December 2, 2020

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

Price Transparency

Implantable Defibrillators

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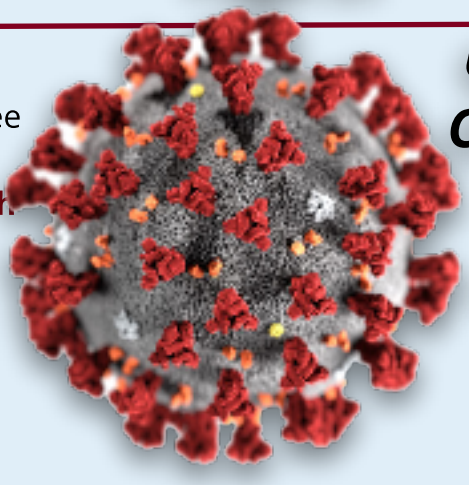


Updated COVID-19 Guide

Page 13

FAST LINKS

WOUND CARE BILLING

Q. Do wound care services have to bill as recurring (e.g. monthly), or can it be billed after each date of service?

A. **Answer:** No. Wound care is not required to be reported on a re-occurring claim. However, the hospital may choose to do so.

The revenue codes for which repetitive outpatient services must be billed monthly are detailed in the following table:

Revenue Code	Description
029X	Durable Medical Equipment (Other than Renal)
0410	Respiratory Services—General
0412	Respiratory Services—Inhalation Services
0419	Respiratory Services—Other Respiratory Services
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech Therapy-Language Pathology
055X	Skilled Nursing
082X	Hemodialysis—Outpatient or Home
083X	Peritoneal Dialysis—Outpatient or Home
084X	Continuous Ambulatory Peritoneal Dialysis (CAPD)—Outpatient or Home
085X	Continuous Cycling Peritoneal Dialysis (CCPD)—Outpatient or Home
0943	Other Therapeutic Services—Cardiac Rehabilitation
0948	Other Therapeutic Services—Pulmonary Rehabilitation

Wound care services is not assigned a particular revenue code, and therefore Wound Care cannot be listed among the revenue codes which must be billed monthly on a repetitive service claim.

However, the document allows that "...Where there are multiple encounters for chemotherapy or other non-repetitive services in a month, they may all be reported on the same claim, or they may be billed separately.

Here's a link to the MLN article on this point:

https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA4047.pdf

Related MLN Matters Article #: MM4047

Date Posted: December 2, 2005

Related CR #: 4047

Update to Repetitive Billing Instructions in Medicare Claims Processing Manual

NEW NCCI EDITS

Q. We started getting edits in our claims scrubbing system for PT and OT evaluations when posted on the same date of service as other charges. We are aware that changes were implemented this year impacting therapy evaluations, but are unable to locate additional details surrounding the change to NCCI. The account example is evaluating against the ER E&M code 99285. Typically with charges that have CCI conflicts and do not allow the use of modifiers, the understanding of the CMS requirement is that we should not be reporting those charges on the same date of service. We are billing on an institutional claim form.

What is your recommendation to appropriately address tehse edits we are seeing? Is the recommendation to bill for denial, or remove the charge?

A. **Answer:** There was no published explanation for the addition of CCI edits which prevent billing a Physical Therapy evaluation with an Emergency Department visit on the same day. Since the PT evaluation is clearly a separate and distinct evaluation performed by a separate healthcare professional, and since OPPS rates were not developed with the notion of "packaging" PT evaluations to the 9928X code, there seems to be no obvious basis for the decision to restrict payment of the PT evaluation code when billed with an ED visit. Without an explanation from Medicare, the new edits appear to be ill-informed and unjust. Here are just two, to illustrate:

CCI Edits OPPS (v26.3, Oct-Dec 2020)

Codes and/or Descriptions: **97161,97162,99284**

Remove "OK To Bill" Results | Export to PDF | Export to Excel | Copy to Clipboard

PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
97161 - PHYSICAL THERAPY EVALUATION: LOW COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY WITH NO PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEM(S) USING STANDARDIZED TESTS AND MEASURES ADDRESSING 1-2 ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; A CLINICAL PRESENTATION WITH STABLE AND/OR UNCOMPLICATED CHARACTERISTICS; AND CLINICAL DECISION MAKING OF LOW COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 20 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY. (Column 2)	99284 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY, AND REQUIRE URGENT EVALUATION BY THE PHYSICIAN, OR OTHER QUALIFIED HEALTH CARE PROFESSIONALS BUT DO NOT POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION. (Column 1)	Column 1/Column 2 Correct Coding	0 - Code Pair cannot be billed
97162 - PHYSICAL THERAPY EVALUATION: MODERATE COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY OF PRESENT PROBLEM WITH 1-2 PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEMS USING STANDARDIZED TESTS AND MEASURES IN ADDRESSING A TOTAL OF 3 OR MORE ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; AN EVOLVING CLINICAL PRESENTATION WITH CHANGING CHARACTERISTICS; AND CLINICAL DECISION MAKING OF MODERATE COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY. (Column 2)	99284 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY, AND REQUIRE URGENT EVALUATION BY THE PHYSICIAN, OR OTHER QUALIFIED HEALTH CARE PROFESSIONALS BUT DO NOT POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION. (Column 1)	Column 1/Column 2 Correct Coding	0 - Code Pair cannot be billed

We checked our Medicare claims database for outpatient claims from your facility reporting both a PT or an OT evaluation (97161-97169) together with an ED visit charge, most commonly 99285. For your facility, Medicare paid $5,130 in the first 6 months of 2020 for PT and/or OT evaluations billed together with an ED visit code. Annualizing that amount, the loss generated by the new CCI edits is over $10,000 a year, which could not come at a worse time as most hospitals struggle financially due to the COVID-19 Public Health Emergency.

NEW NCCI EDITS

Each organization needs to decide whether it chooses to accept the new CCI edits, and write off or reverse the charge for the PT/OT evaluation code on the same claim as an ED visit, or whether to bill the evaluation code with an ED visit in order to obtain a denial on the evaluation. The record of the denial could be useful it Medicare reverses the edits, as it did following massive opposition in January 2020, but that exercise means extra work with no guarantee that the denial will be eventually reversed.

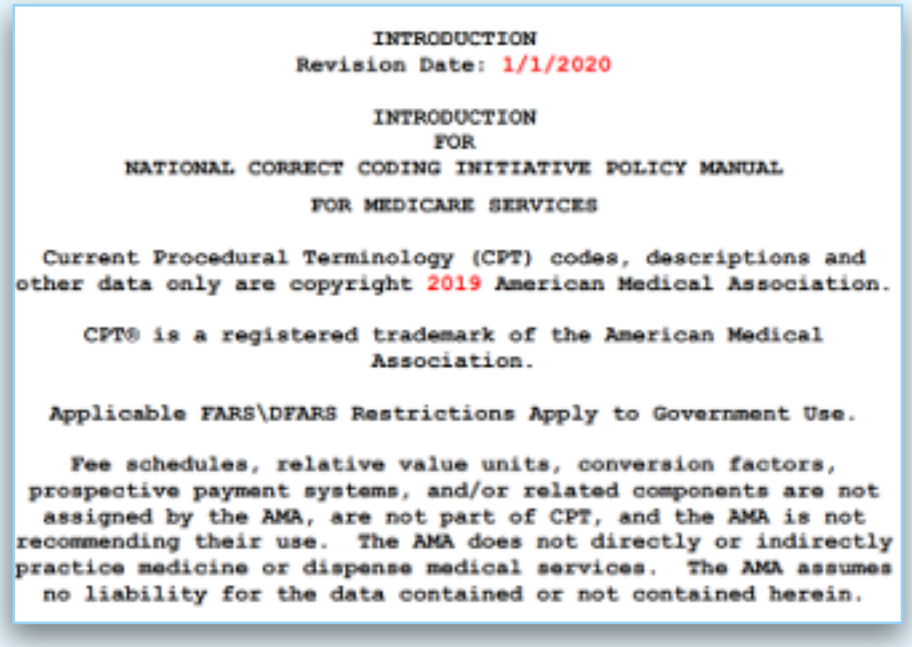
In any event, we have submitted a Freedom of Information Act request to HHS asking for documentation of the process CMS and its contractor, Capitol Bridge LLC, followed to obtain input on the imposition of these new CCI edits. There should be some kind of input process; the NCCI Edit Manual states, in Chapter 1:

Introduction (para-hcfs.com)

Since the NCCI is a CMS program, its policies and edits represent CMS national policy. However, NCCI policies and edits do not supersede any other CMS national coding, coverage, or payment policies. NCCI PTP edits are adopted after due consideration of Medicare policies including the principles described in the National Correct Coding Initiative Policy Manual for Medicare Services, HCPCS and CPT® Manual code descriptors, CPT® Manual coding guidelines, coding guidelines of national societies, standards of medical and surgical practice, current coding practice, and provider billing patterns.

