PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

April 22, 2020

PARA Weekly eJOURNAL

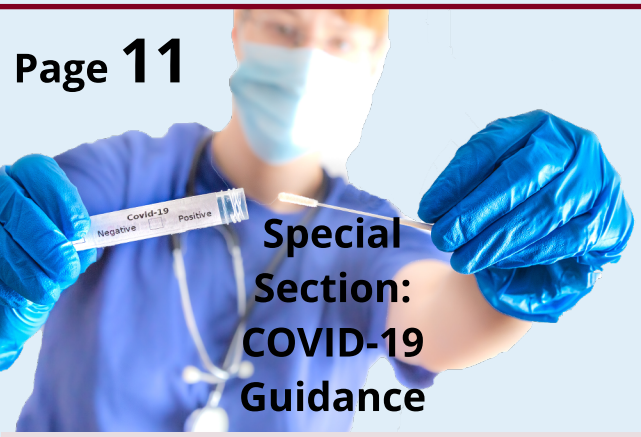
NEWS FOR HEALTHCARE DECISION MAKERS

Page 30

Disaster Coding

PT/OT/SLP Remote Billing

Page 35



Page 11

Special Section: COVID-19 Guidance

FAST LINKS

SPECIAL ANNOUNCEMENT

NUBC™
National Uniform Billing Committee

NUBC Guidance: Claims for COVID 19 Treatment

(Updated)

Usage of the "DR" condition code:
Without codes to specifically indicate COVID-19 (including those cases for which services were provided but the patient ultimately tested negative), the ability of payers to trigger special handling of institutional claims for COVID-19 related services has been significantly limited.

NUBC Recommendation: In order to ensure appropriate flagging of COVID-19 related care, institutional claims for COVID-19 diagnosis or treatment should include:

1. The "DR" condition code, which is used to identify claims that are or may be impacted by specific policies related to a national or regional disaster/emergency.
2. One of the following diagnosis codes, as included in the interim or final ICD-10-CM Official Guidelines for Coding and Reporting (for more information, see https://www.cdc.gov/nchs/icd/icd10cm.htm):
   - B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for services provided before April 1, 2020
   - U07.1 (COVID-19) for services provided on or after April 1, 2020
   - Z03.818 (Encounter for observation for suspected exposure to other biological agents ruled out)
   - Z11.59 (Encounter for screening for other viral diseases)
   - Z20.828 (Contact with and (suspected) exposure to other viral communicable diseases)
3. An appropriate service date. The "DR" condition code should be utilized for COVID-19 related care occurring since January 27th, the date that the Department of Health and Human Services declared the COVID- 19 crisis as a federal public health emergency (January 27th, 2020)

Utilization of Hospital Outpatient Bill Type for COVID Testing Locations:

In order to meet patient needs, many hospitals and health systems have moved testing locations from hospitals to off-campus facilities (e.g. parking lots, parks, football stadiums). In such cases, the NUBC recommends usage of the Hospital Outpatient Type of Bill (013x), the main hospital address and National Provider Identifier (NPI). When paired with the DR condition code (as directed above), the claim will help payers correctly apply site of service restrictions/edits

New Guidance For FQHCs And RHCs

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: SE20016 | Related Change Request (CR) Number: N/A

Article Release Date: April 17, 2020 | Effective Date: N/A

Related CR Transmittal Number: N/A | Implementation Date: N/A

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

To provide as much support as possible to RHCs and FQHCs and their patients during the COVID-19 PHE, both Congress and the Centers for Medicare & Medicaid Services (CMS) have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will make additional discretionary changes as necessary to assure that RHC and FQHC patients have access to the services they need during the pandemic. For additional information, please see the RHC/FQHC COVID-19 FAQs at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

BACKGROUND

New Payment for Telehealth Services

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. Section 3704 of the CARES Act authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs and FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.

Distant site telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). A list of these is available at

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New Guidance For FQHCs And RHCs

https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.

The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that CMS develop payment rates for these services that are similar to the national average payment rates for comparable telehealth services under the PFS. Payment to RHCs and FQHCs for distant site telehealth services is set at $92, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs and FQHCs must put Modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. RHCs will be paid at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. **These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate. RHCs and FQHCs do not need to resubmit these claims for the payment adjustment.**

For telehealth distant site services furnished between July 1, 2020, and the end of the COVID-19 PHE, RHCs and FQHCs will use an RHC/FQHC specific G code, G2025, to identify services that were furnished via telehealth. RHC and FQHC claims with the new G code will be paid at the $92 rate. Only distant site telehealth services furnished during the COVID-19 PHE are authorized for payment to RHCs and FQHCs. If the COVID-PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rates but must be reported on the appropriate cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services." FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled "Other FQHC Services".

Since telehealth distant site services are not paid under the RHC AIR or the FQHC PPS, the Medicare Advantage wrap-around payment does not apply to these services. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.

During the COVID-19 PHE, CMS will pay all of the reasonable costs for any service related to COVID-19 testing, including applicable telehealth services, for services furnished beginning on March 1, 2020. For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries. For services in which the coinsurance is waived, RHCs and FQHCs must put the "CS" modifier on the service line. **RHC and FQHC claims with the "CS" modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1. Coinsurance should not be collected from beneficiaries if the coinsurance is waived.**

Expansion of Virtual Communication Services

Payment for virtual communication services now include online digital evaluation and management services. Online digital evaluation and management services are non-face-to-face,

New Guidance For FQHCs And RHCs

patient-initiated, digital communications using a secure patient portal. The online digital evaluation and management codes that are billable during the COVID-19 PHE are:

- CPT code 99421 (5-10 minutes over a 7-day period)
- CPT code 99422 (11-20 minutes over a 7-day period)
- CPT code 99423 (21 minutes or more over a 7-day period)

To receive payment for the new online digital evaluation and management (CPT codes 99421, 99433, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), RHCs and FQHCs must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for these 5 codes. Claims submitted with G0071 on or after March 1 and for the duration of the PHE will be paid at the new rate of $24.76, instead of the CY 2020 rate of $13.53. **MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid before the claims processing system was updated.**

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

RHCs and FQHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, the area typically served by the RHC, and the area included in the FQHC service area plan, is determined to have a shortage of HHAs, and no request for this determination is required. RHCs and FQHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.

Consent for Care Management and Virtual Communication Services

Beneficiary consent is required for all services, including non-face-to-face services. During the PHE, beneficiary consent may be obtained at the same time the services are initially furnished. For RHCs and FQHCs, this means that beneficiary consent can be obtained by someone working under general supervision of the RHC or FQHC practitioner, and direct supervision is not required to obtain consent. In general, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the billing practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the billing practitioner. For RHCs and FQHCs, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the RHC or FQHC practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the RHC or FQHC practitioner (see: https://www.cms.gov/files/document/covid-final-ifc.pdf).

Accelerated/Advance Payments

In order to increase cash flow to providers and suppliers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/advance payment is a payment intended to provide necessary funds when there is a disruption in claims

New Guidance For FQHCs And RHCs

submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the PHE to any RHC or FQHC who submits a request to their MAC and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/accelerated payments begins at 90 days; however, for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process at https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

ADDITIONAL INFORMATION

View the complete list of coronavirus waivers.

Review information on the current emergencies webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
April 17, 2020	Initial article released.

PTs AS BILLING PROFESSIONALS ON THE 1500

Q. We are enrolling our therapists in Medicare and Medicaid so they can see patients in other settings, like our VA nursing home, and bill on a 1500. What they would like to do is see self-pay patients, or patients who have exhausted their preauthorized insurance visits, and offer a self-pay discount. The question is whether people could come to the hospital for services without an order. From what I can see, an order is required under our COP. Would it make any difference if the therapist billed on a 1500 vs a UB? Thank you.

A. **Answer:** You are correct, the Medicare Conditions of Participation specify that the patient must be under a physician's plan of care. However, the CoP limits what Medicare Part B will pay – not what other services may be delivered that are not payable by Medicare Part B.

Here's the pertinent excerpt:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in part 484 of this chapter for a physical therapist or an appropriately supervised physical therapist assistant but only under the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By, or under the direct supervision of a physical therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform physical therapy services under State law. When a physical therapy service is provided incident to the service of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to physical therapy and physical therapists, except that a license to practice physical therapy in the State is not required.

It may be possible for the hospital to offer self-pay services for patients who have exhausted benefits or have no insurance, provided that:

- any Medicare beneficiary is given an Advance Beneficiary Notice that specifies why the services will be non-covered and how much the services will cost; and

- No services which lack a physician's POC are billed to Medicare (or Medicaid, for that matter.)If the hospital were to pursue this idea, we recommend putting controls in place to make sure that a potentially covered service is not inadvertently rendered without a POC and billed as self-pay, and that any self-pay services which lack a physician-approved POC are not billed as covered services to Medicare, Medicaid, or other group health insurance payers. If the controls fail, the hospital could have a serious compliance problem on its hands.

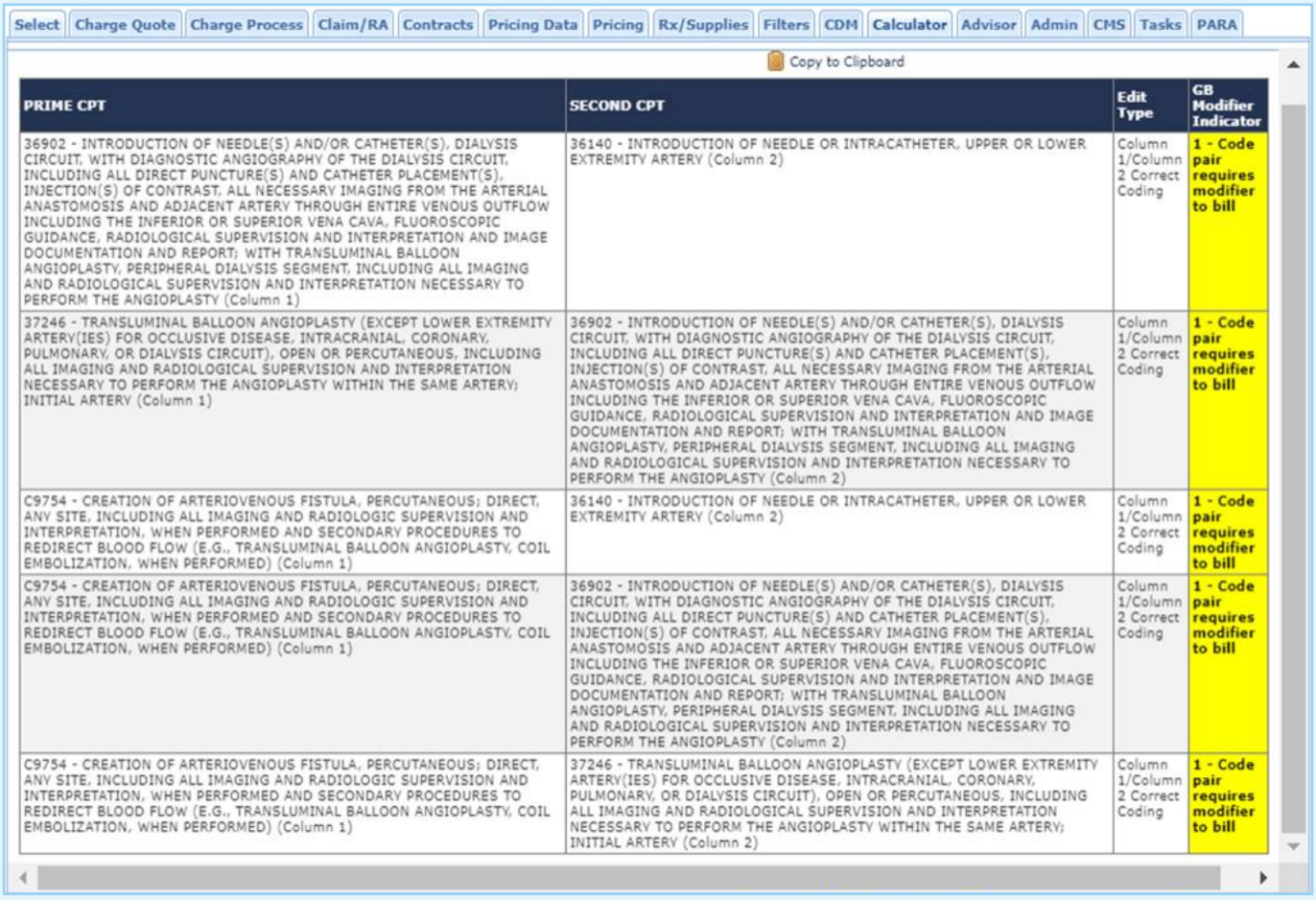
AV FISTULA CREATION

Q. Would we code 36140, 36902, 37246, 37999 or C9754 - bundled AV Fistula Creation. Business Office states "claim denied requesting principal procedure code?"

A. **Answer:** Report HCPCS code C9754 for percutaneous creation of AV fistula utilizing the Ellipsys device. Some payers may have payer specific guidelines for HCPCS codes. If the payer does not accept HCPCS codes, report unlisted CPT® code 37799. Dr. Z's Interventional Radiology coding reference discusses the Ellipsys device to create a percutaneous AV Fistula and instructs coders to report HCPCS code C9754.

This reference confirms C9754 includes the imaging, catheter placement, dilation, and embolization when performed. CPT® codes 36140, 36902, and 37246 are integral components of HCPCS code C9754 per OCE NCCI edits and would not be reported separately. Please refer to the **PARA Data Editor CCS** edits and the Dr. Z's Interventional Radiology reference provided below.

Dr. Z's Interventional Radiology Coding Reference pages: 340-353 #5C9754 for the Ellipsys device to create a percutaneous AV fistula. The Ellipsys device utilizes a single percutaneous venous access and thermal energy to fuse a permanent AV anastomosis for the AV fistula. Code C9754 includes imaging, catheter placements, balloon dilation, and embolization of branches when performed. If reporting for physician, code 37799 is reported instead of C9754.


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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PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
36902 - INTRODUCTION OF NEEDLE(S) AND/OR CATHETER(S), DIALYSIS CIRCUIT, WITH DIAGNOSTIC ANGIOGRAPHY OF THE DIALYSIS CIRCUIT, INCLUDING ALL DIRECT PUNCTURE(S) AND CATHETER PLACEMENT(S), INJECTION(S) OF CONTRAST, ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA, FLUOROSCOPIC GUIDANCE, RADIOLOGICAL SUPERVISION AND INTERPRETATION AND IMAGE DOCUMENTATION AND REPORT; WITH TRANSLUMINAL BALLOON ANGIOPLASTY, PERIPHERAL DIALYSIS SEGMENT, INCLUDING ALL IMAGING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION NECESSARY TO PERFORM THE ANGIOPLASTY (Column 1)	36140 - INTRODUCTION OF NEEDLE OR INTRACATHETER, UPPER OR LOWER EXTREMITY ARTERY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
37246 - TRANSLUMINAL BALLOON ANGIOPLASTY (EXCEPT LOWER EXTREMITY ARTERY(IES) FOR OCCLUSIVE DISEASE, INTRACRANIAL, CORONARY, PULMONARY, OR DIALYSIS CIRCUIT), OPEN OR PERCUTANEOUS, INCLUDING ALL IMAGING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION NECESSARY TO PERFORM THE ANGIOPLASTY WITHIN THE SAME ARTERY; INITIAL ARTERY (Column 1)	36902 - INTRODUCTION OF NEEDLE(S) AND/OR CATHETER(S), DIALYSIS CIRCUIT, WITH DIAGNOSTIC ANGIOGRAPHY OF THE DIALYSIS CIRCUIT, INCLUDING ALL DIRECT PUNCTURE(S) AND CATHETER PLACEMENT(S), INJECTION(S) OF CONTRAST, ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA, FLUOROSCOPIC GUIDANCE, RADIOLOGICAL SUPERVISION AND INTERPRETATION AND IMAGE DOCUMENTATION AND REPORT; WITH TRANSLUMINAL BALLOON ANGIOPLASTY, PERIPHERAL DIALYSIS SEGMENT, INCLUDING ALL IMAGING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION NECESSARY TO PERFORM THE ANGIOPLASTY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
C9754 - CREATION OF ARTERIOVENOUS FISTULA, PERCUTANEOUS; DIRECT, ANY SITE, INCLUDING ALL IMAGING AND RADIOLOGIC SUPERVISION AND INTERPRETATION, WHEN PERFORMED AND SECONDARY PROCEDURES TO REDIRECT BLOOD FLOW (E.G., TRANSLUMINAL BALLOON ANGIOPLASTY, COIL EMBOLIZATION, WHEN PERFORMED) (Column 1)	36140 - INTRODUCTION OF NEEDLE OR INTRACATHETER, UPPER OR LOWER EXTREMITY ARTERY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
C9754 - CREATION OF ARTERIOVENOUS FISTULA, PERCUTANEOUS; DIRECT, ANY SITE, INCLUDING ALL IMAGING AND RADIOLOGIC SUPERVISION AND INTERPRETATION, WHEN PERFORMED AND SECONDARY PROCEDURES TO REDIRECT BLOOD FLOW (E.G., TRANSLUMINAL BALLOON ANGIOPLASTY, COIL EMBOLIZATION, WHEN PERFORMED) (Column 1)	36902 - INTRODUCTION OF NEEDLE(S) AND/OR CATHETER(S), DIALYSIS CIRCUIT, WITH DIAGNOSTIC ANGIOGRAPHY OF THE DIALYSIS CIRCUIT, INCLUDING ALL DIRECT PUNCTURE(S) AND CATHETER PLACEMENT(S), INJECTION(S) OF CONTRAST, ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA, FLUOROSCOPIC GUIDANCE, RADIOLOGICAL SUPERVISION AND INTERPRETATION AND IMAGE DOCUMENTATION AND REPORT; WITH TRANSLUMINAL BALLOON ANGIOPLASTY, PERIPHERAL DIALYSIS SEGMENT, INCLUDING ALL IMAGING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION NECESSARY TO PERFORM THE ANGIOPLASTY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
C9754 - CREATION OF ARTERIOVENOUS FISTULA, PERCUTANEOUS; DIRECT, ANY SITE, INCLUDING ALL IMAGING AND RADIOLOGIC SUPERVISION AND INTERPRETATION, WHEN PERFORMED AND SECONDARY PROCEDURES TO REDIRECT BLOOD FLOW (E.G., TRANSLUMINAL BALLOON ANGIOPLASTY, COIL EMBOLIZATION, WHEN PERFORMED) (Column 1)	37246 - TRANSLUMINAL BALLOON ANGIOPLASTY (EXCEPT LOWER EXTREMITY ARTERY(IES) FOR OCCLUSIVE DISEASE, INTRACRANIAL, CORONARY, PULMONARY, OR DIALYSIS CIRCUIT), OPEN OR PERCUTANEOUS, INCLUDING ALL IMAGING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION NECESSARY TO PERFORM THE ANGIOPLASTY WITHIN THE SAME ARTERY; INITIAL ARTERY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill

