRIL 1, 2020

On January 20, 2017, CMS released Transmittal 3695, which finalizes language in the Medicare Claims Processing Manual relating to the requirements of the "**Medicare Outpatient Observation Notice**" (MOON).

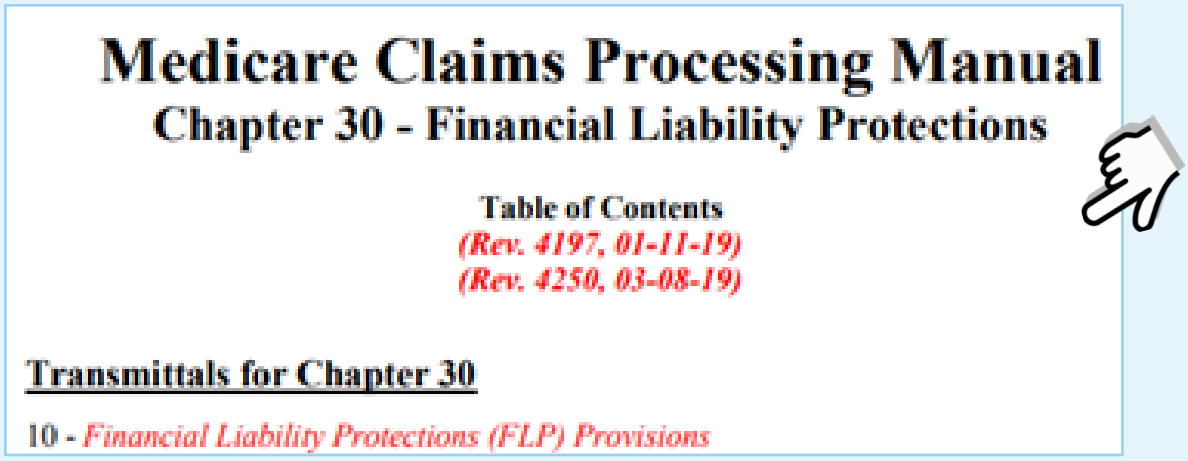
Beginning April 1, 2020, hospitals and CAHs are required to use the new MOON form that extends the expiration date to December 31, 2022.

Hospitals may either use the old or the current form through March 31, 2020.A download for English and Spanish versions of the new MOON form are available from the link below:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON

Chapter 30 of the Medicare Claims Processing Manual Section 400 provides information and instructions on the requirements of the MOON:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf



Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

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(Rev. 4197, 01-11-19)

(Rev. 4250, 03-08-19)

Transmittals for Chapter 30

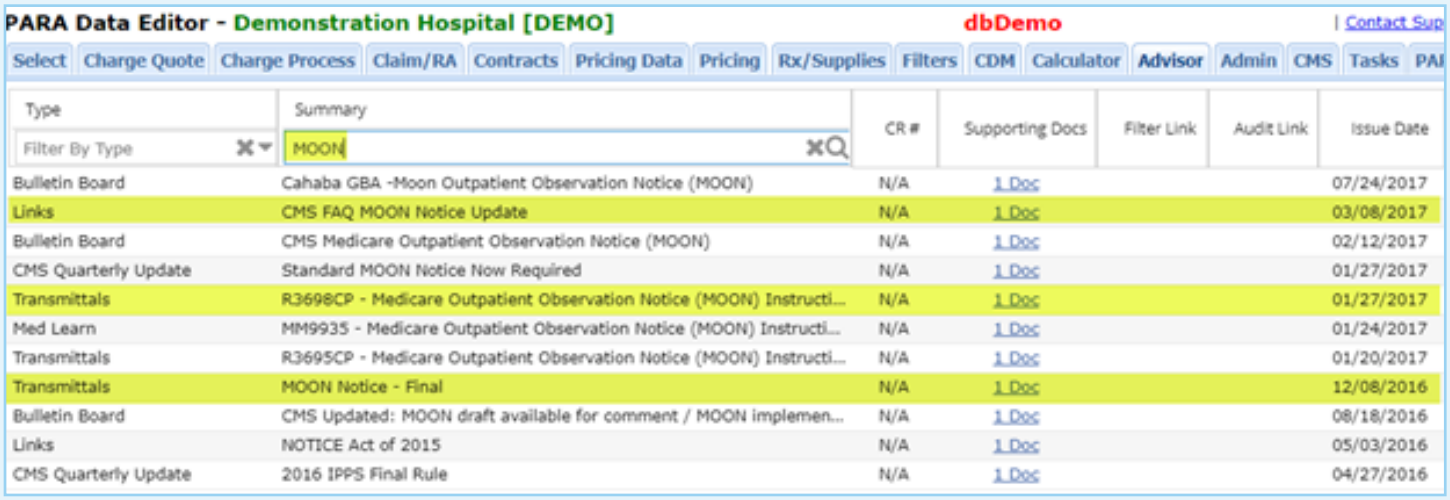
10 - *Financial Liability Protections (FLP) Provisions*

The language changes operationalize the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), which became law in August 2015.Under this law, all hospitals and critical access hospitals (CAHs) are required to provide written notification and an oral explanation of such information to individuals receiving observation services as outpatients for greater than 24 hours.

The NOTICE Act, 2017 IPPS rule, and a CMS Frequently Asked Questions update are available on the **PARA Data Editor Advisor** tab.

Use the search term MOON:

REVISED MOON FORM REQUIRED APRIL 1, 2020



Congress passed the NOTICE Act in August 2015 to prevent Medicare beneficiaries from being blind-sided by patient liability, which is calculated very differently for patients in inpatient status versus observation status, particularly as it pertains to subsequent Skilled Nursing Facility stays. Medicare provides coverage for a medically necessary SNF stay provided it follows a three-day inpatient stay. Beneficiaries discharged to SNF care following three days of observation care, however, have discovered that Medicare will not cover the SNF care.

According to the Medicare Claims Processing Manual:

400.3.3 - Hospital Delivery of the MOON
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals and CAHs must deliver the MOON to beneficiaries in accordance with section 400.2 above. Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification.