Since the NCCI is developed by CMS for the Medicare program, the most important consideration is CMS policy. Prior to initial implementation of the NCCI in 1996, the proposed edits were evaluated by Medicare Part B Carrier Medical Directors, representatives of the American Medical Association's CPT® Advisory Committee, and representatives of other national medical and surgical societies.

The NCCI undergoes continuous refinement with revised edit tables published quarterly. There is a process to address annual changes (additions, deletions, and modifications) of HCPCS/CPT® codes and CPT® Manual coding guidelines. Other sources of refinement are initiatives by the CMS central office and comments from the CMS regional offices, AMA, national medical, surgical, and other healthcare societies/organizations, Medicare contractor medical directors, providers, consultants, other third party payers, and other interested parties.



INTRODUCTION
Revision Date: 1/1/2020

INTRODUCTION
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright 2019 American Medical Association.

CPT® is a registered trademark of the American Medical Association.

Applicable FARS\DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors, prospective payment systems, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

Prior to implementing new edits, CMS generally provides a review and comment period to representative national organizations that may be impacted by the edits. However, there are situations when CMS thinks that it is prudent to implement edits prior to completion of the review and comment period. CMS Central Office evaluates the input from all sources and decides which edits are modified, deleted, or added each quarter.

It is reasonable to object to the new edits on the basis that the rate of reimbursement for the ED visit codes did not include consideration for the PT evaluations that will no longer be reimbursed.If and when we receive a reply to our FOIA request, an article about Medicare's process will be published in the **PARA Weekly** newsletter.

MEDICARE BENEFICIARIES AND ACCESS TO COVID-19 ANTIBODY TREATMENT

The Centers for Medicare & Medicaid Services announced that starting November 10, 2020, Medicare beneficiaries can receive coverage of monoclonal antibodies to treat coronavirus disease 2019 (COVID-19) with no cost-sharing during the public health emergency (PHE).

CMS' coverage of monoclonal antibody infusions applies to bamlanivimab, which received an emergency use authorization (EUA) from the U.S. Food and Drug Administration yesterday.

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

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

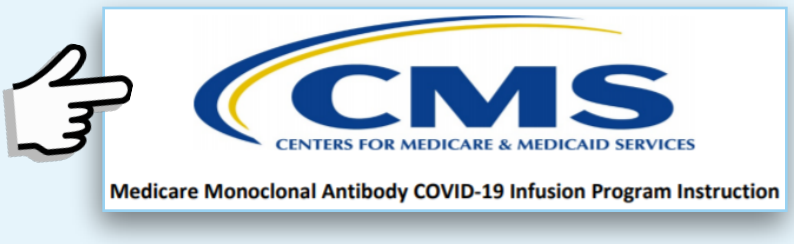
CMS anticipates the announcement today will allow for a broad range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract, to administer this treatment in accordance with the EUA, and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

Under section 6008 of the Families First Coronavirus Response Act (FFCRA), state and territorial Medicaid programs may receive a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), through the end of the quarter in which the COVID-19 PHE ends.

A condition for receipt of this enhanced federal match is that a state or territory must cover COVID-19 testing services and treatments, including vaccines and their administration, specialized equipment, and therapies for Medicaid enrollees without cost sharing.

This means that this monoclonal antibody infusion is expected to be covered when furnished to Medicaid beneficiaries, in accordance with the EUA, during this period, with limited exceptions.To view the Monoclonal Antibody COVID-19 Infusion Program Instruction, visit:

https://www.cms.gov/files/document/covid-medicare-monoclonal-antibody-infusion-program-instruction.pdf