ABDOMINAL WALL/PELVIC ANGIOGRAMS

Q. Please review the documentation of the abdominal wall/pelvic angiogram. We are considering 76937, 36247 x 2 w/ modifier XS, 75726 - XS, 75774 - XS, 36217-XS, 75756-XS, 37244-XU. Is this correct?

A. **Answer:** Report CPT® codes 37244, 36247, 36248, 36217, 75726-59, 75774-59 and 75756-59. From the left common femoral access, the selection right common iliac and to the inferior epigastric is reported as 36247. After the inferior epigastric is embolized, the catheter is placed in the right internal iliac (same vascular family) and advanced to the superior vesical.

This supports an additional 3rd order, and is reported as 36248. After embolization, the subclavian is selected, and catheter is advanced to the right internal mammary (36217). Embolization is completed here. Append modifier -59 to 75726, 75774 and 75756 to bypass the edit when reported with 37244. The images are diagnostic in nature and not part of the imaging included in code 37244. Please refer to the **PARA Data Editor** code descriptions and the Dr. Z's reference which illustrates the location of the iliac vessels from contralateral approach.

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

Report Selection | 2020 Hospital Based HCPCS/CPT® Codes Quarter: Q1 | 2020 CPT® Codes

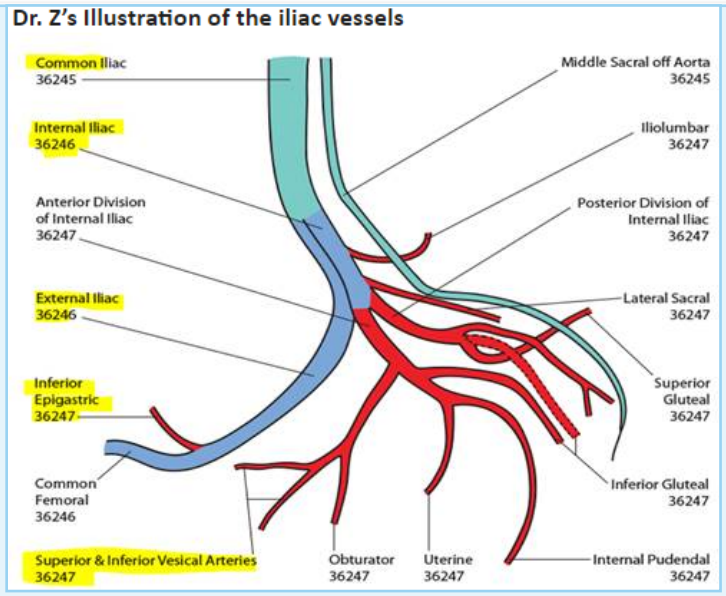
2020 CPT® Codes

Codes and/or Descriptions: **37244,36247,36248,36217,75726,75774,75756**

Export to PDF | Export to Excel

36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	UNCHANGED	Click For Details
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	UNCHANGED	Click For Details
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	UNCHANGED	Click For Details
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	UNCHANGED	Click For Details
75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	UNCHANGED	Click For Details
75756	Angiography, internal mammary, radiological supervision and interpretation	UNCHANGED	Click For Details
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	UNCHANGED	Click For Details

Dr. Z's Illustration of the iliac vessels



ALTERNATIVES TO G2012

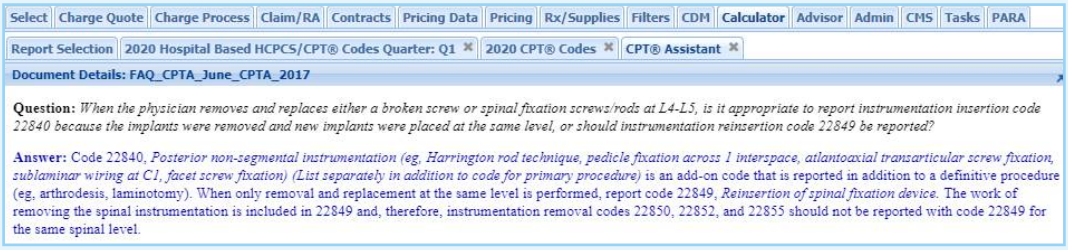
Q. Can **PARA** please review the documentation for appropriate coding and charging of the a L4-L5 anterior lateral interbody fusion with interbody spacer and instrumentation posteriorly with iliac crest aspiration for bone marrow concentration?

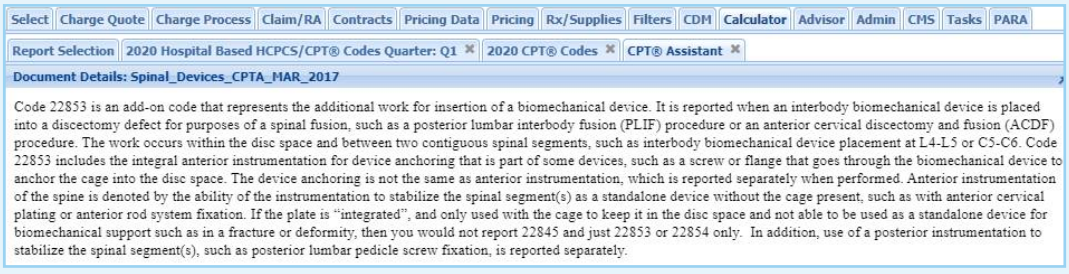
A. **Answer:** CPT® code 22558 is reported correctly for extreme lateral interbody fusion performed at L4-L5. Additional CPT® codes were not reported on the UB, however, supported by documentation.

Report CPT® code 22853 for placement of interbody spacer into the disc space. AMA CPT® Assistant, March 2017 explains that the interbody biomechanical device is placed into a discectomy defect for purposes of spinal fusion.

The work occurs within the disc space and may consist of a synthetic cage or mesh. Report CPT® code 22840 for the posterior instrumentation placed across one interspace. Placement of posterior instrumentation across one interspace is non-segmental per CPT® Assistant, June 2017 page: 10.

Report 20939 for bone marrow aspiration from the left iliac crest. The surgeon describes soaking the mesh spacer with BMA and bone graft. It is unclear what type of bone graft was used. Best practice is to clarify type of bone graft used (allograft vs. autograft) to ensure accurate code assignment. Please refer to the **PARA Data Editor** code descriptions and the AMA CPT® Assistant June 2017 and March 2017 which can be found in the **PARA Data Editor** calculator.





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HEALTHCARE
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COVID-19

april, twenty-twenty

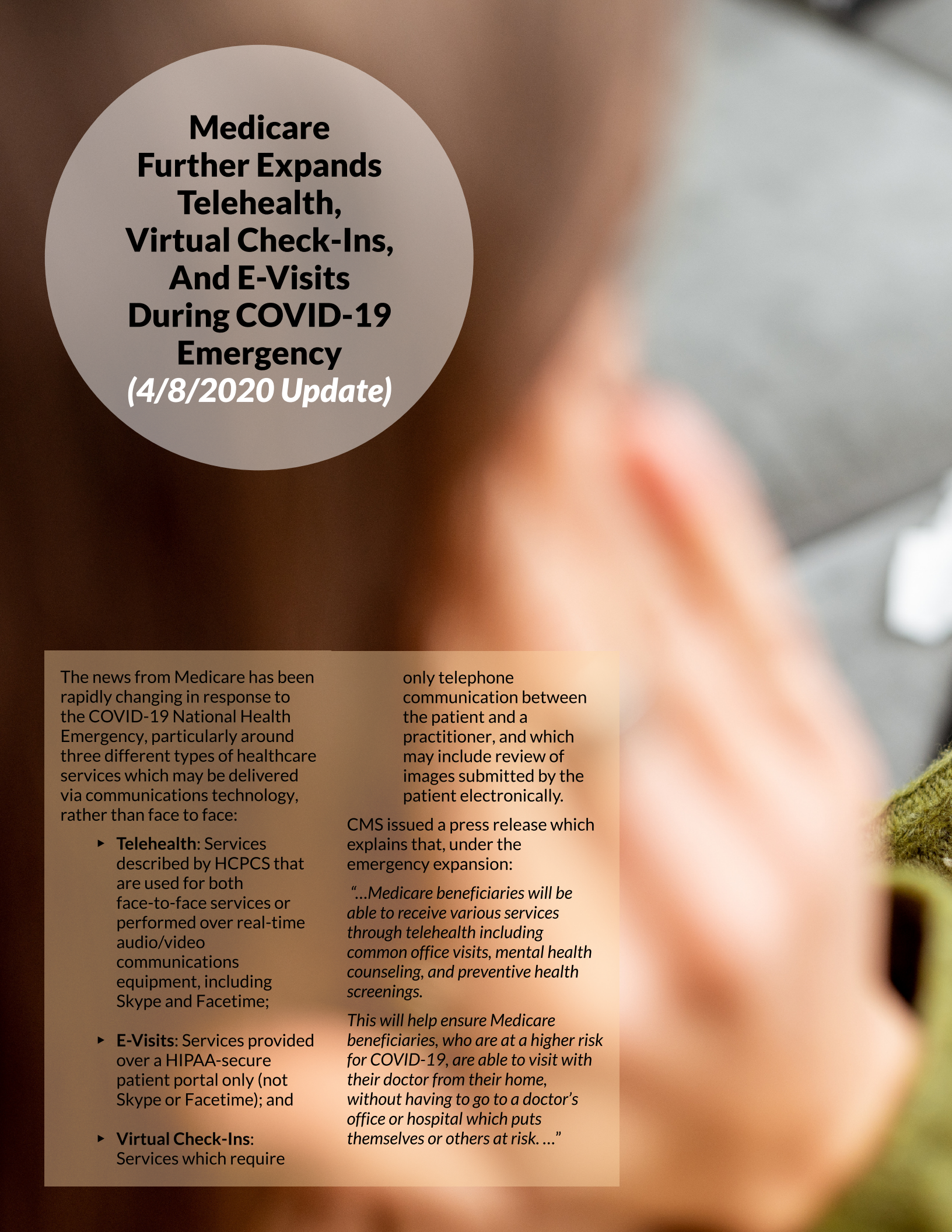
Special
publication

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 Further Expands Telehealth, Virtual Check-Ins, And E-Visits During COVID-19 Emergency *(4/8/2020 Update)*



The news from Medicare has been rapidly changing in response to the COVID-19 National Health Emergency, particularly around three different types of healthcare services which may be delivered via communications technology, rather than face to face:

- **Telehealth**: Services described by HCPCS that are used for both face-to-face services or performed over real-time audio/video communications equipment, including Skype and Facetime;
- **E-Visits**: Services provided over a HIPAA-secure patient portal only (not Skype or Facetime); and
- **Virtual Check-Ins**: Services which require only telephone communication between the patient and a practitioner, and which may include review of images submitted by the patient electronically.

CMS issued a 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. …"

A Medicare provider-specific fact sheet on new waivers and flexibilities is available at

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Among the provisions, great interest has been expressed regarding the following new flexibilities: 1) An expansion of Medicare **telehealth** services billed on professional fee claims allows more services to be rendered by more providers to both **new and established patients** under the "shelter at home" restrictions.Under the original telehealth program, Medicare had a limited list of services that were reimbursed in only rural locations at an approved "originating site" using a HIPAA-secure audio-visual system.

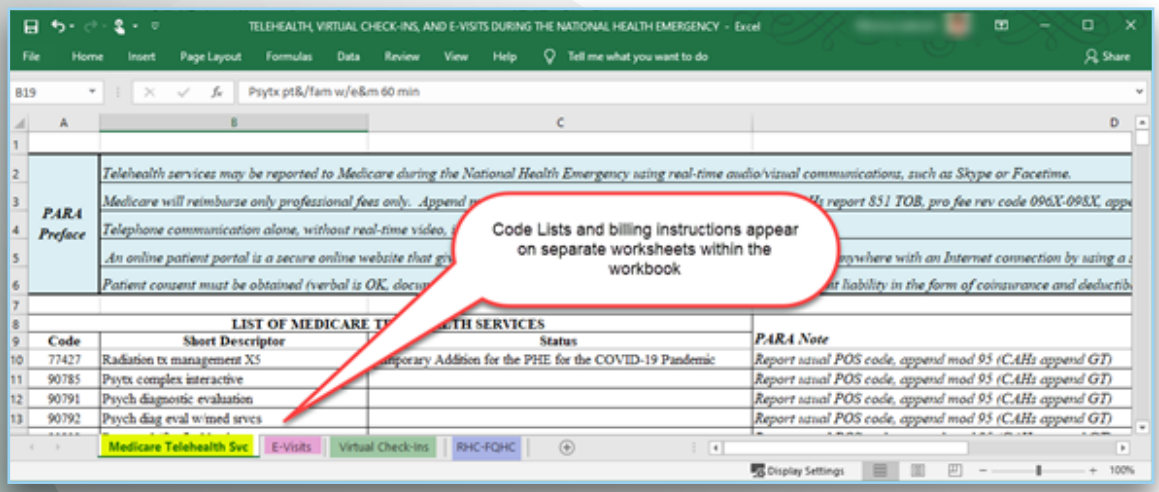
However, Medicare recently expanded the list of billable services, the acceptable technology, the types of professionals that may be reimbursed, and removed the rural geographic limitation.