Since the NOTICE Act has been in effect since August 2015, many hospitals have created an improvised notice that resembles the CMS form. Some hospitals have been providing the beneficiary publication from Medicare at the following link:

https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf

Revised August 2018

Are You a Hospital Inpatient or Outpatient?

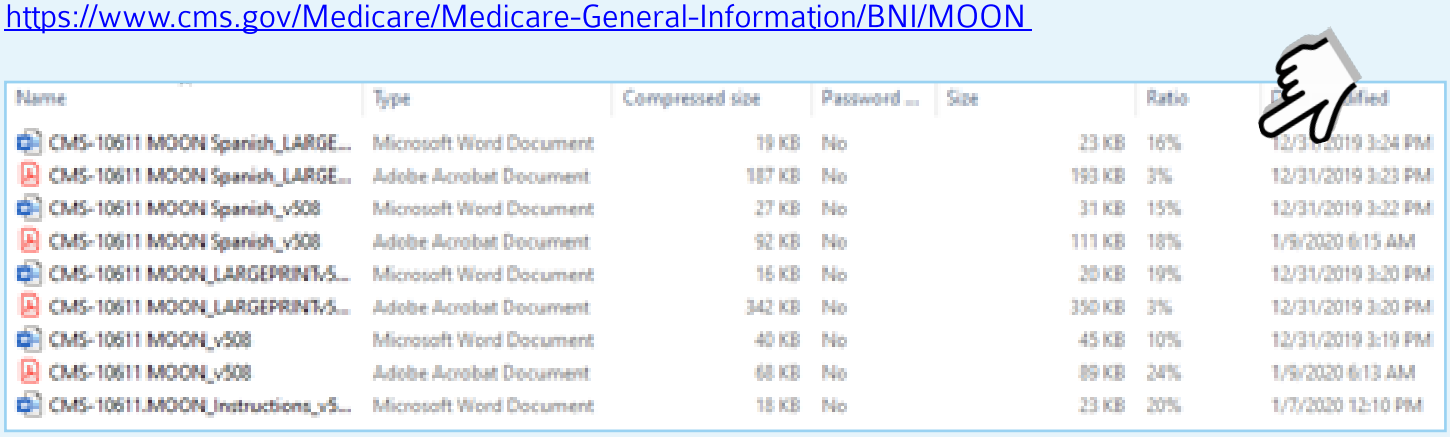
If You Have Medicare – Ask!

Did you know that even if you stay in a hospital overnight, you might still be considered an "outpatient?" Your **hospital status** (whether the hospital considers you an "inpatient" or "outpatient") affects how much **you pay** for hospital services (like X-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility (SNF) following your hospital stay.

REVISED MOON FORM REQUIRED APRIL 1, 2020

The link to the newly required form and its instructions is listed below.A copy of the MOON notice appears on the following pages.

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON



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CMS-10611 MOON Spanish_LARGE...	Microsoft Word Document	19 KB	No	23 KB	16%	12/31/2019 3:24 PM
CMS-10611 MOON Spanish_LARGE...	Adobe Acrobat Document	187 KB	No	193 KB	3%	12/31/2019 3:23 PM
CMS-10611 MOON Spanish_v508	Microsoft Word Document	27 KB	No	31 KB	15%	12/31/2019 3:22 PM
CMS-10611 MOON Spanish_v508	Adobe Acrobat Document	92 KB	No	111 KB	18%	1/9/2020 6:15 AM
CMS-10611 MOON_LARGEPRINTv5...	Microsoft Word Document	16 KB	No	20 KB	19%	12/31/2019 3:20 PM
CMS-10611 MOON_LARGEPRINTv5...	Adobe Acrobat Document	342 KB	No	350 KB	3%	12/31/2019 3:20 PM
CMS-10611 MOON_v508	Microsoft Word Document	40 KB	No	45 KB	10%	12/31/2019 3:19 PM
CMS-10611 MOON_v508	Adobe Acrobat Document	68 KB	No	89 KB	24%	1/9/2020 6:13 AM
CMS-10611.MOON_Instructions_v5...	Microsoft Word Document	18 KB	No	23 KB	20%	1/7/2020 12:10 PM

Page 1 of 2:

(Hospitals may include contact information or logo here)

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Form CMS 10611-MOON Expiration 12/31/2022 OMB approval 0938-1308

REVISED MOON FORM REQUIRED APRIL 1, 2020

Page 2 of 2:

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

_____ Signature of Patient or Representative

_____ Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS 10611-MOON Expiration 12/31/2022 OMB approval 0938-1308

REVISED MOON FORM REQUIRED APRIL 1, 2020

MOON Notice Instructions:

Notice Instructions: Medicare Outpatient Observation Notice

Page 1 of the Medicare Outpatient Observation Notice (MOON)

The following blanks must be completed by the hospital. Information inserted may be typed or legibly hand-written in 12-point font or the equivalent.

Patient Name:

Fill in the patient's full name or attach patient label.

Patient ID number:

Fill in an ID number that identifies this patient, such as a medical record number or the patient's birthdate or attach a patient label. This number should not be the patient's social security number.

"You're a hospital outpatient receiving observation services. You are not an inpatient because:"

Fill in the specific reason the patient is in an outpatient, rather than an inpatient stay.

Page 2 of the MOON

Additional Information:

This may include, but is not limited to, Accountable Care Organization (ACO) information, notation that a beneficiary refused to sign the notice, hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs, Part A cost sharing responsibilities if the beneficiary is subsequently admitted as an inpatient, physician name, specific information for contacting hospital staff, or additional information that may be required under applicable state law.

Hospitals may attach additional pages to this notice if more space is needed for this section.

Oral Explanation:

When delivering the MOON, hospitals and CAHs are required to explain the notice and its content, document that an oral explanation was provided and answer all beneficiary questions to the best of their ability.