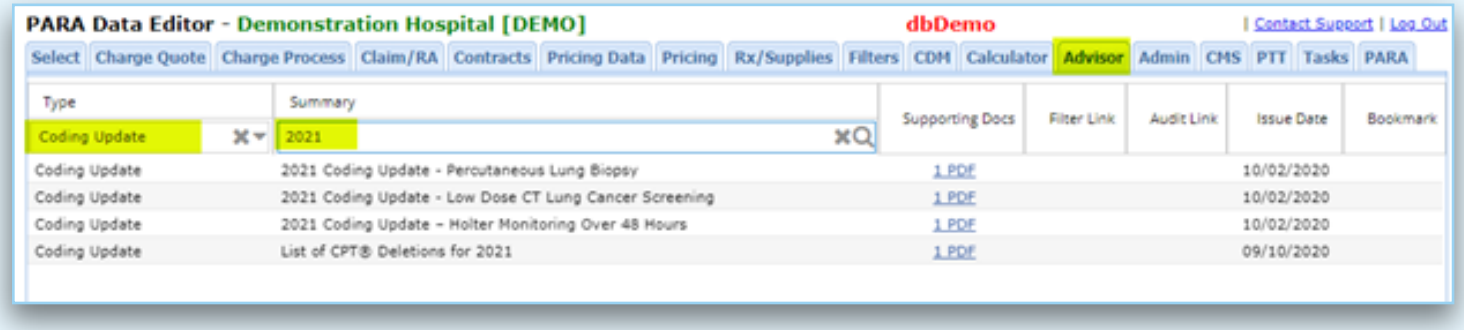
2021 CODING UPDATE DOCUMENTS AVAILABLE

In preparation for the year-end CPT®/HCPCS update, **PARA** has prepared several brief "2021 Coding Update" documents listing deleted codes and possible replacement codes within a particular clinical area or procedure group.The documents are available on the **PARA Data Editor** "Advisor" tab.

The individual coding topics addressed do not encompass all CPT® updates, only those which are most likely to be "hard-coded" to a line item in a facility chargemaster. Topics are divided into immediately related areas, and more than one paper may contain information useful to a service line manager.

In addition, the list of all CPT® codes that will be deleted in 2021 is also available.

Due to CPT® licensing restrictions, these documents cannot be published within the **PARA Weekly eJournal**. **PARA Data Editor** users may access the information on the Advisor tab; search "Coding Update" in the type field, and/or 2020 in the subject field, as illustrated below:



Provisional Medicare coverage information is offered in keeping with the 2021 OPPS Proposed Rule.Following the release of the OPPS Final Rule (typically published in November), coding update papers will be revised to indicate with certainty whether Medicare will accept/cover the new codes.If changes are made to the coding update papers, readers can identify new versions the word "Revised" in the title, and the date issued will be updated.

CMS UPDATES FOR HOSPICE FY 2021

Effective as of October 01, 2020 with final implementation beginning October 05, 2020, CMS will finalize updates to Hospice payment rates, Hospice wage index tables, Hospice aggregate cap amount and Hospice Pricer.

These updates will impact Hospice providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice Agencies.

https://www.cms.gov/files/document/r10372cp.pdf

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10372	**Date: September 24, 2020**
	Change Request 11876

Transmittal 10338, dated August 27, 2020, is being rescinded and replaced by Transmittal 10372, dated, September 24, 2020 to revise the hourly CHC rate on the Hospice Table attachment. All other information remains the same.

SUBJECT: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2021

I. SUMMARY OF CHANGES: This Change Request (CR) updates the hospice payment rates, hospice wage index, and Pricer for FY 2021. The CR also updates the FY 2021 hospice aggregate cap amount. These updates apply to Pub 100-04, Chapter 11, section 30.2.

Hospice Payment Rates:For Fiscal Year (FY) 2021, the hospice payment update percentage (%) is based on the inpatient hospital market basket update of 2.4 percent (%). In accordance with sections 1886(b)(3)(B)(xi)(II) and 1814(i)(I)(C)(v) of the Act, the inpatient hospital market basket update for FY 2021 of 2.4 percent (%) must be reduced by an MFP adjustment mandated by the Affordable Care Act.

The FY 2021 hospice payment rates are effective for services rendered on or after October, 01, 2020 and will remain so until September 30, 2021.

Providers can review hospice payment rates further in the CMS Claims Processing Manual, Chapter 11, Section 30.2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

30.2 - Payment Rates
(Rev. 3378, Issued: 10-16-15, Effective: 01-01-16, Implementation: 01-01-16)

The CMS publishes general hospice payment rates annually to be used for revenue codes 0651, 0652, 0655, and 0656. These rates must then be adjusted by the A/B MAC (A) based on the beneficiary's locality.

CMS UPDATES FOR HOSPICE FY 2021

The FY 2021 hospice payment rates may be reviewed at the end of this article.