Among the added services are:

- Emergency Department Visits, Levels 1-5 (CPT® codes 99281-99285); Critical Care Services (CPT® codes 99291-99292)

- Initial and Subsequent Observation and Observation Discharge Day Management (CPT® codes 99217- 99220; CPT® codes 99224- 99226; CPT® codes 99234- 99236)Home Visits, New and Established Patient, All levels (CPT® codes 99341- 99345; CPT® codes 99347- 99350)1)

Telehealth, continued



- Therapy Services, Physical and Occupational Therapy, by (CPT® codes 97161- 97168; CPT® codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)

- Psychological and Neuropsychological Testing (CPT® codes 96130- 96133; CPT® codes 96136- 96139)

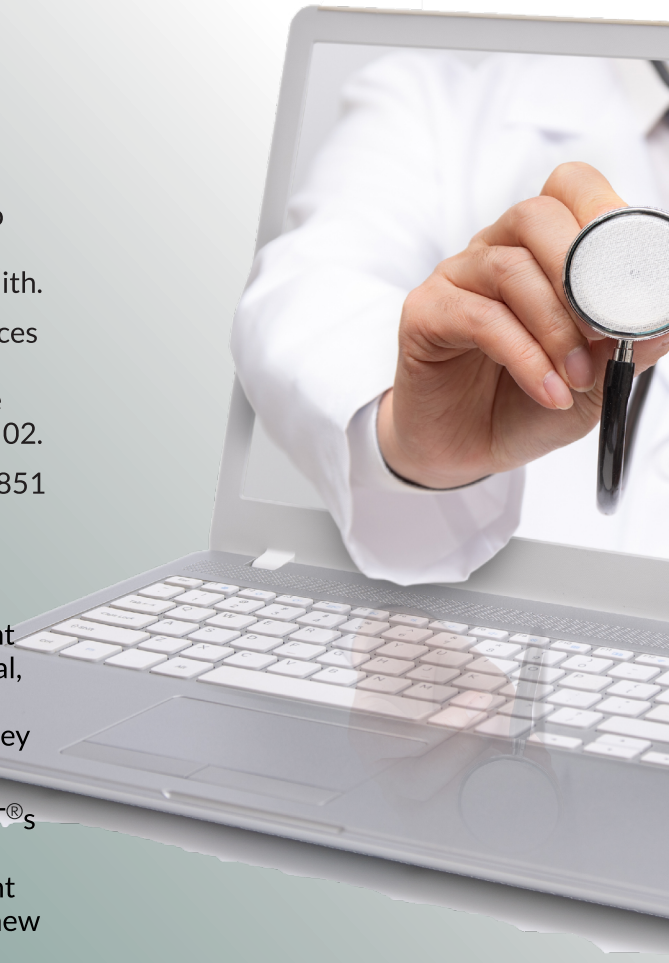
- Office visits: 99201-99215

The acceptable technology for telehealth services now includes real-time audio/visual communications, such as Facetime or Skype, so that the patient may remain at home (HIPAA regulations have been temporarily relaxed so long as providers are rendering care in good faith.

Modifier 95: During the National Health Emergency, telehealth services should be reported on professional fee claims (CMS1500/837p) **with modifier 95 appended** to the telehealth HCPCS. The Place of Service code should report the provider's typical place of service, rather than 02.

Method II Critical Access Hospitals report telehealth services on the 851 type of bill under professional fee revenue codes 096X-098X; CAHs must append modifier GT to indicate that the service was rendered remotely.

2)**Virtual Check-Ins and E-Visits**: CMS also expanded reimbursement to allow more provider types, including LCSWs, Psychologists, physical, occupational, and speech therapists in private practice, to report professional services that are **not** considered "telehealth", because they may rely on phone communication alone, without real-time video.



- **Virtual Check-Ins**: (G2010, G2012, and new coverage for CPT®s 98966-98968 and 99441-99443); which uses phone communication service alone, or with video and/or images sent to the provider by the patient; these codes are valid for both new or established patients during the emergency;

- **E-Visits**: (99421 – 99423 for physicians, and G2061-G2063 for mid-level practitioners) communications with patients conducted over a provider's online patient portal. (E-Visits must use a HIPAA-secure patient portal; providers who wish to deliver E/M

services over technology such as Facetime or Skype should use the telehealth visit codes, not the e-visit codes.)

Virtual check-ins and E-Visits may be reported on professional fee claim forms without a modifier, and under the provider's usual Place of Service code (i.e. 11 or 22). The HCPCS descriptions for these services are exclusive to remote services, and therefore do not require modifier 95. (Similarly, CAHs need not append modifier GT to the virtual check-in or E-visit codes.)

The telehealth/E-Visit/Virtual Check-In expansion is limited to professional fees reported on a CMS1500/837p claim form by an enrolled physician or non-physician practitioner.

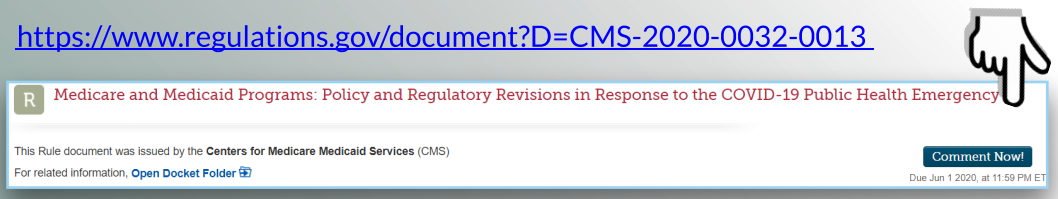
It does not extend to facility fee claims at this time.This has frustrated facility-based physical, occupational, and speech therapists because Medicare will permit telehealth service for independent PT/OT/ST practitioners, but there is currently no provision for reporting telehealth therapy on a facility fee claim. Hospital based therapists must enroll with Medicare as an individual billing practitioner, and bill using the professional fee claim form, in order to be reimbursed for therapy services delivered by telehealth.

CMS has offered expedited enrollment for billing professionals to help meet the needs of the COVID-19 emergency; a fact sheet on provider enrollment relief is available at:

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf.

CMS may make further changes in response to comments. The regulations which implement the expansion are found in the CMS "Interim Final Rule"; CMS will accept public comments until June 1, 2020.

https://www.regulations.gov/document?D=CMS-2020-0032-0013



CMS addresses HIPAA concerns within its "Telemedicine Provider Fact Sheet", which specifically mentions the use of telecommunications that will serve the patient in the home, such as FaceTime or Skype:

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

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

Telehealth, continued

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

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

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.

No modifier CR on telehealth claims: Some providers have inquired about modifiers that were historically required when responding to in regional disasters, such as Hurricane Katrina, which required modifier CR (Catastrophe Related) on professional fees.

CMS does not require modifier CR on telehealth claims during the COVID National Health Emergency, however, claims for other professional fees that are rendered under the "waiver" authority may require modifier CR.

Modifier CS may be appropriate for some visits: Professionals, outpatient facilities, and RHC/FQHC providers are instructed to append **modifier CS** to the line item(s) which were related to the physician's order to test for COVID-19.

If a claim was submitted before this announcement was known, the provider may submit a corrected claim with modifier CS. The official description of modifier CS is a holdover from a past disaster --"Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the gulf of Mexico, including but not limited to subsequent clean-up activities."

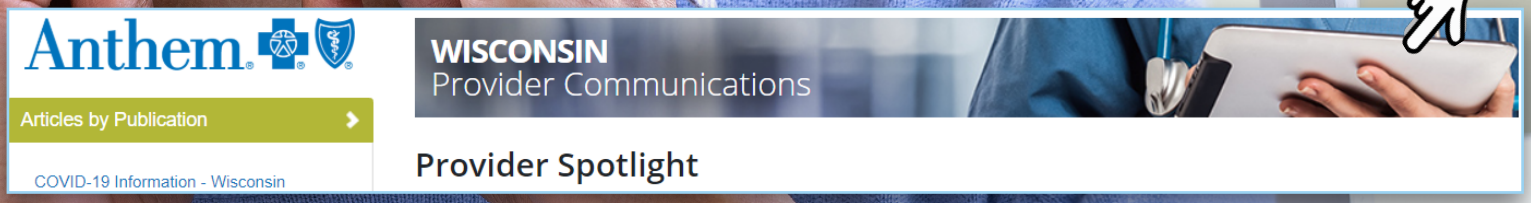
In late March, Medicare announced that professional fees for telemedicine may report the usual POS code used by the billing provider, as long as modifier 95 is appended to the HCPCS on the professional fee claim.

The POS 02 (telehealth) will still be honored, but will result in payment under the Medicare physician fee schedule at the lower "facility" rate. Practitioners who would normally report POS 11 (Office) on claims to Medicare will receive higher reimbursement if they continue to use that POS code and append modifier 95.

Method II Critical Access Hospitals must report modifier GT on telehealth professional fees submitted to Medicare on a UB04/837i outpatient claim.

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



Telehealth, continued

What codes would be appropriate to consider for a telehealth visit with a patient who wants to receive health guidance related to COVID-19?

Based on standard coding guidelines from the AMA and HCPCS, Anthem would recognize telehealth modifiers 95 or GT that are appended with office visit codes 99201-99215, for reimbursement as a telehealth service. Anthem also recognizes, but does not require Place of Service (POS) code "02" for reporting telehealth services.

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

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

1. **Q: How will recently enacted legislation allow CMS to utilize Medicare telehealth to address the declared Coronavirus (COVID-19) public health emergency?**

   A: The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home.

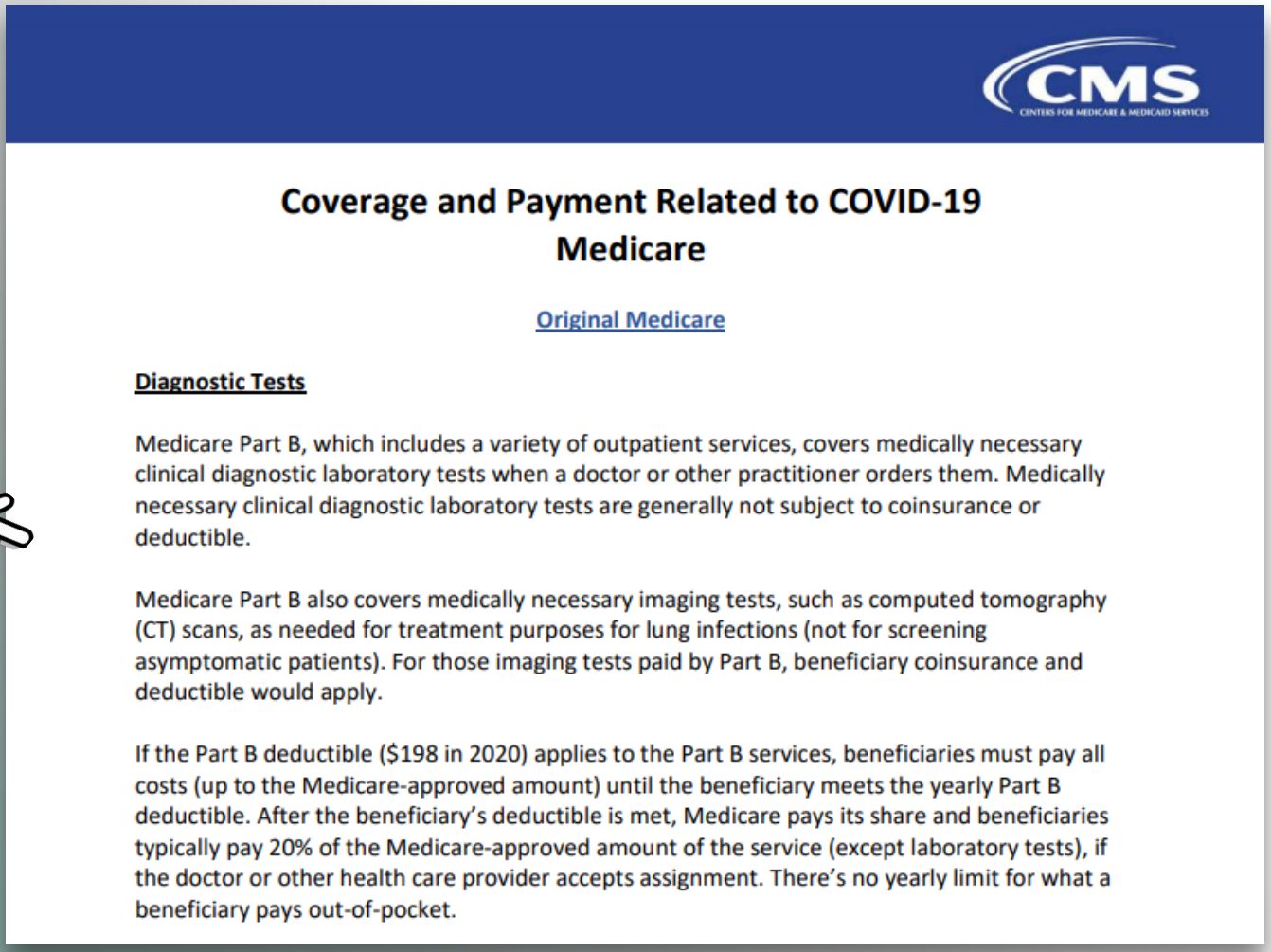
https://apps.para-hcfs.com/para/Documents/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COVID-19 Emergency Declaration
Health Care Providers Fact Sheet

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers combat and contain the spread of 2019 Novel Coronavirus Disease (COVID-19). In response to COVID-19, CMS is empowered to take proactive steps through 1135 waivers and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are available:

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



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Coverage and Payment Related to COVID-19 Medicare

Original Medicare

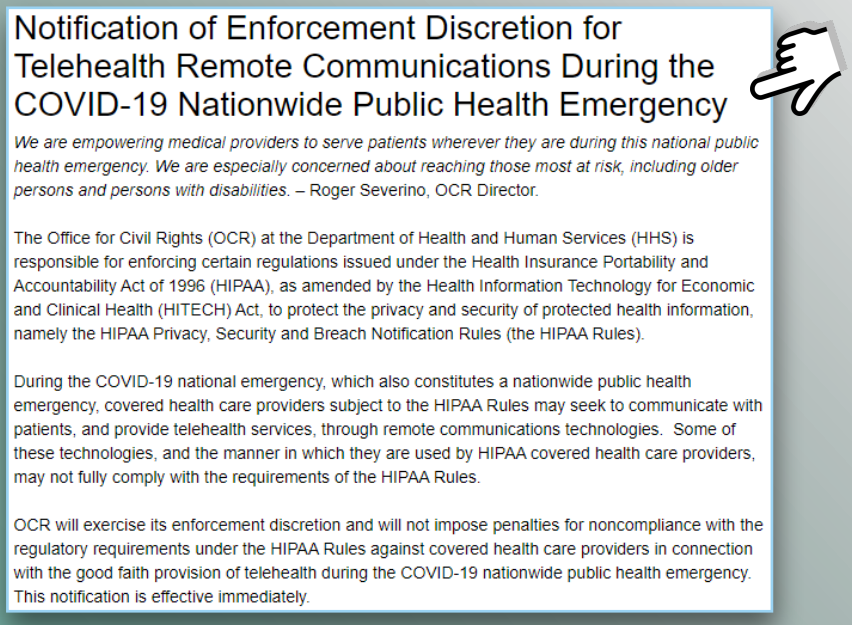
Diagnostic Tests

Medicare Part B, which includes a variety of outpatient services, covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. Medically necessary clinical diagnostic laboratory tests are generally not subject to coinsurance or deductible.

Medicare Part B also covers medically necessary imaging tests, such as computed tomography (CT) scans, as needed for treatment purposes for lung infections (not for screening asymptomatic patients). For those imaging tests paid by Part B, beneficiary coinsurance and deductible would apply.

If the Part B deductible ($198 in 2020) applies to the Part B services, beneficiaries must pay all costs (up to the Medicare-approved amount) until the beneficiary meets the yearly Part B deductible. After the beneficiary's deductible is met, Medicare pays its share and beneficiaries typically pay 20% of the Medicare-approved amount of the service (except laboratory tests), if the doctor or other health care provider accepts assignment. There's no yearly limit for what a beneficiary pays out-of-pocket.

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.

COVID-19 Lab Testing And Specimen Collection Update

Special Update

During the last week of March, 2020, CMS announced the creation of two new Level II HCPCS to reimburse the collection of specimens for COVID-19 testing.The CMS announcement indicates the new codes are reimbursed to only independent laboratories (which we interpret to include outpatient hospital labs) effective for services billed with a line item date of service on or after March 1, 2020.

G2023- Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source

G2024- Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

While a hospital laboratory is deemed to be an independent laboratory, the CMS "Interim Final Rule" specifies that G2023 and G2024 are limited to collection performed in the patient home, or for a non-hospital inpatient (such as a patient in a Skilled Nursing Facility.) Here's the section from the rule, page 94:

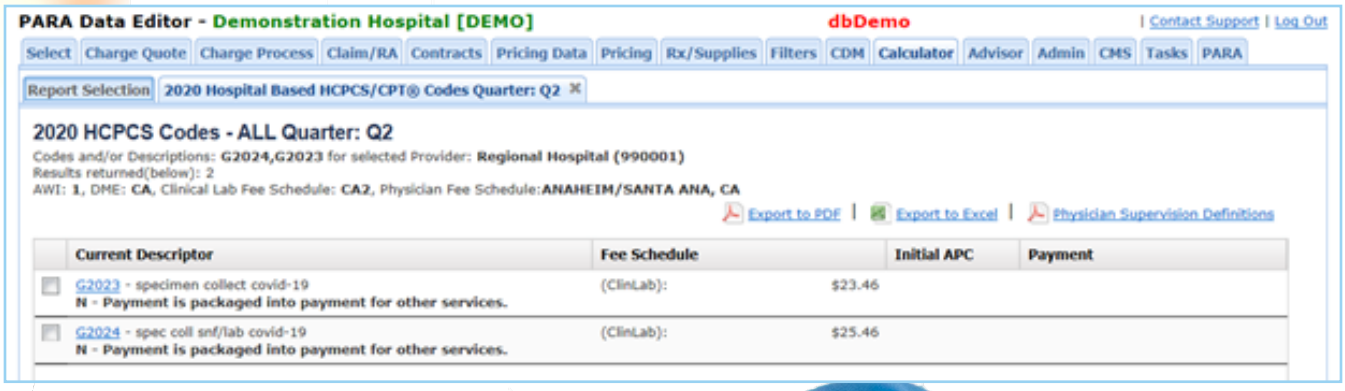
https://www.cms.gov/files/document/covid-final-ifc.pdf

"Under this policy, the nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally will be $23.46 and for individuals in a SNF or individuals whose samples will be collected by laboratory on behalf of an HHA will be $25.46.