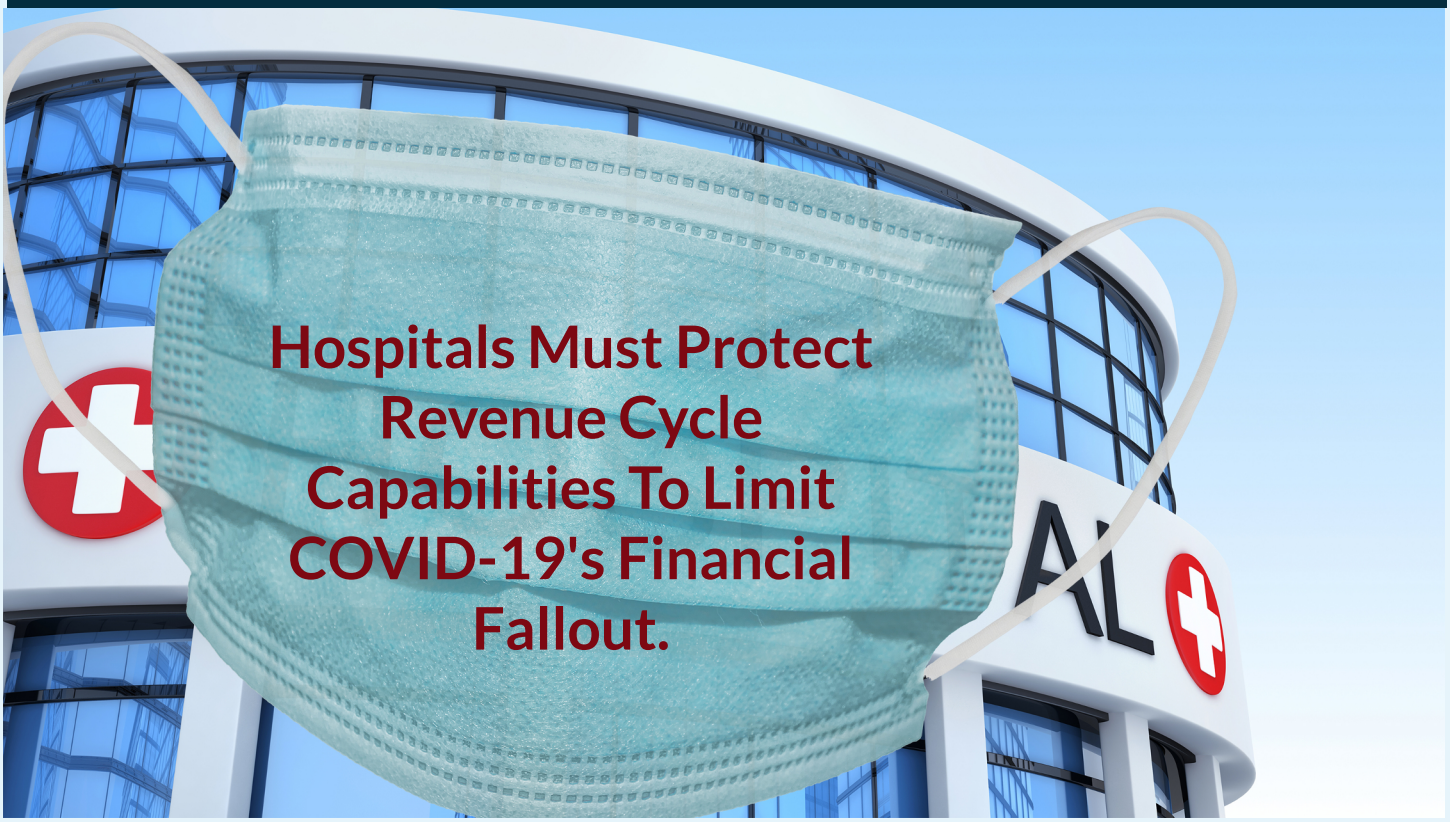
Instructions CMS-10611 OMB expiration: 12-31-2022

Signature of Patient or Representative:

Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents. If a representative's signature is not legible, print the representative's name by the signature.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

NEW WHITE PAPER FROM HFRI



AS the COVID-19 crisis deepens, hospitals nationwide are scrambling to overcome unprecedented clinical and patient-care demands and disruptions. As essential as these efforts are, it is also important that providers take steps to protect their revenue cycle operations and limit the economic fallout the pandemic is likely to produce.

These actions can include adjusting financial projections to reflect the fast-changing operational environment and implementing alternative revenue cycle processes to help preserve cash flow. Hospitals with appropriate safeguards should allow revenue cycle staff to work from home. They should also consider enlisting trusted third parties to supplement key elements of the revenue cycle, including accounts receivable management, to avoid cash flow disruptions.

A world turned upside down

With infection rates exploding, hospitals have been focused on increasing capacity, ensuring adequate supplies and equipment, and developing plans to triage an expected patient surge, while decreasing or eliminating elective and non-critical surgeries. In the interest of sustaining operations over the long-term, however, taking decisive action to meet the anticipated financial impact of the COVID-19 pandemic should not be ignored.

Specifically, hospitals must revise financial performance targets, cash flow projections and operational plans to reflect the following:

- The extended suspension of higher-margin elective surgeries
- The impact of increased supply costs and potential supply chain disruptions
- The effect on rising labor costs due to extended operational demands
- The balance sheet implications of declining investment income due to equity losses
- The possibility of payer disruptions affecting prompt reimbursement

NEW WHITE PAPER FROM HFRI

In mid-March, Moody's Investors Service reversed earlier predictions of 2%-to-3% cash flow growth for the not-for-profit and public healthcare sector in 2020. Instead, the company reported that revenue will likely decline "as an increasing number of hospitals cancel more profitable elective surgeries or procedures and halt other services in preparation for a surge in coronavirus cases. At the same time, expenses will rise with higher staffing costs and the need for supplies such as personal protective equipment."[1]

Moody's noted that while they assumed the outbreak may be somewhat contained in the second half of the year and that a gradual recovery will follow, "there is a high degree of uncertainty. Therefore, risk that the outbreak will be prolonged and the economic fallout will be more severe is elevated."