Hospice Inpatient and Aggregate Caps:

CMS finalized aligning the cap accounting year with the publishing of the CY2016 Hospice Wage Index and Payment Rate Final Rule (80FR47142). In this update, the inpatient cap and the hospice aggregate cap were implemented beginning in FY2017.

The FY 2021 cap year will start October 01, 2020 and will remain until September 30, 2021.

Inpatient cap for the FY2021 cap year, CMS will calculate the percentage (%) of all hospice days that were provided as inpatient days (GIP care and Respite care are included) beginning October 01, 2020 until September 30, 2021.

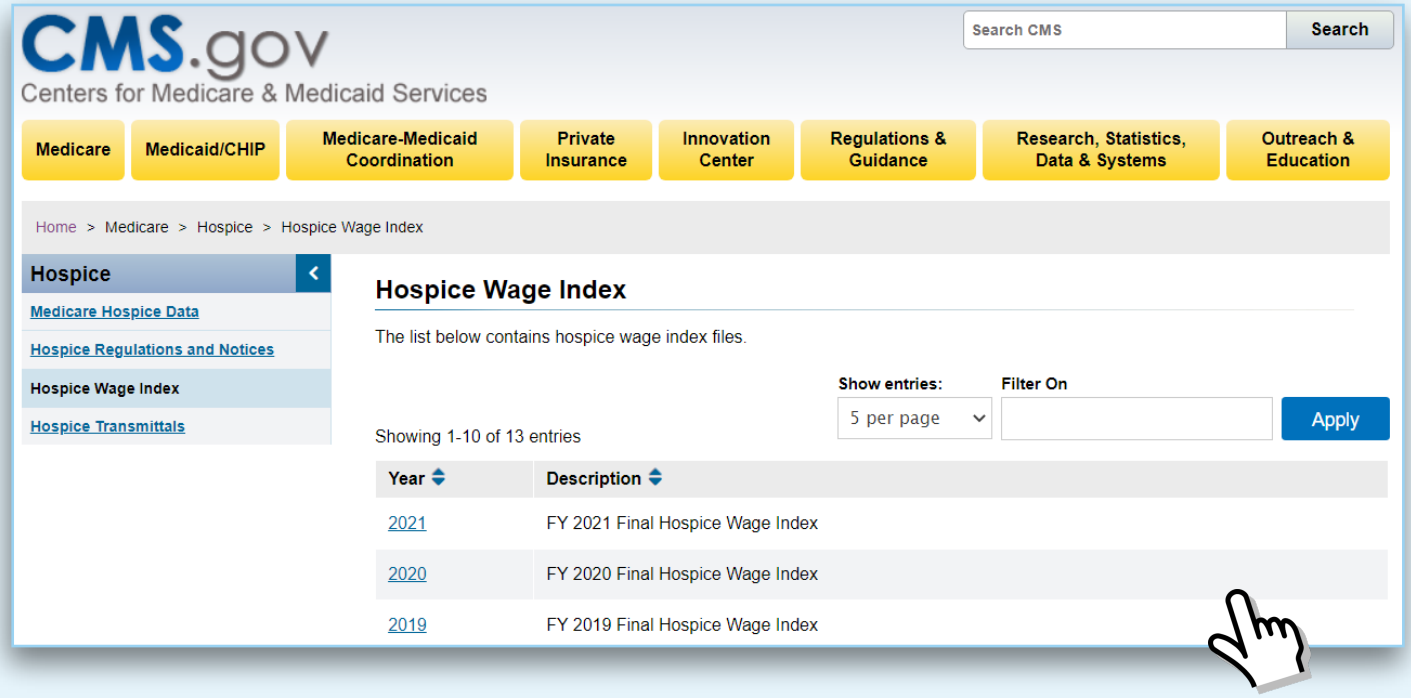
The hospice cap amount for the FY2021 cap year is equal to the FY2020 cap amount ($29,964.78) updated by the FY2021 hospice designated payment percentage of 2.4 percent (%), which equates to the FY2021 cap amount of $30,683.93.

Hospice Wage Index:

The revised payment rates and wage index will be updated in the Hospice Pricer and sent to the Medicare contractors.

Note: The wage index will NOT be published in the Federal Register but will be made available on the CMS website.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index



CMS UPDATES FOR HOSPICE FY 2021

Effective September 14, 2018, the Office of Management and Budget (OMB) issued a provider transmittal (OMB Bulletin #18-04), which detailed revisions to the delineation of Metropolitan Statistical Areas (MSAs), Micropolitan Statistical Areas, and Combined Statistical Areas with guidance on uses of the delineation in the designated areas. Based on these delineations, the revisions are being incorporated into the hospice wage index for FY2021.