Medicare-enrolled independent laboratories can bill Medicare for the specimen collection fee using one of two new HCPCS codes for specimen collection for COVID-19 testing and bill for the travel allowance with the current HCPCS codes set forth in section 60.2 of the Medicare Claims Processing Manual (P9603 and P9604). Our policy will also incorporate the clarification in the definition of homebound as discussed in section II.F. of this IFC, relating to the clarification of homebound status under the Medicare home health benefit."

Therefore, Medicare will **not** reimburse hospitals for swab collection performed for outpatients or inpatients which are not in a SNF or at home (homebound)--at least not at this time.

During the CMS "Office Hours" teleconference on 4/13/2020, Medicare representatives acknowledged that hospitals cannot report



G2023 for outpatients that are not homebound or in a SNF. They hinted that CMS will evaluate whether facilities should be reimbursed for G2023 (or another code) in the future. While appears to be under consideration but at this time, G2023 is not reimbursed for outpatient specimen collection that is not in a SNF or the patient's home.

If the laboratory sends a tech to collect a COVID-19 test specimen for an individual in a SNF or to a homebound patient on behalf of a Home Health Agency, Medicare will also reimburse mileage in keeping with the established HCPCS for that purpose, P9603 or P9604.

P9603- Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually traveled

P9604- Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge

(For further information on calculating and billing the travel allowance, see **PARA's** Q&A document at

https://apps.para-hcfs.com/para/Documents/Q&A%20-%20Lab%20Travel%20Allowance.pdf.

CMS has indicated that due to the COVID-19 emergency, the definition of "homebound" includes those patients for whom travel is "medically contra-indicated" as determined by a physician. The discussion of the definition of "homebound" is on page 100 of the Interim Final Rule at the link on the following page.

https://www.cms.gov/files/document/covid-final-ifc.pdf

"In defining an individual who is homebound for purposes of the specimen collection fee and the travel allowance under section 1833(h)(3) of the Act, the manual refers to Chapters 7 and 15 of Pub. 100-02, the Medicare Benefit Policy Manual.

The definition of "homebound" in Chapters 7 and 15 of Pub. 100-02 originate from the statutory definition of "confined to the home" (that is, "homebound") under sections 1814(a) and 1835(a) of the Act.

As discussed in section II.F. of this IFC, relating to the clarification of homebound status under the Medicare home health benefit patients are considered "confined to the home" (that is, "homebound") if it is medically contraindicated for the patient to leave the home.

When it is medically contraindicated

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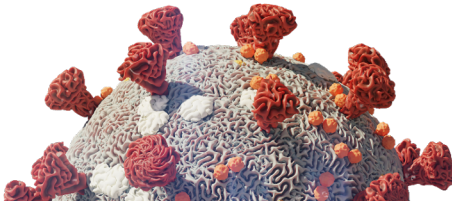


COVID-19 Lab Testing, con't.

for a patient to leave the home, there exists a normal inability for an individual to leave home and leaving home safely would require a considerable and taxing effort.

"As an example for the PHE for COVID-19 pandemic, this would apply for those patients:

(1) where a physician has determined that it is medically contraindicated for a beneficiary toleave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or

(2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

A patient who is exercising "self-quarantine" for his or her own safety, would not be considered "homebound" unless it is also medically contraindicated for the patient to leave the home. Determinations of whether the patient is homebound must be based on an assessment of each beneficiary's individual condition.For the PHE for the COVID-19 pandemic, the CDC is currently advising that older adults and individuals with serious underlying health conditions stay home (CDC's guidance is interim and is expected to continue to be updated as warranted).

As such, during the PHE for the COVID-19 pandemic, we expect that many Medicare beneficiaries could be considered "homebound". In light of this clarification regarding the definition of homebound, we are noting this clarification pertains to the specimen collection fee and travel allowance in the PHE for COVID-19 pandemic testing for homebound patients; that is, a patient is considered homebound for purposes of the fees under sections1833(h)(3) and 1834A(b)(5) of the Act if it is medically contraindicated for the patient to leave home."

As previously reported by **PARA**, the COVID-19 tests are reported by laboratories with the following codes:

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
U0001	CDC 2019 Novel Coronavirus (2019-NCOV) real-time RT-PCR diagnostic panel
U0002	U0002 - 2019-NCOV Coronavirus, SARS-COV-2/2019-NCOV (COVID-19), any technique, multiple types or subtypes (includes all targets), Non-CDC

Payment rates are approximately $36 for U0001, and $51 for U0002, until Medicare establishes national payment rates using its annual process later this year.

As of this update, the payment rates for 87635 has not been announced.

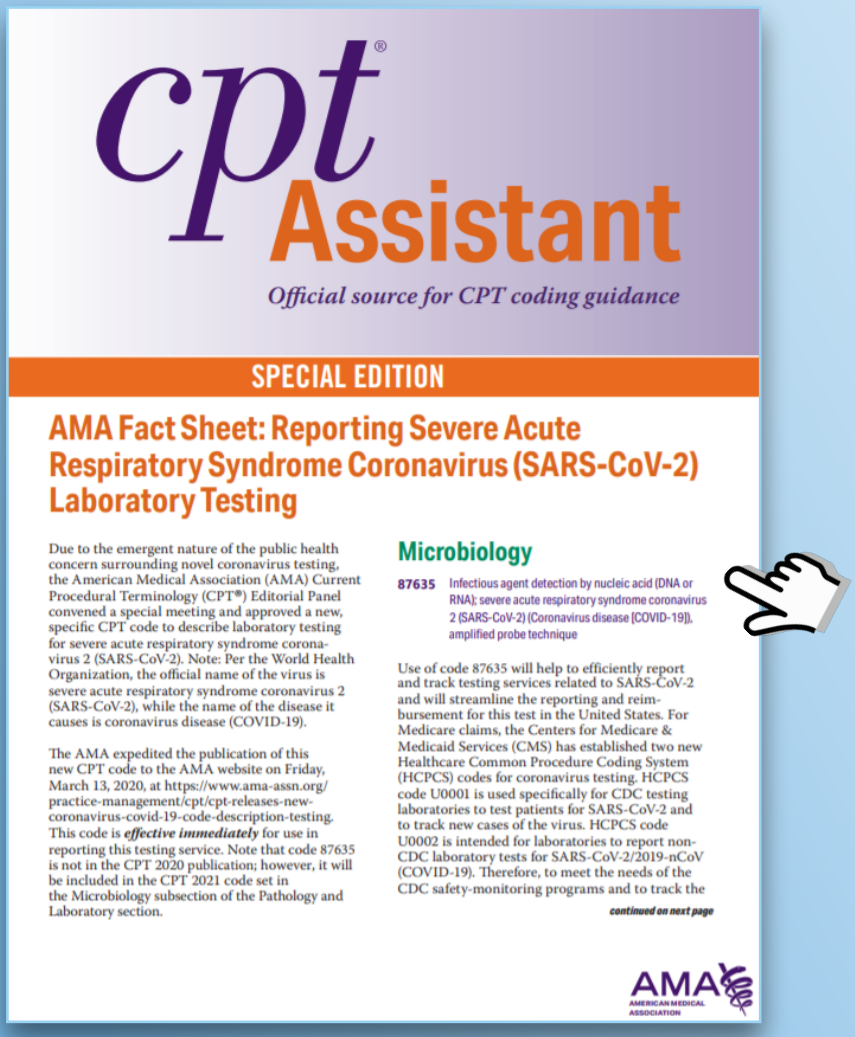
The rates for U0001 and U0002 were published at the following link:

MAC Jurisdiction (J)	MAC States/Territories	U0001 Test Price	U0002 Test Price
J6 – National Government Services (NGS)	Illinois, Minnesota, Wisconsin	$35.91	$51.31
JK – National Government Services (NGS)	Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	$35.91	$51.31
JH – Novitas Solutions	Arkansas, Colorado, New Mexico, Oklahoma, Texas Louisiana, Mississippi	$35.92	$51.33

https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf

The American Medical Association has published a special edition of CPT® Assistant regarding new CPT® 87635 at the following link:

https://www.ama-assn.org/system/files/2020-03/cpt-assistant-guide-coronavirus.pdf



cpt® Assistant

Official source for CPT coding guidance

SPECIAL EDITION

AMA Fact Sheet: Reporting Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2) Laboratory Testing

Due to the emergent nature of the public health concern surrounding novel coronavirus testing, the American Medical Association (AMA) Current Procedural Terminology (CPT®) Editorial Panel convened a special meeting and approved a new, specific CPT code to describe laboratory testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Note: Per the World Health Organization, the official name of the virus is severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), while the name of the disease it causes is coronavirus disease (COVID-19).

The AMA expedited the publication of this new CPT code to the AMA website on Friday, March 13, 2020, at https://www.ama-assn.org/practice-management/cpt/cpt-releases-new-coronavirus-covid-19-code-description-testing. This code is ***effective immediately*** for use in reporting this testing service. Note that code 87635 is not in the CPT 2020 publication; however, it will be included in the CPT 2021 code set in the Microbiology subsection of the Pathology and Laboratory section.

Microbiology

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

Use of code 87635 will help to efficiently report and track testing services related to SARS-CoV-2 and will streamline the reporting and reimbursement for this test in the United States. For Medicare claims, the Centers for Medicare & Medicaid Services (CMS) has established two new Healthcare Common Procedure Coding System (HCPCS) codes for coronavirus testing. HCPCS code U0001 is used specifically for CDC testing laboratories to test patients for SARS-CoV-2 and to track new cases of the virus. HCPCS code U0002 is intended for laboratories to report non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). Therefore, to meet the needs of the CDC safety-monitoring programs and to track the

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AMA AMERICAN MEDICAL ASSOCIATION

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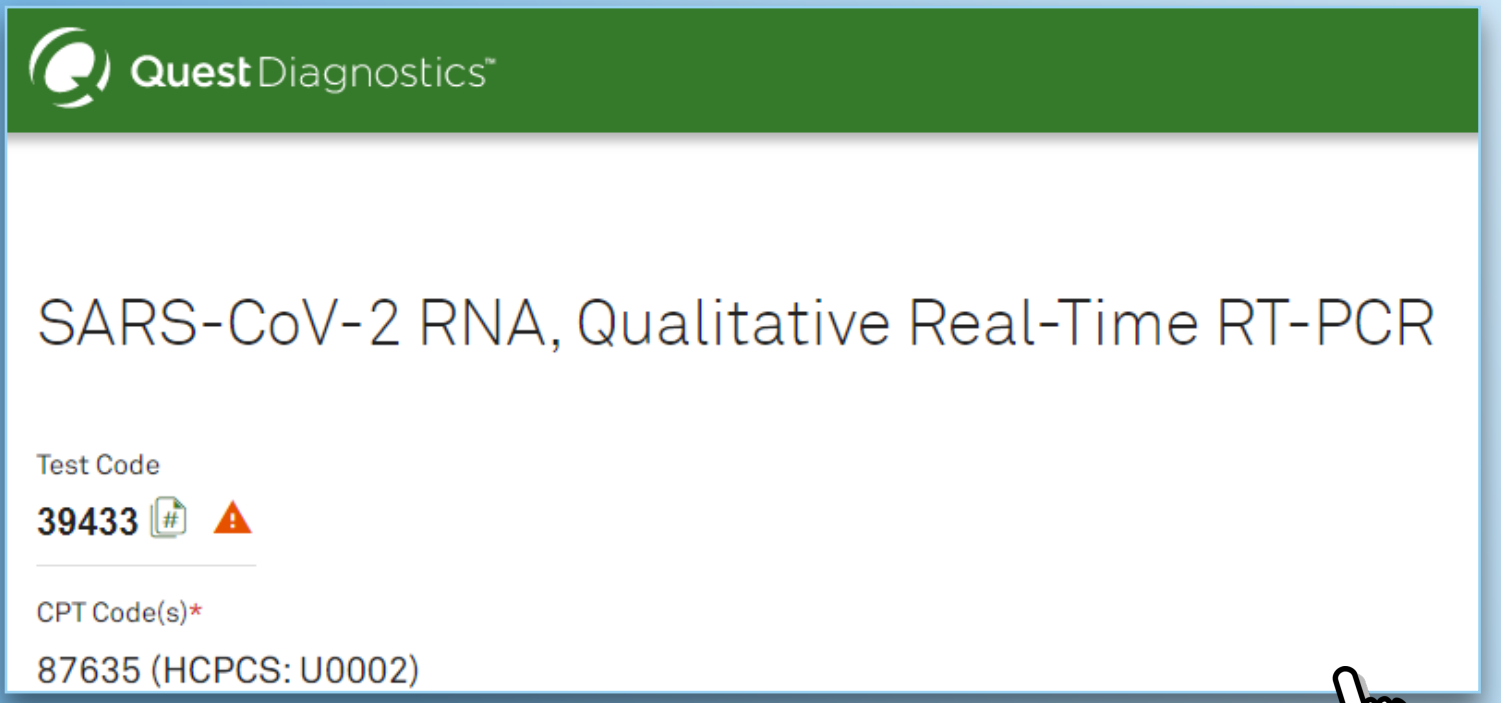
COVID-19 Lab Testing, con't.

Some large commercial laboratories appear to be opting for 87635, including LabCorp and Quest:

https://www.labcorp.com/coronavirus-disease-covid-19/health-plan-information#main

https://testdirectory.questdiagnostics.com/test/test-detail/39433/sars-cov-2-rna-qualitative-real-time-rt-pcr?q=39433&cc=MASTER



COVID-19 Resource Guide

Coronavirus

When President Trump declared a national emergency on March 13, 2020,CMS took action nationwide to aggressively respond to Cororavirus.

·You can read the blanket waivers for COVID-19 in the List of Blanket Waivers (PDF)UPDATED (4/9/20).

Secretary Azar used his authority in the Public Health Service Act to declare a public health emergency (PHE) in the entire United States on January 31, 2020 giving us the flexibility to support our beneficiaries, effective January 27, 2020

Get waiver & flexibility information

General information & updates:

- Coronavirus.gov is the source for the latest information about COVID-19 prevention, symptoms, and answers to common questions.
- USA.gov has the latest information about what the U.S. Government is doing in response to COVID-19.
- ·CDC.gov/coronavirushas the latest public health and safety information from CDC and for the overarching medical and health provider community on COVID-19.