Operational considerations

In addition to making necessary adjustments in their financial projections, hospitals should be aware of operational issues related to the COVID-19 outbreak that could negatively impact cash flow and overall performance.

Among them:

- Coders should be educated in the use of the new COVID-19-related CPT® and HCPCS codes for both private payer and government claims. And under the National Emergency Authority, Medicare has expanded payments for professional services via telehealth, virtual check-ins, and e-visits.Failure to code COVID-19-related care correctly will likely result in denials and payment delays, which may be more difficult and time-consuming to resolve in the current environment. For new coding information related to COVID-19, click here

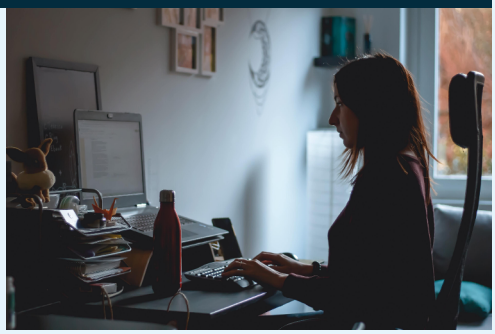
- It is important that hospitals monitor clearinghouse or bank electronic data interchange (EDI) capabilities to ensure 837 and 835 files containing claims and payment information continue to transit between payers and providers. Some hospitals have reported sporadic interruptions in their EDI services. Any substantial downtime that prevents timely claims submission or denial resolution could have a significant impact on collections

- Hospital payer mix may shift rapidly as a growing number of individuals suddenly find themselves out of work. Organizations should monitor claims frequently to determine if Medicare and Medicaid volume is increasing and/or commercial reimbursement is falling. Significant changes could have a major impact on budget projections

- Payer hold times for hospital staff working denials in many instances have increased due to limited staff availability at insurance company call centers. As a result, any automation processes that allow claims to be resolved without direct payer-provider interaction should be brought to bear

- If they haven't done so already, hospitals should work with payers to enable the receipt of 266/267 claim status files from clearinghouses to ensure up-to-date information regarding the status of unpaid claims. Payer portals should also be used to monitor and track unpaid claims

NEW WHITE PAPER FROM HFRI



Working remotely

As hospitals reduce non-critical, on-site staff, ensuring that revenue cycle employees can continue coding, filing claims and handling accounts receivable follow-up from home is essential to keep cash coming in.

Critical infrastructure elements needed to support secure, remote revenue cycle operations include:

- Robust work-at-home platforms
- Encryption both for data at rest and data in flight
- Multifactor authentication
- Secure operating environments

Internal encryption capabilities built into laptops and remote workstations are essential to reduce or eliminate breach risks surrounding the transfer of protected health information. Also important are virtual private networks and multi-factor logon authentication secure operating environments

Trusted and timely third-party assistance

Whether hospitals and other providers elect to shift revenue cycle staff to the home setting or not, they should consider partnering with a trusted third party capable of taking over elements of the revenue cycle for the duration of the crisis.

Healthcare Financial Resources (HFRI) provides a full range of outsourced AR follow-up services, including aging claims resolution, denial management and bad debt mitigation to help ensure claims are clean and paid the first time around to mitigate any delays. More than 98% of the company's workforce is now deployed remotely and all of HFRI's remote work processes are HITRUST CSF®-certified.

HFRI additionally uses data analytics and intelligent automation to expedite claims resolution, often without human touchpoints. And for clients using the **PARA Data Editor**, our services are built for remote access, so organizations can continue business as usual regardless of where personnel are working.

Most importantly, **HFRI** has the ability to scale up quickly to handle additional workflow. With assistance from the client, we can be up and running to manage aging AR and denials in a few days' time. That means your organization can minimize or avoid cash flow disruptions while concentrating valuable employee resources in other areas.

Contact us today to learn how we can help your organization preserve cash flow throughout the COVID-19 crisis.

[1]"Not-for-profit and public healthcare – US: Outlook changes to negative as coronavirus accentuates cash flow constraints," Moody's Investors Service, March 18, 2020

HEALTHCARE FINANCIAL RESOURCES

MLN CONNECTS

PARA invites you to check out the **mlnconnects** page available from the Centers For Medicare and Medicaid (CMS). It's chock full of news and information, training opportunities, events and more! Each week **PARA** will bring you the latest news and links to available resources. **Click each link for the PDF!**

Thursday, March 26, 2020

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

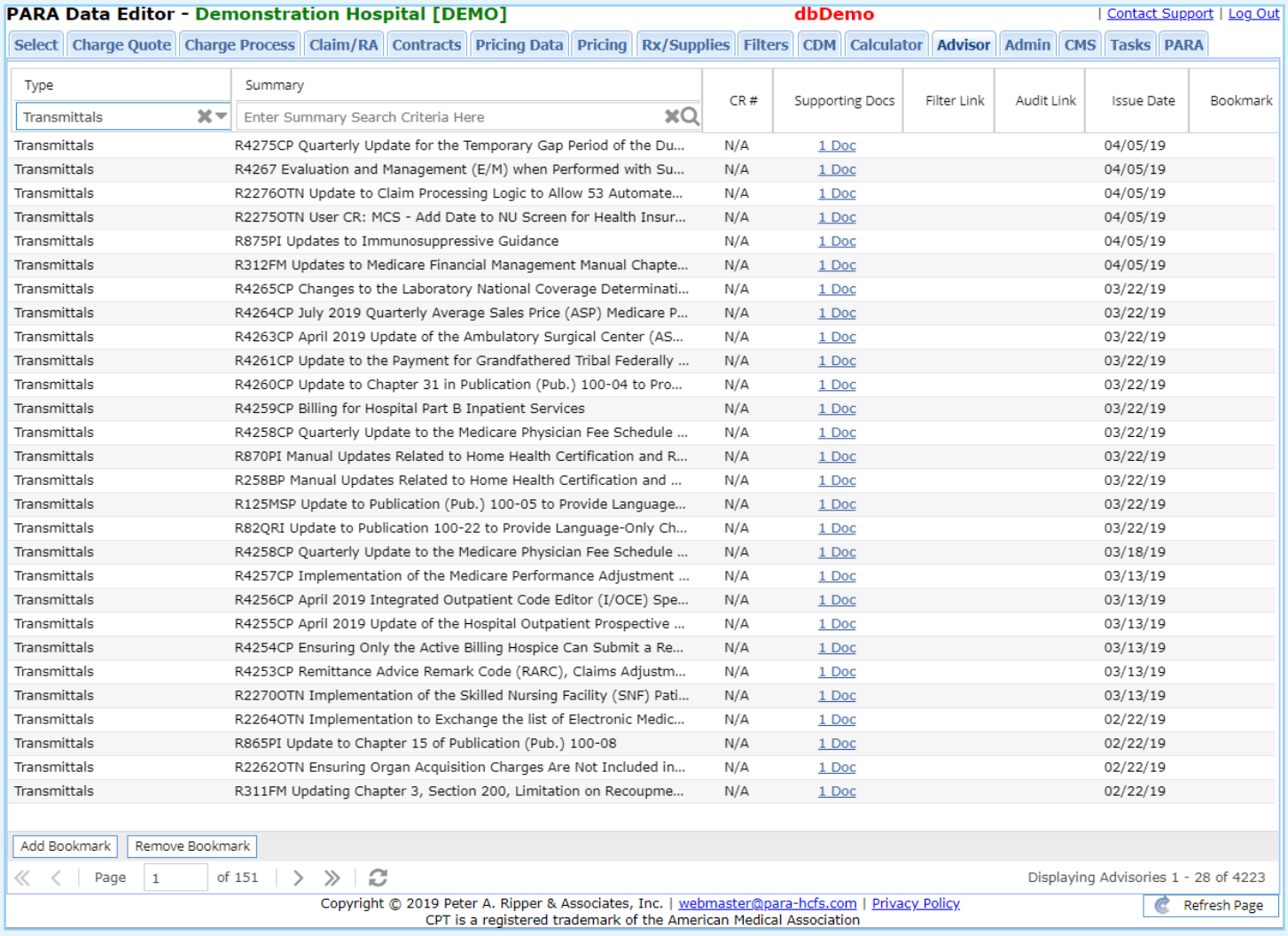
·Ground Ambulance Data Collection System Call: Audio Recording and Transcript

View this edition as a PDF (PDF)

There were FIVE new or revised MedLearns released this week.

To go to the full Transmittal document **simply click on the screen shot or the link.**

FIND ALL THESE MEDLEARNS IN THE **ADVISOR** TAB OF THE **PDE** 5



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Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx/Supplies | Filters | CDM | Calculator | **Advisor** | Admin | CMS | Tasks | PARA

Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date	Bookmark
Transmittals	Enter Summary Search Criteria Here						
Transmittals	R4275CP Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			04/05/19	
Transmittals	R4267 Evaluation and Management (E/M) when Performed with Su...	N/A	1 Doc			04/05/19	
Transmittals	R2276OTN Update to Claim Processing Logic to Allow 53 Automate...	N/A	1 Doc			04/05/19	
Transmittals	R2275OTN User CR: MCS - Add Date to NU Screen for Health Insur...	N/A	1 Doc			04/05/19	
Transmittals	R875PI Updates to Immunosuppressive Guidance	N/A	1 Doc			04/05/19	
Transmittals	R312FM Updates to Medicare Financial Management Manual Chapte...	N/A	1 Doc			04/05/19	
Transmittals	R4265CP Changes to the Laboratory National Coverage Determinati...	N/A	1 Doc			03/22/19	
Transmittals	R4264CP July 2019 Quarterly Average Sales Price (ASP) Medicare P...	N/A	1 Doc			03/22/19	
Transmittals	R4263CP April 2019 Update of the Ambulatory Surgical Center (AS...	N/A	1 Doc			03/22/19	
Transmittals	R4261CP Update to the Payment for Grandfathered Tribal Federally ...	N/A	1 Doc			03/22/19	
Transmittals	R4260CP Update to Chapter 31 in Publication (Pub.) 100-04 to Pro...	N/A	1 Doc			03/22/19	
Transmittals	R4259CP Billing for Hospital Part B Inpatient Services	N/A	1 Doc			03/22/19	
Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/22/19	
Transmittals	R870PI Manual Updates Related to Home Health Certification and R...	N/A	1 Doc			03/22/19	
Transmittals	R258BP Manual Updates Related to Home Health Certification and ...	N/A	1 Doc			03/22/19	
Transmittals	R125MSP Update to Publication (Pub.) 100-05 to Provide Language...	N/A	1 Doc			03/22/19	
Transmittals	R82QRI Update to Publication 100-22 to Provide Language-Only Ch...	N/A	1 Doc			03/22/19	
Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/18/19	
Transmittals	R4257CP Implementation of the Medicare Performance Adjustment ...	N/A	1 Doc			03/13/19	
Transmittals	R4256CP April 2019 Integrated Outpatient Code Editor (I/OCE) Spe...	N/A	1 Doc			03/13/19	
Transmittals	R4255CP April 2019 Update of the Hospital Outpatient Prospective ...	N/A	1 Doc			03/13/19	
Transmittals	R4254CP Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
Transmittals	R4253CP Remittance Advice Remark Code (RARC), Claims Adjustm...	N/A	1 Doc			03/13/19	
Transmittals	R2270OTN Implementation of the Skilled Nursing Facility (SNF) Pati...	N/A	1 Doc			03/13/19	
Transmittals	R2264OTN Implementation to Exchange the list of Electronic Medic...	N/A	1 Doc			02/22/19	
Transmittals	R865PI Update to Chapter 15 of Publication (Pub.) 100-08	N/A	1 Doc			02/22/19	
Transmittals	R2262OTN Ensuring Organ Acquisition Charges Are Not Included in...	N/A	1 Doc			02/22/19	
Transmittals	R311FM Updating Chapter 3, Section 200, Limitation on Recoupme...	N/A	1 Doc			02/22/19	

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The link to this MedLearn MM11745

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July 2020 Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM11745 | Related Change Request (CR) Number: 11745

Related CR Release Date: March 27, 2020 | Effective Date: July 1, 2020

Related CR Transmittal Number: R10017CP | Implementation Date: July 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for Medicare Part B drugs provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11745 informs MACs 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 (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 (OPPS) are incorporated into the Outpatient Code Editor (OCE) 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.