Clinical & technical guidance:

For all clinicians

- CMS Dear Clinician Letter (PDF) (4/6/20)

For all health care providers

- CMS Non-Emergent, Elective Medical Services, and Treatment Recommendations (PDF)(4/6/20)
- CMS Adult Elective Surgery and Procedures Recommendations (PDF)(3/19/20)
- Fact sheet:Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge(3/30/20)
- Guidance memo - Exceptions and Extensions for Quality Reporting and Value-based Purchasing Programs (PDF)(3/27/20)

For health care facilities

- 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios (PDF)(4/13/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers(4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Outpatient Settings: FAQs and Considerations(4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs)(4/8/20)
- Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19)UPDATED (4/8/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Dialysis FacilitiesUPDATED (4/8/20)
- COVID-19 Long-Term Care Facility Guidance (PDF)(4/3/20)
- Accelerated and Advanced Payments Fact Sheet (PDF)(3/28/2020)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes-REVISED (PDF)(3/13/20)
- Guidance for Use of Certain Industrial Respirators by Health Care Personnel(3/10/20)

COVID-19 Resource Guide

- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) by Hospice Agencies(3/9/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge(3/4/20)
- Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)(2/6/20)

For Labs

- Frequently Asked Questions (FAQs), CLIA Guidance During the COVID-19 Emergency (PDF)(3/27/20)
- Notification to Surveyors of the Authorization for Emergency Use of the CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel Assay and Guidance for Authorized Laboratories(2/6/20)

For Programs of All-Inclusive Care for the Elderly (PACE) Organizations

- Frequently Asked Questions from the PACE Community (PDF)(4/14/20)
- Guidance for PACE Organizations Regarding Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) (PDF)(3/17/20)

Billing And Coding Guidance:

- Frequently Asked Questions to Assist Medicare Providers (PDF)UPDATED (4/11/20)
- CMS Dear Clinician Letter (PDF)(4/6/20)
- Fact sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers During COVID-19 Emergency (PDF)(3/30/20)
- Fact sheet:Medicare Coverage and Payment Related to COVID-19 (PDF)UPDATED (3/23/20)
- Fact sheet:Medicare Telemedicine Healthcare Provider Fact Sheet(3/17/20)
- Medicare Telehealth Frequently Asked Questions(3/17/20)
- MLN Matters article:Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (PDF)(3/17/20)
- Frequently Asked Questions about Medicare Fee-for-Service Emergency-Related Policies and Procedures**Without**an 1135 Waiver (PDF)(3/16/20)
- Frequently Asked Questions about Medicare Fee-for-Service Emergency-Related Policies and Procedures**With**an 1135 Waiver (PDF)(3/16/20)
- Fact sheet:Medicare Administrative Contractor (MAC) COVID-19 Test Pricing (PDF)(3/13/20)
- Fact sheet:Medicaid and CHIP Coverage and Payment Related to COVID-19 (PDF)(3/5/20)COVID-19: New ICD-10-CM Code and Interim Coding Guidance(2/20/20)

For Health Care Facilities

- 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios (PDF)(4/13/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers(4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Outpatient Settings: FAQs and Considerations(4/8/20)

COVID-19 Resource Guide

Survey And Certification Guidance:

- Clinical Laboratory Improvement Amendments (CLIA) Laboratory Guidance During COVID-19 Public Health Emergency(3/27/20)
- Prioritization of Survey Activities(3/23/20)
- Frequently Asked Questions for State Survey Agency and Accrediting Organization Coronavirus Disease 2019 (COVID-19) (PDF)(3/10/20)
- Frequently Asked Questions and Answers on EMTALA (PDF)(3/9/20)
- Suspension of Survey Activities(3/4/20)

Coverage Guidance:

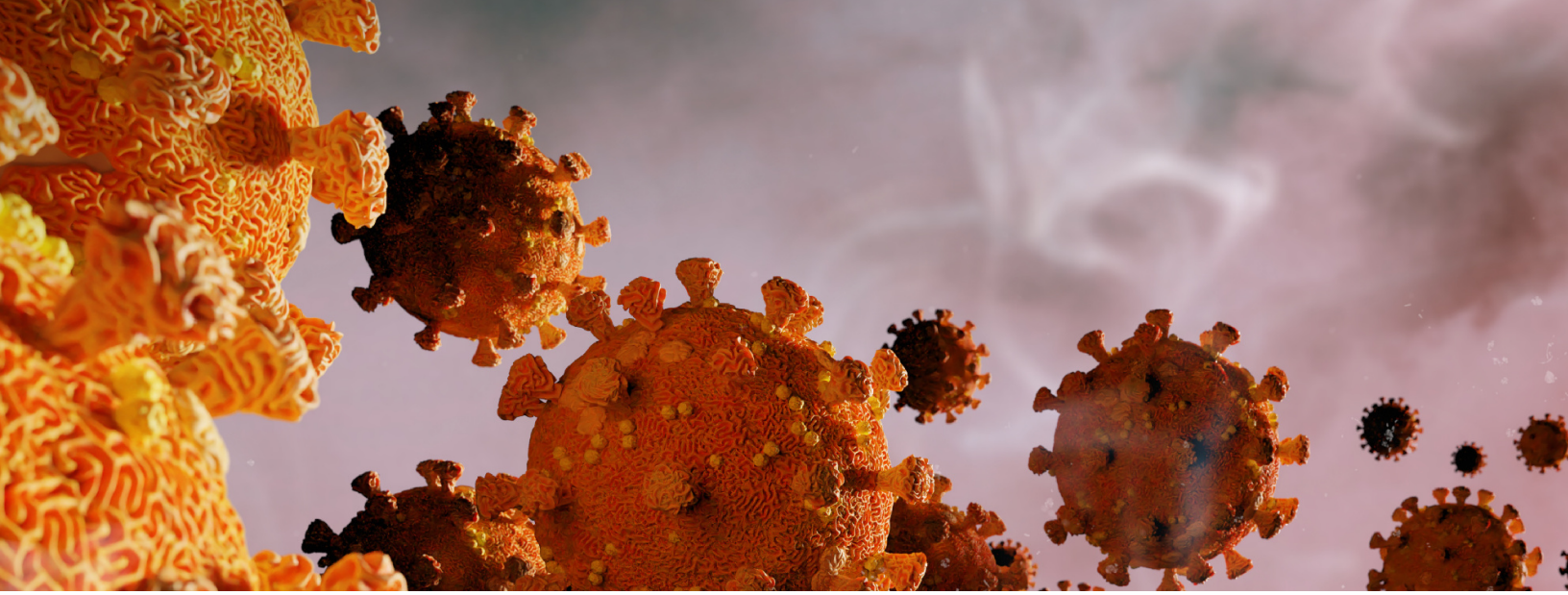
- Frequently Asked Questions to Assist Medicare Providers (PDF)UPDATED (4/11/20)
- VIDEO-MLN Medicare Coverage and Payment of Virtual Services(4/10/20)
- CMS Dear Clinician Letter (PDF)(4/6/20)
- Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkit (PDF)(3/27/20)
- Fact sheet:Medicare Coverage and Payment Related to COVID-19 (PDF)UPDATED (3/23/20)
- General Telemedicine Toolkit (PDF)(3/20/20)
- End-Stage Renal Disease (ESRD) Provider Telehealth and Telemedicine Toolkit (PDF)(3/20/20)
- FAQs on Catastrophic Plan Coverage and the Coronavirus Disease 2019 (COVID-19) (PDF)(3/19/20)
- Fact sheet:Medicare Telemedicine Healthcare Provider Fact Sheet(3/17/20)
- Medicare Telehealth Frequently Asked Questions(3/17/20)
- FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19) (PDF)(3/13/20)
- Guidance to help Medicare Advantage and Part D Plans Respond to COVID-19 (PDF)(3/10/20)
- Fact sheet:Medicaid and CHIP Coverage and Payment Related to COVID-19 (PDF)(3/5/20)
- Fact sheet:Individual and Small Group Market Insurance Coverage (PDF)(3/5/20)

Provider Enrollment Guidance:

- Guidance for Processing Attestations from Ambulatory Surgery Centers (ASCs) Temporarily Enrolling as Hospitals During the COVID-19 Public Health Emergency(4/3/20)
- Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)-UPDATED (3/30/20) (PDF)

Medicaid & CHIP Guidance:

- Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs)(4/15/20)
- Federal Medical Percentage Map (FMAP)&Families First Coronavirus Response Act – Increased FMAP FAQs3/27/20
- State Medicaid Director Letter (SMDL) #20-002 with New Section 1115 Demonstration Opportunity to Aid States With Addressing the Public Health Emergency(3/22/20)
- Section 1135 Waiver Checklist(3/22/20)
- Section 1915 Waiver, Appendix K Template(3/22/20)
- State Plan Flexibilities(3/22/20)



On April 7, 2020 CMS announced on that retroactive to March 18, 2020, Medicare will waive the Medicare cost-sharing liability for medical services (e.g. office visits, emergency department visits).

This can lead to a provider's decision to order a COVID-19 lab test (U0001, U0002, or 87635.)

This means that Medicare beneficiaries will not be liable for coinsurance or deductible for those services that led to the decision to test, and Medicare will pay the full allowable amount.

Additionally, the CARES Act temporarily suspended the 2% sequestration discount from May 1, 2020 through December 31, 2020.

Professionals, outpatient facilities, and RHC/FQHC providers are instructed to append **modifier CS** to the line item(s) representing services that led to the physician's order to test for COVID-19.

If a claim was submitted before this announcement was known, the provider may submit a corrected claim with modifier CS – thereby relieving the patient of the coinsurance and deductible (and increasing the direct payment to the billing provider.)

The official description of modifier CS is a holdover from a past disaster – "Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the gulf of Mexico, including but not limited to subsequent clean-up activities."

A link and an excerpt from the CMS announcement appear in this article.

Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services.

These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE):

That result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test, and, are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services

Report Modifier CS For Certain COVID-19 Services

New Billing And Coding Guidance

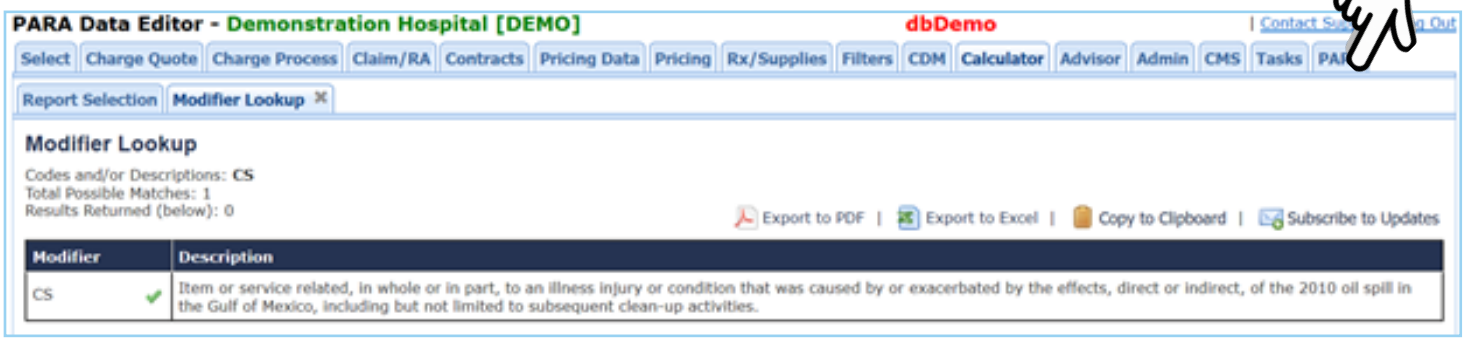
- Online digital evaluation and management services
- Cost-sharing does not apply to the above medical visit services for which payment is made to:
- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

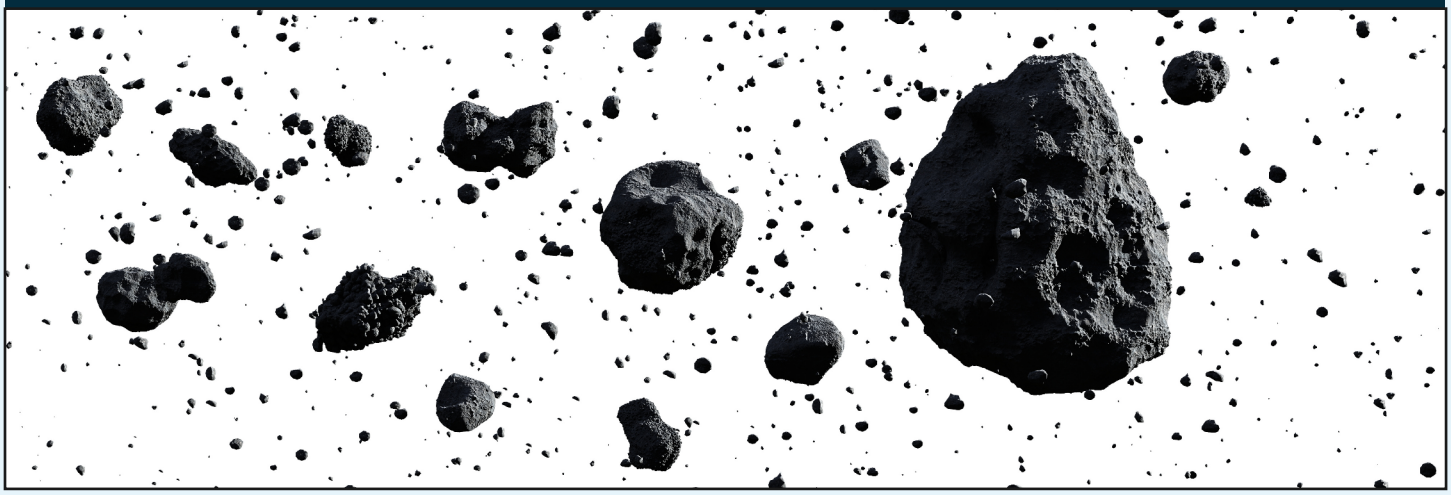
For professional claims, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment.

For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the CS modifier must resubmit applicable claims submitted on or after 3/18/2020, with the CS modifier to visit lines to get 100% payment.

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913



COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE



CMS guidance on the use of condition code DR (Disaster Related) on facility fee claims, and modifier CR (Catastrophe Related) on either facility fee claims or professional fee claims, has evolved over the course of the first weeks of the National Health Emergency. In the early days of the emergency, CMS indicated that neither CR nor DR were required.

However, since that time, CMS has instructed providers to report these codes when care is provided under one of the Section 1135 waivers to address the National Health Emergency.Waivers include, for example:

- Suspension of enforcement of EMTALA requirements (permitting patients seeking emergency department care to be screened at an off-site location)
- Provider Licensing and Enrollment (permitting cross-state practice and expedited enrollment)
- Suspension of Enforcement Activities related to HIPAA (for FaceTime, Skype, etc. in good faith to serve patient needs during the National Health Emergency.)
- Telehealth (expanded to non-rural areas, as well as an expanded list of service codes)
- The timeliness of physician signature requirements on orders

In an FAQ document posted on April 17, 2020, CMS provided the following guidance:

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

General Billing Requirements

1. Question: Regarding the use of the condition code "DR" and modifier "CR", should these codes be used for all billing situations relating to COVID-19 waivers?

Answer: Yes. Use of the "DR" condition code and "CR" modifier are mandatory for institutional and non-institutional providers in billing situations related to COVID-19 for any Updated: 4/17/2020 pg. 36 claim for which Medicare payment is conditioned on the presence of a "formal waiver" (as defined in the CMS Internet Only Manual, Publication 100-04, Chapter 38, § 10).

The DR condition code is used by institutional providers only, at the claim level, when all of the services/items billed on the claim are related to a COVID-19 waiver. The CR modifier is used by both institutional and non-institutional providers to identify Part B line item services/items that are related to a COVID-19 waiver.

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

The FAQs in this document supplement the following previously released FAQs: 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf, and Without 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf).

We note that in many instances, the general statements of the FAQs referenced above have been superseded by COVID-19-specific legislation, emergency rules, and waivers granted under section 1135 of the Act specifically to address the COVID-19 public health emergency (PHE). The policies set out in this FAQ are effective for the duration of the PHE unless superseded by future legislation.

A few answers in this document explain provisions from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 (March 27, 2020). CMS is thoroughly assessing this new legislation and new and revised FAQs will be released as implementation plans are announced.

The interim final rule with comment period (IFC), CMS-1744-IFC, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, is available at the following link: https://www.cms.gov/files/document/covid-final-ifc.pdf

COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

From this published FAQ, **PARA** offers the following interpretation:

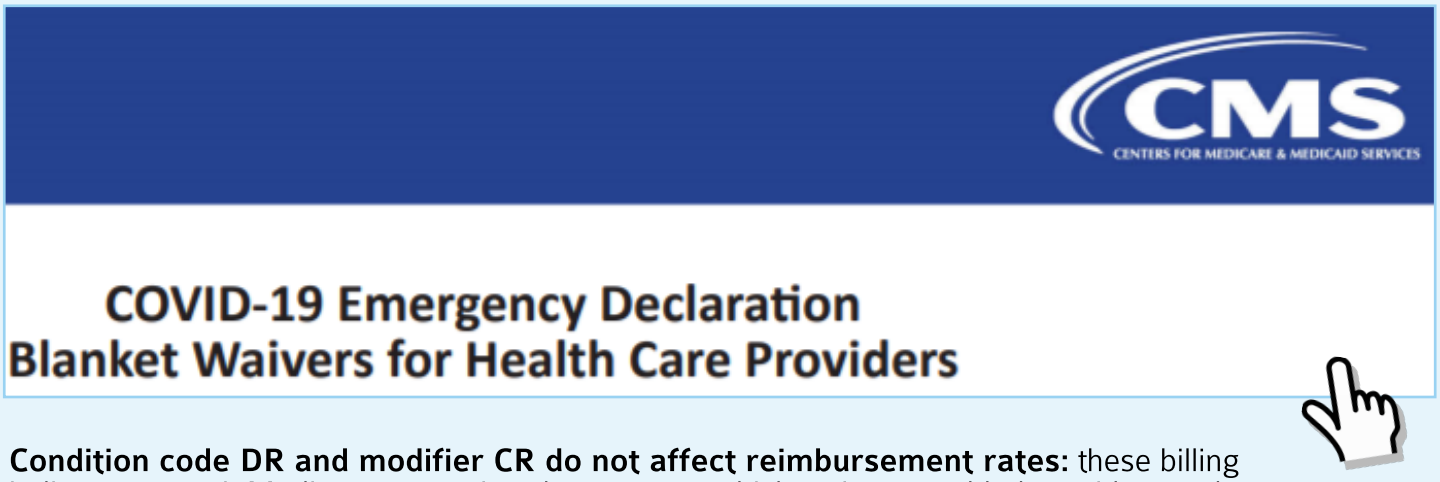
- **For facility fee claims, both inpatient and outpatient:** report condition code DR if all the services on the claim were rendered under a COVID-19 waiver; for example, if care is provided at an unusual location (e.g. a hotel used as a temporary hospital during the COVID-19 emergency)

- **For facility fee outpatient claims:** if some, but not all, services reported on a claim were rendered under a COVID-19 waiver, report modifier CR on the line items that were rendered subject to the waiver.For example, if an emergency department visit/assessment was performed in a temporary parking lot tent used for triage, report modifier CR on the code that represents that service. However, any services performed using the hospital's usual facilities do not require the CR modifier, such as imaging and lab tests that are performed within the hospital itself

- **Professional fees:** for services rendered in temporary locations, such as an extension of the emergency department in a parking lot tent or at a temporary hospital location such as a gymnasium, should report the appropriate CPT®/HCPCS with modifier CR

Additional information about the various waivers is available at the following link:

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf



Condition code DR and modifier CR do not affect reimbursement rates: these billing indicators permit Medicare to monitor the extent to which waivers enabled providers and practitioners to respond to the COVID-19 emergency.