BACKGROUND

The ASP methodology is based on quarterly data manufacturers submit to CMS. CR 11745 instructs MACs to download and implement the July 2020 and, if released, the revised April 2020, January 2020, October 2019, and July 2019 drug pricing files for Medicare Part B drugs

CR 11745 addresses the following pricing files:

- File: July 2020 ASP and ASP NOC -- Effective Dates of Service: July 1, 2020, through September 30, 2020
- File: April 2020 ASP and ASP NOC -- Effective Dates of Service: April 1, 2020, through June 30, 2020
- File: January 2020 ASP and ASP NOC -- Effective Dates of Service: January 1, 2020, through March 31, 2020
- File: October 2019 ASP and ASP NOC -- Effective Dates of Service: October 1, 2019,

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The link to this MedLearn MM11734

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KNOWLEDGE • RESOURCES • TRAINING

Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.2, Effective July 1, 2020

MLN Matters Number: MM11734 | Related Change Request (CR) Number: 11734

Related CR Release Date: March 27, 2020 | Effective Date: July 1, 2020

Related CR Transmittal Number: R10012CP | Implementation Date: July 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11734 provides the quarterly update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. Please be sure your billing staffs know of the updates.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of NCCI Procedure-to-Procedure (PTP) edits, Version 26.2, effective July 1, 2020, will be available via the CMS Virtual Data Center (VDC). A test file will be available on or about May 2, 2020, and a final file will be available on or about May 17, 2020.

Version 26.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. To simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE). It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits.

CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or

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The link to this MedLearn MM11628

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KNOWLEDGE • RESOURCES • TRAINING

Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020

MLN Matters Number: MM11628 Revised

Related Change Request (CR) Number: 11628

Related CR Release Date: March 25, 2020

Effective Date: April 1, 2020

Related CR Transmittal Number: R10015CP

Implementation Date: April 6, 2020

Note: We revised this article on March 26, 2020, to reflect a revised CR11628 issued on March 25. The CR revision had no impact on 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.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11628 contains the quarterly update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. Please be sure your billing staffs know of the updates.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of NCCI Procedure-to-Procedure (PTP) edits, Version 26.1 effective April 1, 2020, will be available via the CMS Virtual Data Center (VDC). A test file will be available on or about January 31, 2020, and a final file will be available on or about February 14, 2020.

Version 26.1 will include all previous versions and updates from January 1, 1996 to the present. In the past, NCCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. To simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE). It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or

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KNOWLEDGE • RESOURCES • TRAINING

Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendment (CLIA) Edits

MLN Matters Number: MM11640 Revised

Related Change Request (CR) Number: 11640

Related CR Release Date: March 20, 2020

Effective Date: April 1, 2020

Related CR Transmittal Number: R10009CP

Implementation Date: April 6, 2020

Note: We revised this article on March 24, 2020, to reflect an updated CR 11640. In the article, we revised the transmittal number, CR release date and link to the transmittal. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11640 informs the MACs about new HCPCS codes for 2020 that are subject to and excluded from Clinical Laboratory Improvement Amendment (CLIA) edits. Please make sure your billing staffs are aware of this update.

BACKGROUND

Note: On March 5, CMS released information about developing a second HCPCS billing code (U0002), which laboratories can use to bill for certain 2019-Novel Coronavirus (COVID-19) and SARS-Co-V-2 diagnostic tests to help increase testing and track new cases, in addition to a previous HCPCS billing code (U0001), which laboratories can use to test for SARS-Co-V-2. (See https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests.)

CLIA regulations require facilities to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for an HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The link to this MedLearn MM11702

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KNOWLEDGE • RESOURCES • TRAINING

April Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM11702 | Related Change Request (CR) Number: 11702

Related CR Release Date: March 20, 2020 | Effective Date: April 1, 2020

Related CR Transmittal Number: R10004CP | Implementation Date: April 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters® Article is for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services that Medicare reimburses under the DMEPOS fee schedule.

PROVIDER ACTION NEEDED

CR 11702 informs DME MACs 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 at: https://www.cms.gov/files/document/chapter-23-fee-schedule-administration-and-coding-requirements.pdf. Make sure your billing staff is aware of this update.

BACKGROUND

CR 11702 provides instructions for the April 2020 DMEPOS Rural ZIP code file containing the Quarter 2, 2020 Rural ZIP code changes. Also included in the update is the former Competitive Bidding Area (CBA) ZIP code file containing the Quarter 2, 2020 Round 1 2017 and Round 2 Re-compete CBA ZIP codes. An April update to the 2020 DMEPOS and PEN fee schedule files is not required.

The following DMEPOS fee schedule and ZIP code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html:

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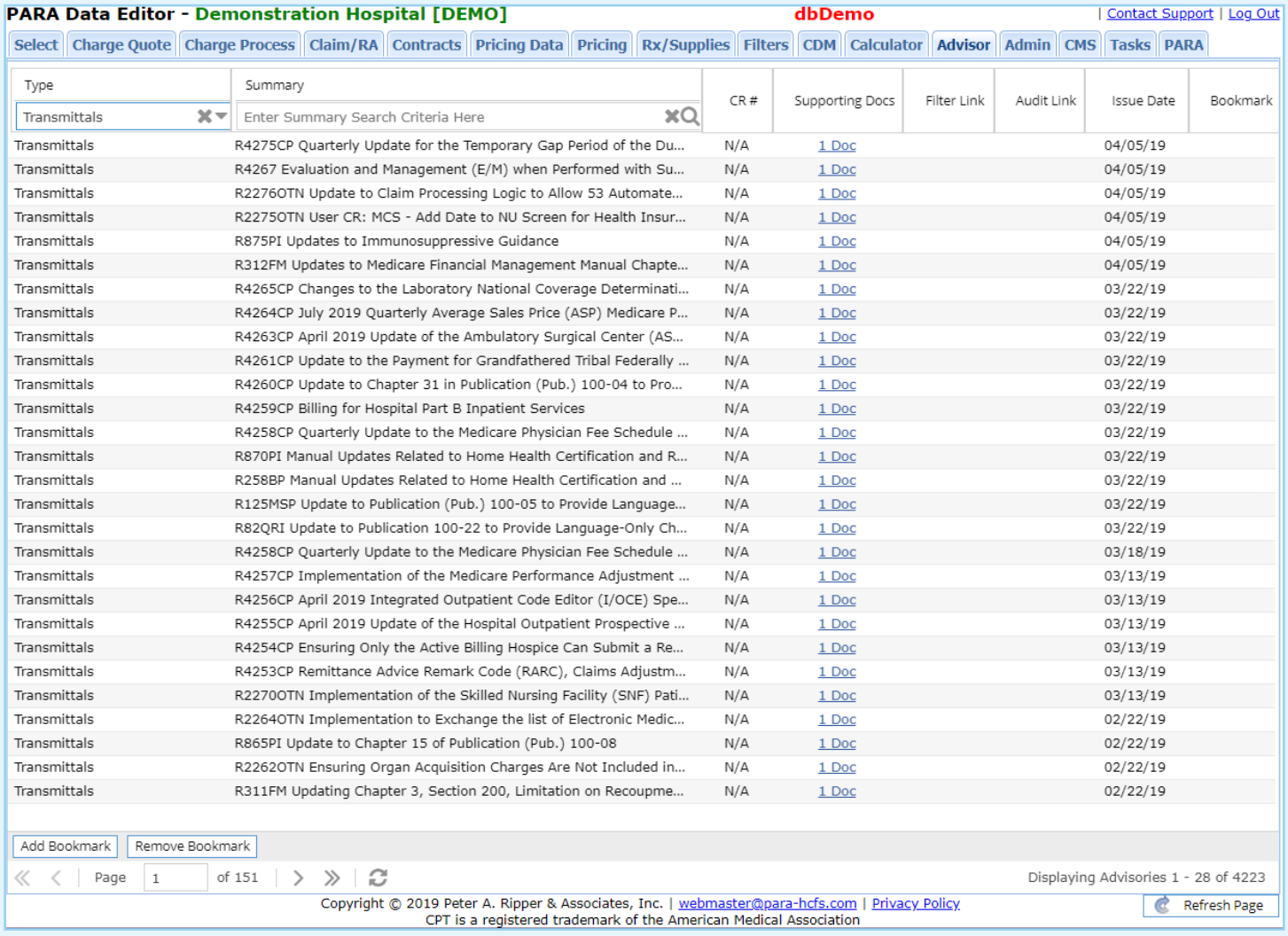
There were SEVEN new or revised Transmittals released this week.

To go to the full Transmittal document **simply click on the screen shot or the link.**

FIND ALL THESE TRANSMITTALS IN THE **ADVISOR** TAB OF THE **PDE** 7



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Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx/Supplies | Filters | CDM | Calculator | **Advisor** | Admin | CMS | Tasks | PARA

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Transmittals	Enter Summary Search Criteria Here						
Transmittals	R4275CP Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			04/05/19	
Transmittals	R4267 Evaluation and Management (E/M) when Performed with Su...	N/A	1 Doc			04/05/19	
Transmittals	R2276OTN Update to Claim Processing Logic to Allow 53 Automate...	N/A	1 Doc			04/05/19	
Transmittals	R2275OTN User CR: MCS - Add Date to NU Screen for Health Insur...	N/A	1 Doc			04/05/19	
Transmittals	R875PI Updates to Immunosuppressive Guidance	N/A	1 Doc			04/05/19	
Transmittals	R312FM Updates to Medicare Financial Management Manual Chapte...	N/A	1 Doc			04/05/19	
Transmittals	R4265CP Changes to the Laboratory National Coverage Determinati...	N/A	1 Doc			03/22/19	
Transmittals	R4264CP July 2019 Quarterly Average Sales Price (ASP) Medicare P...	N/A	1 Doc			03/22/19	
Transmittals	R4263CP April 2019 Update of the Ambulatory Surgical Center (AS...	N/A	1 Doc			03/22/19	
Transmittals	R4261CP Update to the Payment for Grandfathered Tribal Federally ...	N/A	1 Doc			03/22/19	
Transmittals	R4260CP Update to Chapter 31 in Publication (Pub.) 100-04 to Pro...	N/A	1 Doc			03/22/19	
Transmittals	R4259CP Billing for Hospital Part B Inpatient Services	N/A	1 Doc			03/22/19	
Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/22/19	
Transmittals	R870PI Manual Updates Related to Home Health Certification and R...	N/A	1 Doc			03/22/19	
Transmittals	R258BP Manual Updates Related to Home Health Certification and ...	N/A	1 Doc			03/22/19	
Transmittals	R125MSP Update to Publication (Pub.) 100-05 to Provide Language...	N/A	1 Doc			03/22/19	
Transmittals	R82QRI Update to Publication 100-22 to Provide Language-Only Ch...	N/A	1 Doc			03/22/19	
Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/18/19	
Transmittals	R4257CP Implementation of the Medicare Performance Adjustment ...	N/A	1 Doc			03/13/19	
Transmittals	R4256CP April 2019 Integrated Outpatient Code Editor (I/OCE) Spe...	N/A	1 Doc			03/13/19	
Transmittals	R4255CP April 2019 Update of the Hospital Outpatient Prospective ...	N/A	1 Doc			03/13/19	
Transmittals	R4254CP Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
Transmittals	R4253CP Remittance Advice Remark Code (RARC), Claims Adjustm...	N/A	1 Doc			03/13/19	
Transmittals	R2270OTN Implementation of the Skilled Nursing Facility (SNF) Pati...	N/A	1 Doc			03/13/19	
Transmittals	R2264OTN Implementation to Exchange the list of Electronic Medic...	N/A	1 Doc			02/22/19	
Transmittals	R865PI Update to Chapter 15 of Publication (Pub.) 100-08	N/A	1 Doc			02/22/19	
Transmittals	R2262OTN Ensuring Organ Acquisition Charges Are Not Included in...	N/A	1 Doc			02/22/19	
Transmittals	R311FM Updating Chapter 3, Section 200, Limitation on Recoupme...	N/A	1 Doc			02/22/19	