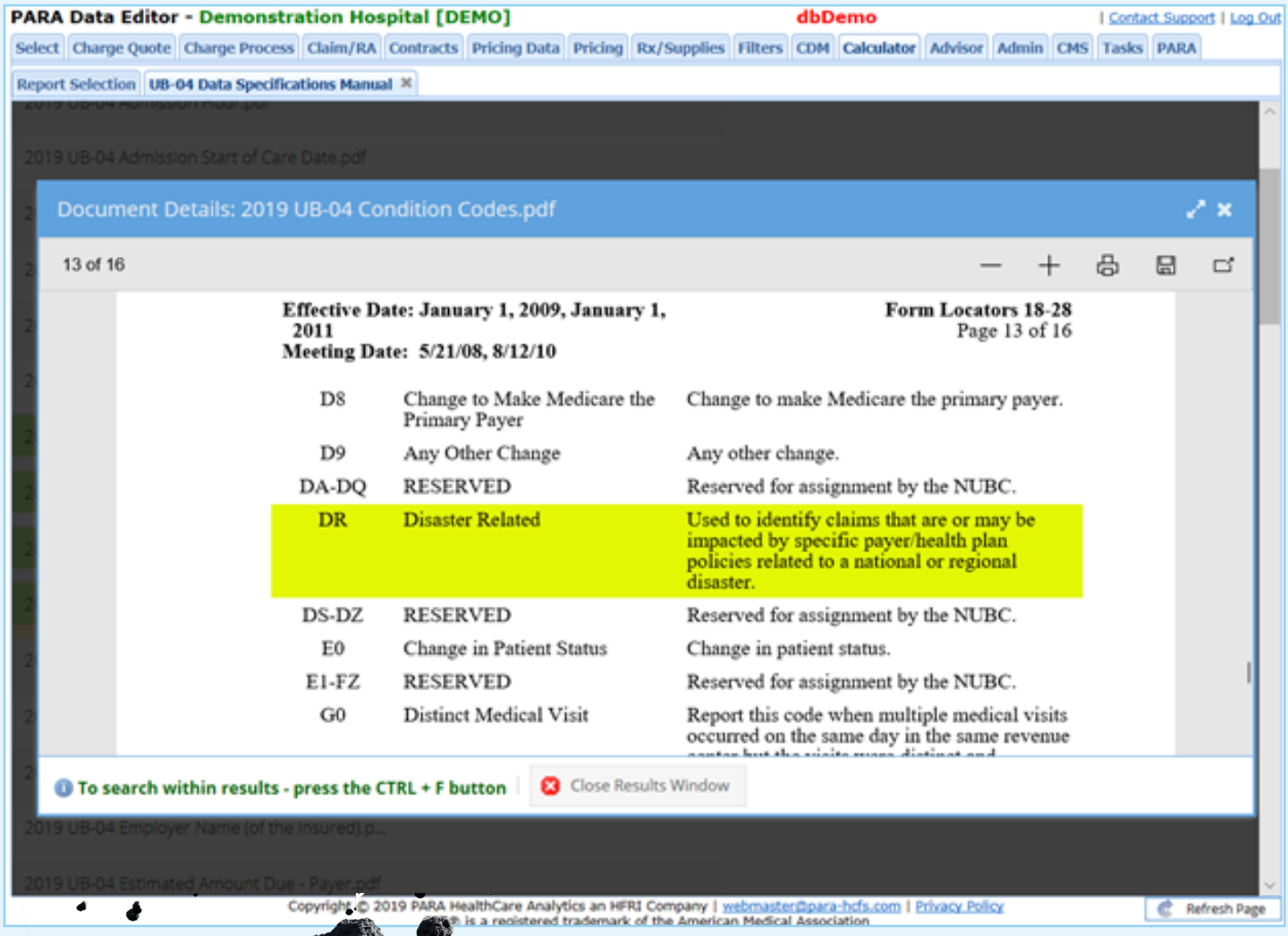
The requirement to report the DR condition code or CR modifier depends on whether the conditions of service were only permissable due to a waiver: If, for example, an acute-care facility admitted and cared for a COVID-19 patient at its usual location, with its established medical providers, from the time of admission to discharge, no condition code DR is necessary, because the care did not require a special exception from the ordinary rules governing the delivery of care.

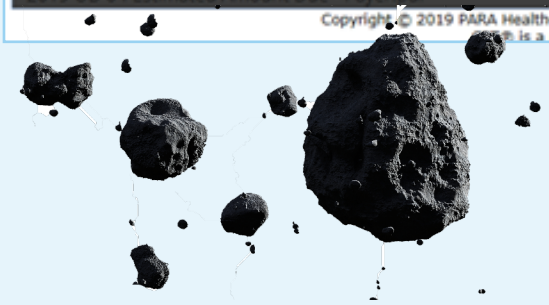
If, on the other hand, inpatient care is rendered via telehealth at an urban hospital (attending physician does not have a face-to-face encounter), the facility fee claim should report condition code DR, and the professional fee claim for the inpatient services via telehealth should report modifier CR (in addition to modifier 95 to indicate telehealth services.)

CMS announced that it will pay an increase of 20% more in DRG reimbursement for IPPS hospitals rendering COVID-19 inpatient care. That increased reimbursement is not dependent on condition code DR; claims which are eligible for increased reimbursement based on the ICD-10 codes alone.

COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

The definition of modifiers and condition codes are available on the **PARA Data Editor Calculator** tab:

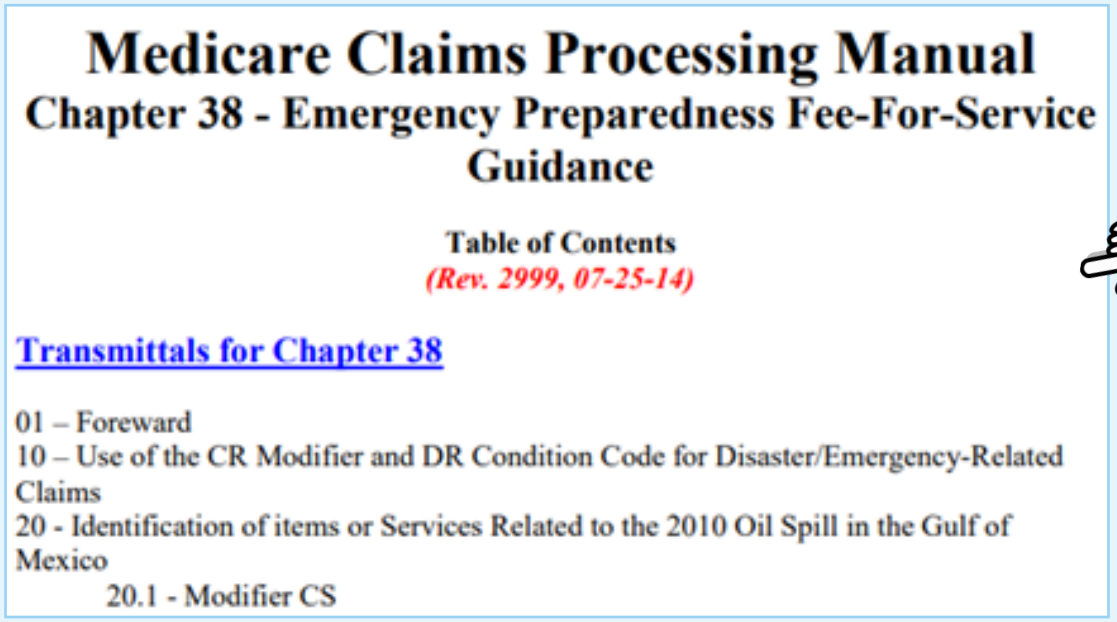




COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

Medicare Claims Processing Manual, Chapter 38 – Emergency Preparedness For-Fee-Service Guidance provides additional information on the use of Modifier CR and Condition Code DR.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf



Medicare Claims Processing Manual

Chapter 38 - Emergency Preparedness Fee-For-Service Guidance

Table of Contents

(Rev. 2999, 07-25-14)

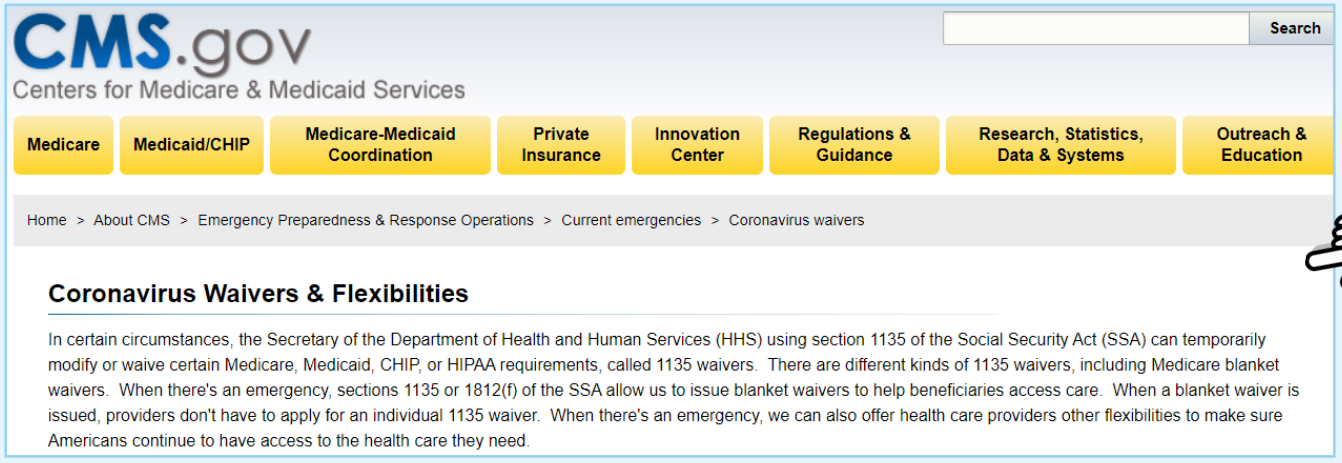
Transmittals for Chapter 38

01 – Foreward
10 – Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims
20 - Identification of items or Services Related to the 2010 Oil Spill in the Gulf of Mexico
20.1 - Modifier CS

While some commercial payors may instruct providers to bill according to CMS instructions, others may have unique billing guidelines; providers should consult the payor website or representative for billing guidance.

Each state may have additional waiver provisions as well.CMS Coronavirus Waivers & Flexibilities website provides a link for each applicable state:

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers



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Home > About CMS > Emergency Preparedness & Response Operations > Current emergencies > Coronavirus waivers

Coronavirus Waivers & Flexibilities

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements, called 1135 waivers. There are different kinds of 1135 waivers, including Medicare blanket waivers. When there's an emergency, sections 1135 or 1812(f) of the SSA allow us to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver. When there's an emergency, we can also offer health care providers other flexibilities to make sure Americans continue to have access to the health care they need.

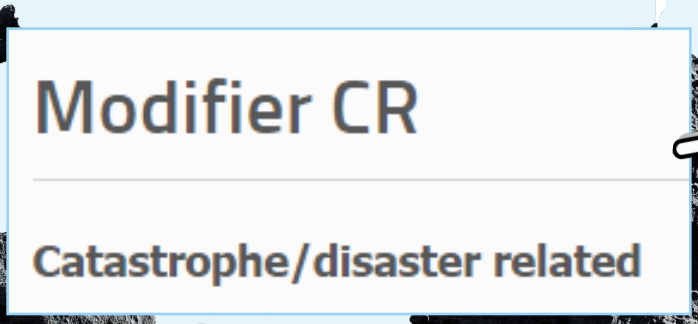
Additional Emergency/ Disaster Instructions may be provided by the Medicare Administrative Contractors (MACS) through their websites.

COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

WPS –Modifier CR Fact Sheet:

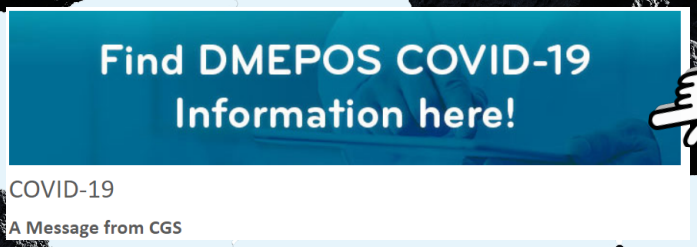
https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/modifier-cr/!ut/p/z0/fY2xDoIwFEV_BOfG5lVMCCsaDTEOjYOBLqYppTyFFtqifr7o5GAcz8299wCDEpjmd1Tco9G8m7li8eWYZXG2TGh-iApK02J3Xm2TfJ2clrAH9r8wP0S22BOK2MB9S1A3Bko1YS0d4bomVjozWSEdlL2psUFpibDvHV7HkaXAhNFePj2Uj8EFH9A-kFp16NqOejOgIGLOpA2p6Dj2LqS_BCH9Fgw3ViUuXbwA3O-mwg!!/

Noridian –Modifier CR: https://med.noridianmedicare.com/web/jddme/topics/modifiers/cr



CGS –Covid-19 (includes tips and tricks for CR/DR):

https://www.cgsmedicare.com/jb/covid-19.html



For more information about waivers, CMS has prepared a helpful slide presentation at:
https://www.cms.gov/files/document/cms-waivers-and-covid-19-response.pdf

PT/OT/SLP THERAPIST REMOTE BILLING CODES

During the National Health Emergency, Medicare expanded the use of a few communication-based technology service codes to permit physical, occupational, and speech therapists to report a limited number of remote services when billing on a professional fee claim form (CMS1500/837p.)Therapists billing through an outpatient department of a hospital are not permitted to report remote service codes at this time—although CMS is "optimistic that changes can happen in the near future."

There are two code sets which require different communications technology: telephone codes and patient portal codes.Telephone codes--with the exception of G2010, which requires review of an image provided by the patient, the following services may be conducted entirely by telephone, without real-time video.

If performed by a therapist, report modifier GP, GO, or GN as appropriate to the therapist's discipline.Modifier 95 is not required, as these HCPCS indicate the remote nature by definition.On the professional fee claim form, report the Place of Service code that would have been reported for an in-person service.

G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; **5-10** minutes of medical discussion
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; **5-10** minutes of medical discussion
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; **11-20** minutes of medical discussion
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; **21-30** minutes of medical discussion

PT/OT/SLP THERAPIST REMOTE BILLING CODES

Patient Portal Codes: Three additional codes require the use of an online patient portal.An online patient portal is a secure online website that gives patients 24-hour access to personal health information over an Internet connection by using a secure username and password.Report the therapy modifier GP/GO/GN as appropriate to the therapist's discipline; report the Place of Service code that would have been reported for an in-person service.

G2061	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; **5-10 minutes**
G2062	Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; **11-20 minutes**
G2063	Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; **21 or more minutes**

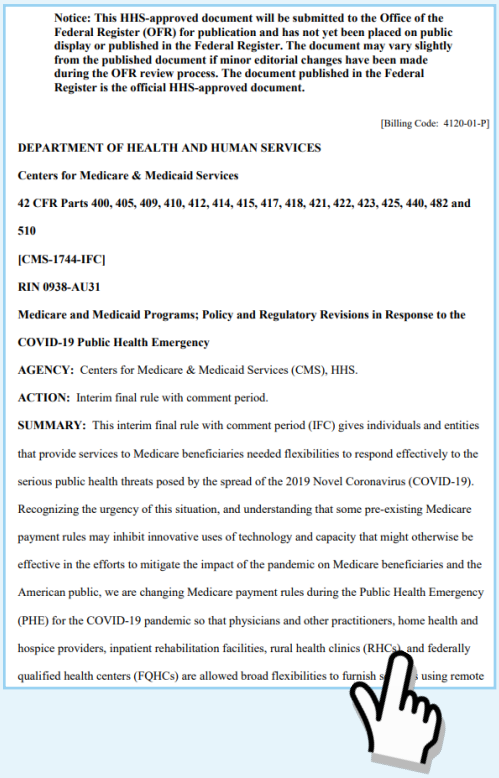
Although Medicare added many other physical, occupational, and speech therapy codes to the telehealth service list during the COVID-19 National Health Emergency, only providers who may independently report an evaluation and management service, without a referral from another provider, may report telehealth codes.Since Medicare requires that all PT/OT/ST services must be performed on an order from a physician and under an approved plan of care, therapists are not eligible to report the therapy codes over real-time audio/visual communications.

An excerpt from the CMS "Interim Final Rule" explains:

https://www.cms.gov/files/document/covid-final-ifc.pdf

...

16. Therapy ServicesWe have received a number of requests, most recently for CY 2018 PFS rulemaking, that we add therapy services to the Medicare telehealth list. In the CY 2018 PFS final rule, we noted that section 1834(m)(4)(E) of the Act specifies the types of practitioners who may furnish and bill for Medicare telehealth services as those practitioners under section 1842(b)(18)(C) of the Act. Physical therapists, occupational therapists and speech-language pathologists are not among the practitioners identified in section 1842(b)(18)(C) of the Act. We stated in the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements"



Notice: This HHS-approved document will be submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the Federal Register is the official HHS-approved document.

[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 400, 405, 409, 410, 412, 414, 415, 417, 418, 421, 422, 423, 425, 440, 482 and 510

[CMS-1744-IFC]

RIN 0938-AU31

Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period (IFC) gives individuals and entities that provide services to Medicare beneficiaries needed flexibilities to respond effectively to the serious public health threats posed by the spread of the 2019 Novel Coronavirus (COVID-19). Recognizing the urgency of this situation, and understanding that some pre-existing Medicare payment rules may inhibit innovative uses of technology and capacity that might otherwise be effective in the efforts to mitigate the impact of the pandemic on Medicare beneficiaries and the American public, we are changing Medicare payment rules during the Public Health Emergency (PHE) for the COVID-19 pandemic so that physicians and other practitioners, home health and hospice providers, inpatient rehabilitation facilities, rural health clinics (RHCs), and federally qualified health centers (FQHCs) are allowed broad flexibilities to furnish s... using remote

PT/OT/SLP THERAPIST REMOTE BILLING CODES

final rule (81 FR 80198, November 15, 2016) (hereinafter referred to as the CY 2017 PFS final rule) that because these services are predominantly furnished by physical therapists, occupational therapists and speech-language pathologists, we did not believe it would be appropriate to add them to the list of telehealth services at this time. In a subsequent request to consider adding these services for 2018, the original requester suggested that we might propose these services to be added to the list so that they can be furnished via telehealth when furnished by eligible distant site practitioners.

Since the majority of the codes are furnished over 90 percent of the time by therapy professionals, who are not included on the statutory list of eligible distant site practitioners,we stated that we believed that adding therapy services to the telehealth listcould result in confusion about who is authorized to furnish and bill for these services when furnished via telehealth.

In light of the PHE for the COVID-19 pandemic, we believe that the risks associated with confusion are outweighed by the potential benefits for circumstances when these services might be furnished via telehealth by eligible distant site practitioners.

We believe this is sufficient clinical evidence to support the addition of therapy services to the Medicare telehealth list on a category 2 basis.However, we note that the statutory definition of distant site practitioners under section 1834(m) of the Act does not include physical therapists, occupational therapists, or speech-language pathologists, meaning that it does not provide for payment for these services as Medicare telehealth services when furnished by physical therapists, occupational therapists, or speech-language pathologists.

CPT codes:

- 97161 (Physical therapy evaluation: low complexity, ...
- 97162 (Physical therapy evaluation: moderate complexity, ...
- 97163 (Physical therapy evaluation: high complexity, ...
- 97164 (Re-evaluation of physical therapy established plan of care, ...
- 97165 (Occupational therapy evaluation, low complexity, ...
- 97166 (Occupational therapy evaluation, moderate complexity, ...
- 97167 (Occupational therapy evaluation, high complexity, ...
- 97168 (Re-evaluation of occupational therapy established plan of care, ...
- 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; ...
- 97112 (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation ...
- 97116 (Therapeutic procedure, 1 or more areas, each 15 minutes; gait training
- (includes stair climbing)
- 97535 (Self-care/home management training (eg, activities of daily living (ADL) andcompensatory training, ...
- 97750 (Physical performance test or measurement ...
- 97755 (Assistive technology assessment ...
- 97760 (Orthotic(s) management and training ...
- 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), ...
- 92521 (Evaluation of speech fluency (eg, stuttering, cluttering))
- 92522 (Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
- 92523 (Evaluation of speech sound production ...
- 92524 (Behavioral and qualitative analysis of voice and resonance)
- 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual)"...

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).

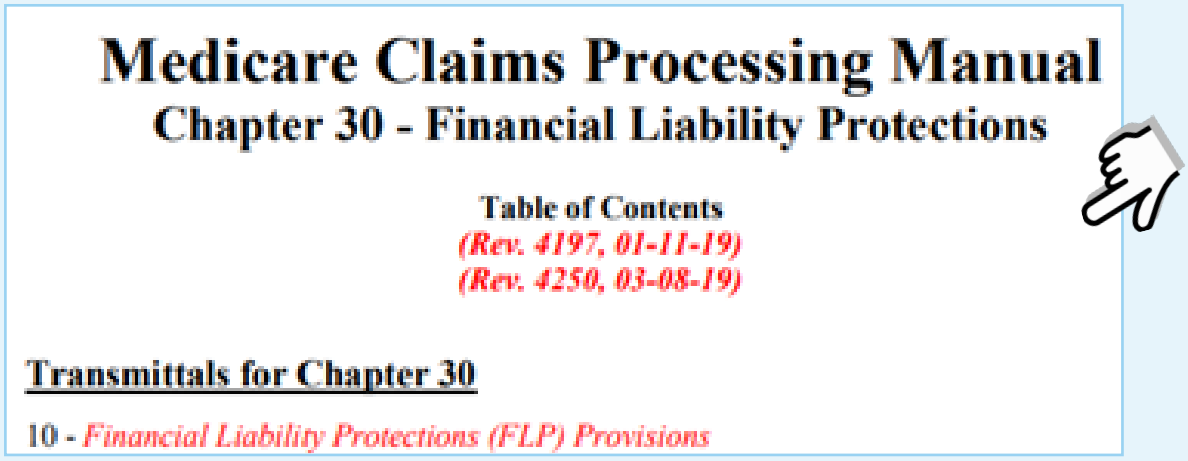
Beginning April 1, 2020, hospitals and CAHs are required to use the new MOON form that extends the expiration date to December 31, 2022.

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

Table of Contents

(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

PARA Data Editor - Demonstration Hospital [DEMO] dbDemo | Contact Sup

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

Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date
Filter By Type	MOON					
Bulletin Board	Cahaba GBA -Moon Outpatient Observation Notice (MOON)	N/A	1 Doc			07/24/2017
Links	CMS FAQ MOON Notice Update	N/A	1 Doc			03/08/2017
Bulletin Board	CMS Medicare Outpatient Observation Notice (MOON)	N/A	1 Doc			02/12/2017
CMS Quarterly Update	Standard MOON Notice Now Required	N/A	1 Doc			01/27/2017
Transmittals	R3698CP - Medicare Outpatient Observation Notice (MOON) Instructi...	N/A	1 Doc			01/27/2017
Med Learn	MM9935 - Medicare Outpatient Observation Notice (MOON) Instructi...	N/A	1 Doc			01/24/2017
Transmittals	R3695CP - Medicare Outpatient Observation Notice (MOON) Instructi...	N/A	1 Doc			01/20/2017
Transmittals	MOON Notice - Final	N/A	1 Doc			12/08/2016
Bulletin Board	CMS Updated: MOON draft available for comment / MOON implemen...	N/A	1 Doc			08/18/2016
Links	NOTICE Act of 2015	N/A	1 Doc			05/03/2016
CMS Quarterly Update	2016 IPPS Final Rule	N/A	1 Doc			04/27/2016

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?

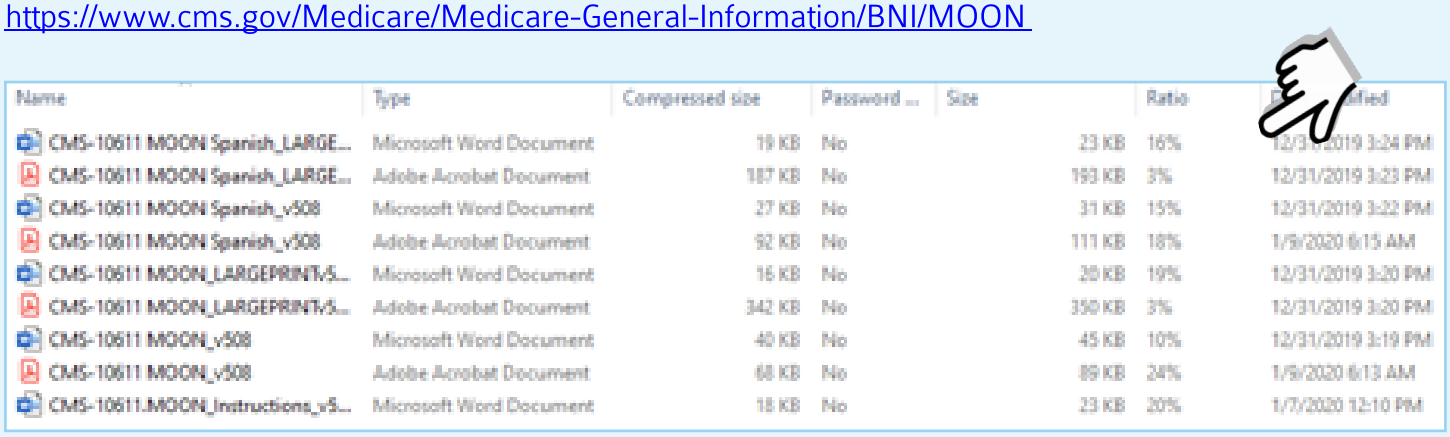
If You Have Medicare – Ask!

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



Name	Type	Compressed size	Password ...	Size	Ratio	Modified
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.

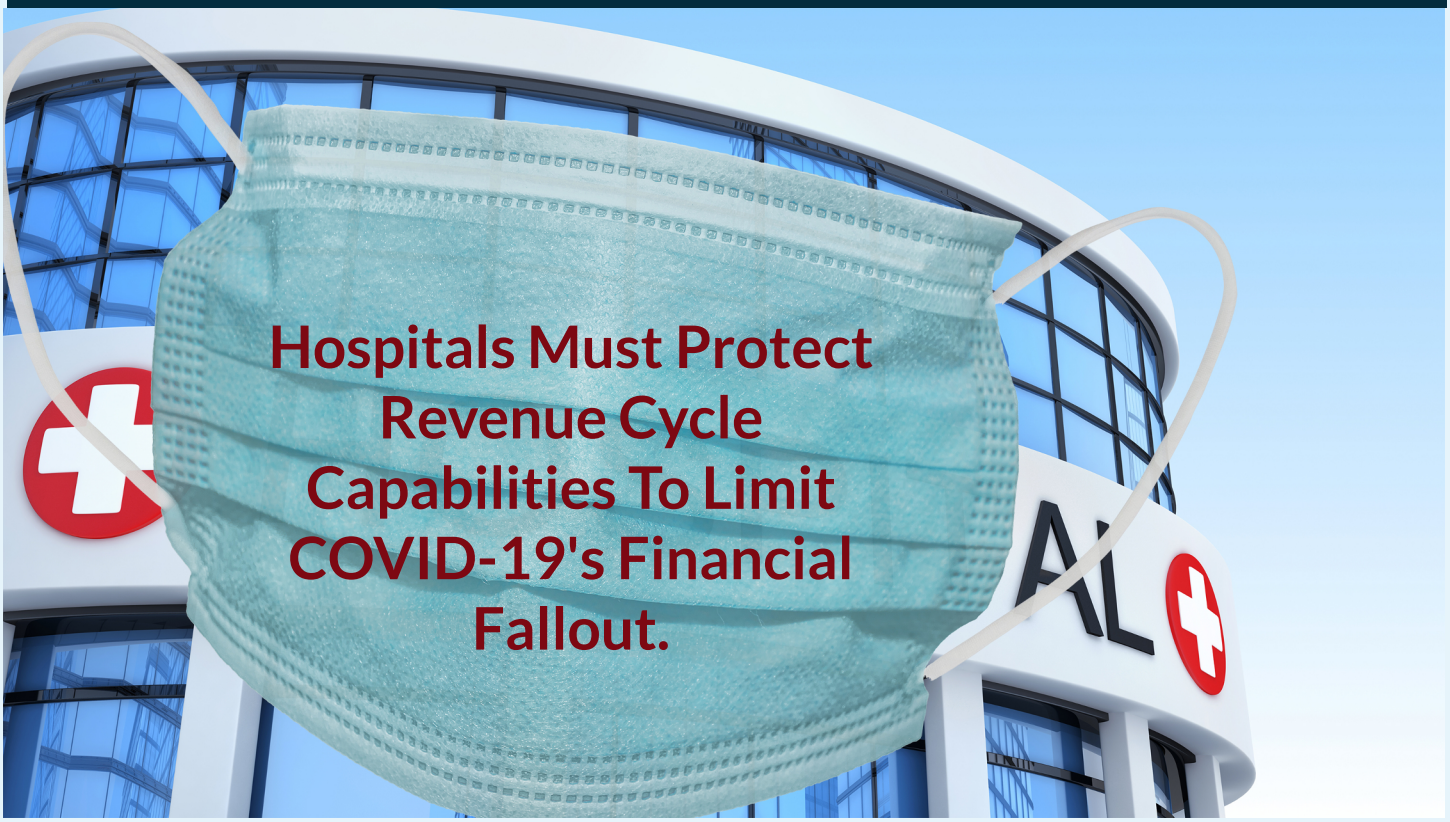
Instructions CMS-10611 OMB expiration: 12-31-2022

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

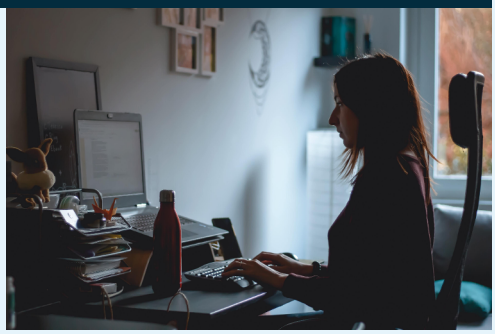
- It is important that hospitals monitor clearinghouse or bank electronic data interchange (EDI) capabilities to ensure 837 and 835 files containing claims and payment information continue to transit between payers and providers. Some hospitals have reported sporadic interruptions in their EDI services. 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, April 16, 2020

News

IPF Prospective Payment System Proposed Rule for FY 2021

·SNF Proposed Payment and Policy Changes for FY 2021

Events

·Ground Ambulance Organizations: Data Collection for Medicare Providers Call — May 7

MLN Matters® Articles

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

·Quarterly Update to the Fiscal Year 2020 Inpatient Psychiatric Facilities Pricer