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The link to this Transmittal R10017CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10017	**Date: March 27, 2020**
	Change Request 11745

SUBJECT: July 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

I. SUMMARY OF CHANGES: The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply the contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in Chapter 4, section 50 of the Internet Only Manual.

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

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For Medicare Administrative Contractors (MACs):
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R100210TN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10021	**Date: March 27, 2020**
	Change Request 11516

Transmittal 2438, dated February 21, 2020, is being rescinded and replaced by Transmittal 10021, dated, March 27, 2020 to remove business requirement 11516.7 and to change the PA Program Indicator in the attachment Criteria Template. All other information remains the same.

SUBJECT: Implementation of Additional Requirement to add Healthcare Common Procedure Coding System (HCPC) and Current Procedural Terminology (CPT) - HCPC/CPT as Paired Items of Service for Prior Authorization and Medicare Claims Processing for Part A, Part B, DME, and Home Health and Hospice

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the additional claims processing requirements for prior authorization programs and Medicare claims processing to add Healthcare Common Procedure Coding System (HCPC) and Current Procedural Terminology (CPT)-HCPCS/CPT as paired items of serivce for future processing. Adding the HCPCS/CPT as paired items of service is necessary to ensure the system knows where to identify new paired items of service when it is a HCPCS/CPT pair for future program files.

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

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IV. ATTACHMENTS:
One Time Notification

The link to this Transmittal R10012CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10012	**Date: March 27, 2020**
	Change Request 11734

SUBJECT: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.2, Effective July 1, 2020

I. SUMMARY OF CHANGES: This is the quarterly update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to publication 100-04, chapter 23, section 20.9.

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10018OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10018	**Date: March 26, 2020**
	Change Request 11010

Transmittal 2303, dated May 9, 2019, is being rescinded and replaced by Transmittal 10018, dated, March 26, 2020 to revise the effective and implementation dates. All other information remains the same.

SUBJECT: Shared System Enhancement 2018: Rewrite Fiscal Intermediary Shared System (FISS) module FSSB6001, Common Working File (CWF) Unsolicited Response Function

I. SUMMARY OF CHANGES: The Centers for Medicare & Medicaid Services (CMS) directs FISS to refactor a portion of the FISS claim adjustments and reporting related to trailers 16, 20, and 24. By splitting the current process into separate, well-designed functions, CMS anticipates streamlining future maintenance and consolidating the current reporting, where possible, to all related Unsolicited Response processing.

EFFECTIVE DATE: April 1, 2019 - Rules mining, requirements, design, and development of a complete Regression Test Bed; July 1, 2019 - Complete coding; October 1, 2019 - Rules mining, requirements, design and development; January 1, 2020 - Complete rules mining, requirements, design, and coding; April 1, 2020 - Requirements, design and coding; October 1, 2020 - Test plan, coding documentation, and present requirements; January 1, 2021 - Implementation
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019 - Rules mining, requirements, design, and development of a complete Regression Test Bed; July 1, 2019 - Complete coding; October 7, 2019 - Rules mining, requirements, design and development; January 6, 2020 - Complete rules mining, requirements, design, and coding; April 6, 2020 - Requirements, design and coding; October 5, 2020 - Test plan, coding documentation, and present requirements; January 4, 2021 - Implementation

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The link to this Transmittal R10013CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10013	**Date: March 25, 2020**
	Change Request 11691

Transmittal 4544, dated March 6, 2020, is being rescinded and replaced by Transmittal 10013, dated, March 25, 2020 to revise section I.B.3 to add new Coronavirus CPT codes U0002 and 87635, and to add a new section I.B.4.f.to revise a status indicator for Q5118, (Injection, bevacizumab-bvzr, biosimilar, (zirabev), 10 mg) from status indicator "E2" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to status indicator = "K" (Paid under OPPS; separate APC payment). We are also updating table 3 and adding new table 7 to the Attachment A. All other information remains the same.

SUBJECT: April 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the April 2020 OPPS update. The April 2020 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This Recurring Update Notification applies to Chapter 4, section 50.7.

The April 2020 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2020 I/OCE CR.

EFFECTIVE DATE: April 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020

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The link to this Transmittal R10009CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10009	**Date: March 20, 2020**
	Change Request 11640

Transmittal 4542, dated March 6, 2020, is being rescinded and replaced by Transmittal 10009, dated, March 20, 2020 to revise the background section removing the first instance of code 0091U. All other information remains the same.

SUBJECT: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

I. SUMMARY OF CHANGES: This Change Request (CR) informs contractors about the new HCPCS codes for 2020 that are subject to and excluded from CLIA edits. This Recurring Update Notification applies to Chapter 16, section 70.9.

EFFECTIVE DATE: April 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10015CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10015	**Date: March 25, 2020**
	Change Request 11628

Transmittal 4497, dated January 17, 2020, is being rescinded and replaced by Transmittal 10015, March 25, 2020, to revise the file names in Business Requirements 11628.1 and 11628.2. All other information remains the same.

SUBJECT: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020

I. SUMMARY OF CHANGES: This is the quarterly update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to publication 100-04, chapter 23, section 20.9.

EFFECTIVE DATE: April 1, 2020
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IMPLEMENTATION DATE: April 6, 2020

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IV. ATTACHMENTS:

Recurring Update Notification

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