·Claim Status Category and Claim Status Codes Update — Revised

·Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications

·Inpatient Rehabilitation Facility Prospective Payment System — Revised

·Medicare Overpayments — Revised

·Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services— Revised

Multimedia

·Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course — Revised

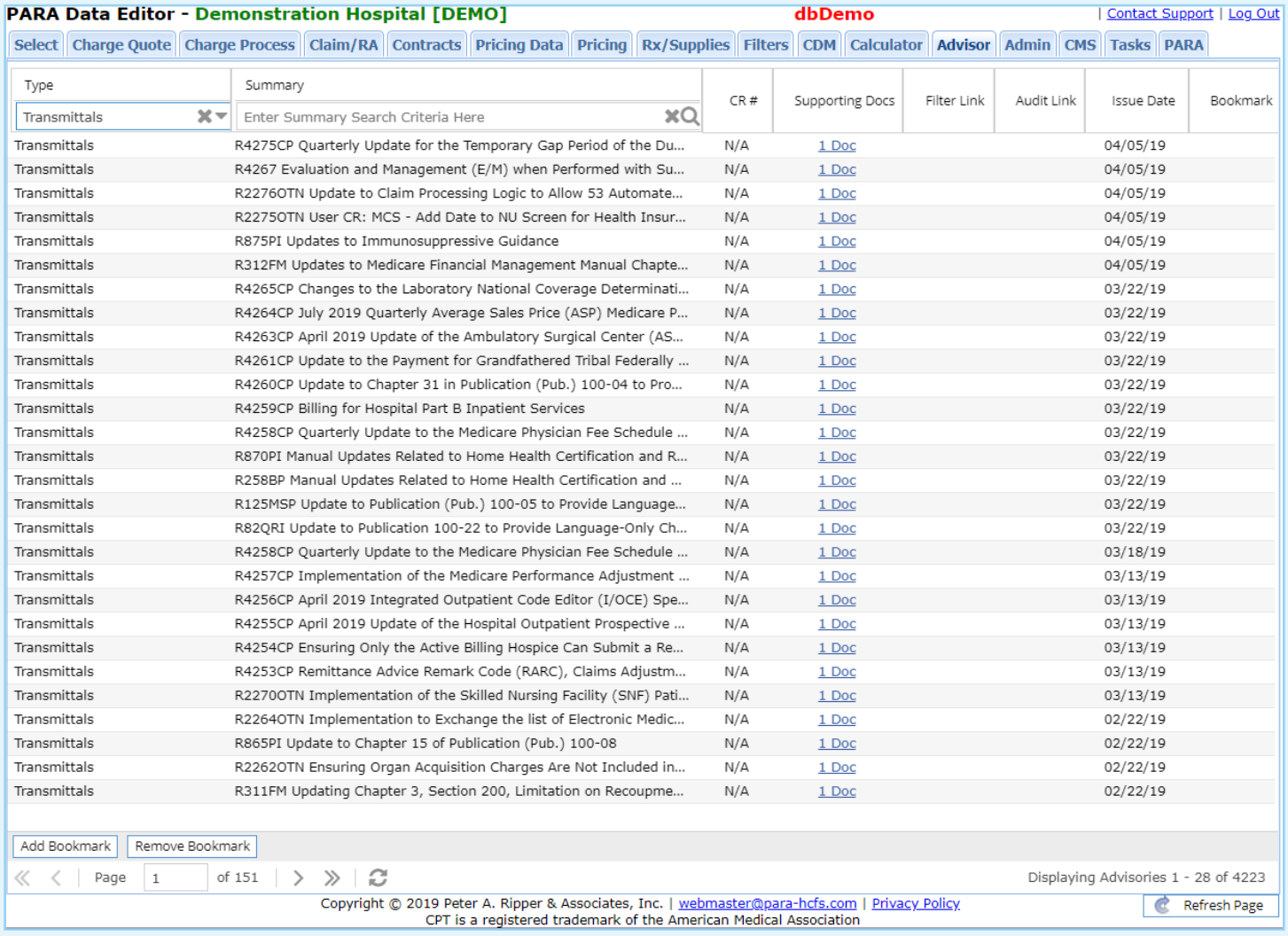
·Medicare Part C and Part D Data Validation Web-Based Training Course — RevisedView this edition as PDF (PDF)

There were SIX 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**

6



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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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Page 1 of 151 Displaying Advisories 1 - 28 of 4223

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The link to this MedLearn MM11489

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

MLN Matters Number: MM11489 Revised

Related CR Release Date: April 16, 2020

Related CR Transmittal Number: R10054CP

Related Change Request (CR) Number: 11489

Effective Date: April 1, 2020

Implementation Date: April 6, 2020

Note: We revised this article on April 16, 2020, to reflect an updated Change Request (CR) 11489 that revised the WPC website address in the background section of the CR (page 2 in this article). All other information remains the same.

PROVIDER TYPE 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 11489 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print if they use that software

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy requires that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

CR 11489 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. The Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. The SSMs must make sure that Medicare does not report any

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

The link to this MedLearn MM11680

mln MATTERS®

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April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1

MLN Matters Number: MM11680 Revised

Related Change Request (CR) Number: 11680

Related CR Release Date: April 16, 2020

Effective Date: April 1, 2020

Related CR Transmittal Number: R10053CP

Implementation Date: April 6, 2020

Note: We revised this article on April 16, 2020, to reflect a revised CR 11680. The CR revisions added changes to the summary of Quarterly Release Modifications in Table 1. We made corresponding revisions in the article. Also, we revised the CR release date, transmittal number, and the web address of the article. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article provides the summary of changes to the Integrated OCE (I/OCE) instructions and specifications for the I/OCE that is being updated for April 1, 2020. These changes are in Version 21.2, including 21.1.R1 and 21.1.R2. Please make sure your billing staff is aware of this update.

BACKGROUND

CR 11680 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/COE is being updated for April 1, 2020. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated I/OCE.

This I/OCE will be used in the Outpatient Prospective Payment System (OPPS) and for non-OPPS claims for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the HH PPS or to a hospice beneficiary for the treatment of a non-terminal illness.

The I/OCE specifications will be posted on the Centers for Medicare & Medicaid Services website at http://www.cms.gov/OutpatientCodeEdit/.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

The link to this MedLearn MM11638

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

MLN Matters Number: MM11638 Revised
Related Change Request (CR) Number: 11638
Related CR Release Date: April 15, 2020
Effective Date: July 1, 2020
Related CR Transmittal Number: R10052CP
Implementation Date: July 6, 2020

Note: We revised this article on April 16, 2020, to reflect an updated Change Request (CR) 11638 that revised the WPC website address in the background section of the CR (page 2 in this article). 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 11638 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print versions if they use that software.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that, as appropriate, CARCs and RARCs are required in the remittance advice and coordination of benefits transactions. CARCs and RARCs provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the RARC/CARC code update schedule that results in publication three times per year, around March 1, July 1, and November 1.

CMS provides a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. The Medicare system maintainers have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. The maintainers must make sure that Medicare does not report any

The link to this MedLearn MM11694

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April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM11694 Revised

Related Change Request (CR) Number: 11694

Related CR Release Date: April 13, 2020

Effective Date: April 1, 2020

Related CR Transmittal Number: R10046CP

Implementation Date: April 6, 2020

Note: We revised this article on April 14, 2020, due to a revised Change Request (CR) 11694 that added information on Q4206 to the policy section of the CR (page 6 in this article). 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 subject to the Ambulatory Surgical Center (ASC) Payment System and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11694 describes changes to and billing instructions for various payment policies implemented in the April 2020 ASC payment system update. This notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staffs are aware of these updates.

BACKGROUND

CR 11694 contains Calendar Year (CY) 2020 payment rates for separately payable procedures/services, drugs and biologicals, including descriptors for newly created Current Procedural Terminology (CPT) and Level II HCPCS codes. A corrected January 2020 Ambulatory Surgical Center Fee Schedule (ASCFS) File, an April 2020 Ambulatory Surgical Center Payment Indicator (ASC PI) File, and an April 2020 Ambulatory Surgical Center Drug File will be issued. No April 2020 ASCFS and no ASC Code Pair file will be issued due to CR 11694. The changes are as follows:

1. Drugs, Biologicals, and Radiopharmaceuticals

a. New HCPCS Codes and Dosage Descriptors for Certain Drugs and Biologicals Effective April 1, 2020

Several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are effective April 1, 2020, and are listed in Table 1.

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Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM11467 Revised | Related Change Request (CR) Number: 11467

Related CR Release Date: April 10, 2020 | Effective Date: April 1, 2020

Related CR Transmittal Number: R10045CP | Implementation Date: April 6, 2020

Note: We revised this article on April 10, 2020, to reflect a revised Change Request (CR) 11467. CR 11467 was revised to update the Uniform Resource Locators (URLs) references (page 2 in this article) in Background Section in the CR. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same. All other information remains the same.

PROVIDER TYPE 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 11467 updates the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staff is aware of this update.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards. These standards were adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claims. Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six (6) months for implementation of newly added or changed codes.

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New Waived Tests

MLN Matters Number: MM11747
Related Change Request (CR) Number: 11747
Related CR Release Date: April 17, 2020
Effective Date: July 1, 2020
Related CR Transmittal Number: R10048CP
Implementation Date: July 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11747 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that they can accurately process claims. Make sure your billing staffs are aware of these newly added waived complexity tests.

BACKGROUND

The Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test.

Note: The tests mentioned on the first page of the list attached to CR 11747 (CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- 80305QW, May 31, 2019, BTNX, Inc. Rapid Response Drug Screening Test Cup-OTC (Urine)
- 80305QW, May 31, 2019, BTNX, Inc. Rapid Response Drug Screening Test Panel-OTC (Urine)
- 80305QW, May 31, 2019, BTNX, Inc. Rapid Response Drug Screening Test Strip-OTC (Urine)
- 80305QW, June 28, 2019, BTNX, Inc. Rapid Response Drug Screening Panel
- 80305QW, June 28, 2019, BTNX, Inc. Rapid Response Drug Screening Cup

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There were SIX new or revised
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To go to the full Transmittal document **simply click on the screen shot or the link.**

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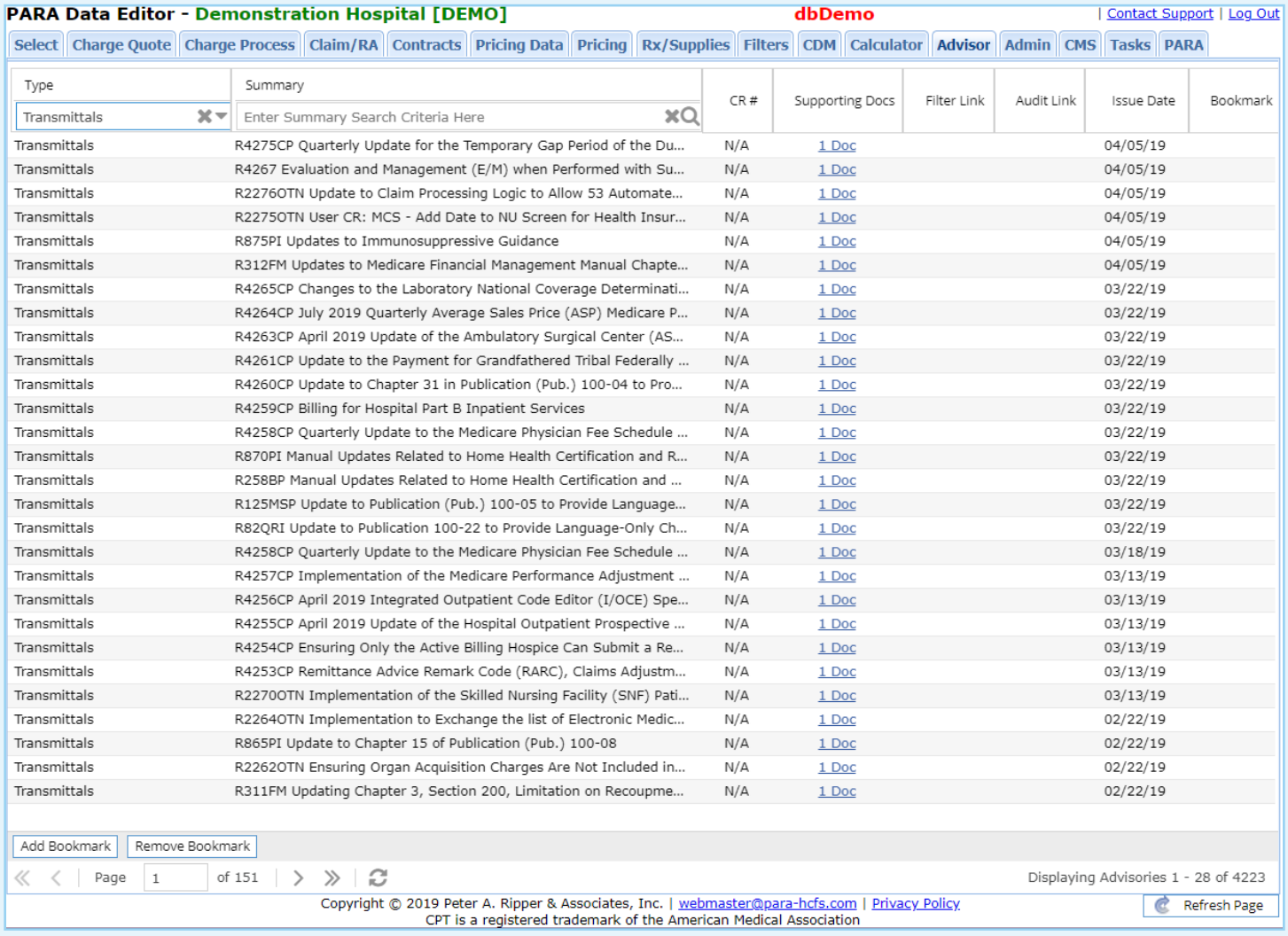

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Transmittals	Enter Summary Search Criteria Here						
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Transmittals	R2276OTN Update to Claim Processing Logic to Allow 53 Automate...	N/A	1 Doc			04/05/19	
Transmittals	R2275OTN User CR: MCS - Add 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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Page 1 of 151 Displaying Advisories 1 - 28 of 4223

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The link to this Transmittal R10054CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10054	**Date: April 16, 2020**
	Change Request 11489

Transmittal 4461, dated November 15, 2019, is being rescinded and replaced by Transmittal 10054, dated, April 16, 2020, to revise the WPC website address in the background section. All other information remains the same.

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

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the RARC and CARC lists and to instruct ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update MREP and PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of Publication (Pub.) 100-04.

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

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10053CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10053	**Date: April 16, 2020**
	Change Request 11680

Transmittal 10027, dated April 1, 2020, is being rescinded and replaced by Transmittal 10053, dated, April 16, 2020 to revise both the Summary of Changes and Summary of Modifications attachments. All other information remains the same.

SUBJECT: April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1

I. SUMMARY OF CHANGES: This notification provides the Integrated OCE instructions and specifications for the Integrated OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The attached recurring update notification applies to publication 100-04, chapter 4, section 40.1.

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

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10052CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10052	**Date: April 15, 2020**
	Change Request 11638

Transmittal 4536, dated February 21, 2020, is being rescinded and replaced by Transmittal 10052, dated, April 15, 2020, to revise the WPC website address in the background section. All other information remains the same.

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

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the RARC and CARC lists and to instruct ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update MREP and PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of Publication (Pub.) 100-04.

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

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10049FM

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10049	**Date: April 13, 2020**
	Change Request 11781

SUBJECT: Notice of New Interest Rate for Medicare Overpayments and Underpayments -3rd Qtr Notification for FY 2020

I. SUMMARY OF CHANGES: Medicare Regulation 42 CFR Section 405.378 provides for the charging and payment of interest on overpayments and underpayments to Medicare providers. The Secretary of Treasury certifies an interest rate quarterly. Treasury utilizes the most comprehensive data available on consumer interest rates to determine the certified rate. Interest is assessed on delinquent debts in order to protect the Medicare Trust Funds. The attached Recurring Update Notification applies to Chapter 3, Section 10.

EFFECTIVE DATE: April 20, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 20, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10046CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10046	**Date: April 13, 2020**
	Change Request 11694

Transmittal 4545, dated March 13, 2020, is being rescinded and replaced by Transmittal 10046, dated, April 13, 2020 to add information of the Correction to Q4206 to the policy section. All other information remains the same.

SUBJECT: April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System

I. SUMMARY OF CHANGES: This recurring update notification describes changes to and billing instructions for various payment policies implemented in the April 2020 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

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

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10045CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10045	**Date: April 10, 2020**
	Change Request 11467

Transmittal 4460, dated November 15, 2019, is being rescinded and replaced by Transmittal 10045, dated April 10, 2020 to correct the WPC website information in the Background section. All other information remains the same.

SUBJECT: Claim Status Category and Claim Status Codes Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. This Recurring Update Notification (RUN) can be found in chapter 31, section 20.7 of Publication (Pub.) 100-04.

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

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

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

Recurring Update Notification

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- Contingency-Based Flat Rate Fee Schedule
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- Staffing Shortages
- Recent Legacy Conversion
- Write-offs Over 2.5%
- Small Balance Accounts That Are Untouched For 30 Days
- Net A/R Days Greater Than 45

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