As a result, for FY 2021, this transition to help mitigate any significant negative impacts that hospices may experience due to CMS proposing to adopt the revised OMB delineations, CMS will apply a 5 percent (%) cap on any decrease in a geographic area's wage index value from FY2020 to FY2021.

However, due to the method that the transition wage index is calculated, some Core Based Statistical Areas (CBSAs) and statewide rural areas will have more than one (1) wage index value associated with that CBSA or rural area. As an example, some counties that change OMB designations will have a wage index value that is different than the wage index value associated with the CBSA or rural area they are moving to because of the transition. Overall, each county will have only one (1) wage index value.

For counties that correspond to a different transition wage index value, the CBSA number will not be able to be used for FY2021 claims. In these cases, a number other than the CBSA number will be needed to identify the appropriate wage index value for claims for hospice care provided in FY2021. These numbers are five (5) digits in length and begin with "50".

These counties are defined in the table at the end of this article.

https://www.cms.gov/medicaremedicare-fee-service-paymenthospicehospice-regulations-and-notices/cms-1733-f

CMS-1733-F

Regulation No.	CMS-1733-F
Title	FY 2021 Hospice Payment Rate Update Final Rule
Display Date	2020-07-31
Publication Date	2020-08-04

The final rule went on display at the Office of the Federal Register's Public Inspection Desk on July 31, 2020, and will be available until the regulation is published on August 4, 2020. See CMS-1733-F in the "Related Links" section below.

Downloads

FY 2021 Final Hospice Wage Index (Updated 08/20/2020) (ZIP)
Model Hospice Election Statement - Modified July 2020 (PDF)
Model Hospice Election Statement Addendum - Modified July 2020 (PDF)

CMS UPDATES FOR HOSPICE FY 2021

	Previous CBSA	Urban/ Rural	CBSA Name FY 2020	New CBSA	Urban/ Rural	CBSA NAME FY 2021	FY 2021 Wage Index with 5% CAP	CBSA Number or Alternate Number that would go in the CBSA field on the claim
2	33860	URBAN	Montgomery, AL	3386	URBAN	Montgomery, AL	0.80	33860
629	14010	URBAN	Bloomington, IL	99914	RURAL	ILLINOIS	0.8773	50001
784	31140	URBAN	Louisville/Jefferson County, KY-IN	99915	RURAL	INDIANA	0.8402	50002
953	48620	URBAN	Wichita, KS	99917	RURAL	KANSAS	0.8122	50004
980	31740	URBAN	Manhattan, KS	31740	URBAN	Manhattan, KS	0.8720	50003
986	31740	URBAN	Manhattan, KS	31740	URBAN	Manhattan, KS	0.8720	50003
1123	31140	URBAN	Louisville/Jefferson County, KY-IN	99918	RURAL	KENTUCKY	0.8402	50005
1235	25180	URBAN	Hagerstown-Martinsburg, MD-WV	25180	URBAN	Hagerstown-Martinsburg, MD-WV	0.8618	50024
1245	99922	RURAL	MASSACHUSETTS	44140	URBAN	Springfield, MA	1.0506	50006
1334	28020	URBAN	Kalamazoo-Portage, MI	99923	RURAL	MICHIGAN	0.9434	50007
1410	33460	URBAN	Minneapolis-St. Paul-Bloomington, MN-W	99924	RURAL	MINNESOTA	1.0788	50008
1431	32820	URBAN	Memphis, TN-MS-AR	99925	RURAL	MISSISSIPPI	0.8315	50009
1644	13740	URBAN	Billings, MT	99927	RURAL	MONTANA	0.8763	50010
1723	24260	URBAN	Grand Island, NE	99928	RURAL	NEBRASKA	0.9102	50011
1817	35614	URBAN	New York-Jersey City-White Plains, NY-	35154	URBAN	New Brunswick-Lakewood, NJ	1.2108	50012
1818	35614	URBAN	New York-Jersey City-White Plains, NY-	35154	URBAN	New Brunswick-Lakewood, NJ	1.2108	50012

Table 1: FY2021 Hospice Payment Rates for Hospices that Submit the Required Quality Data:

Code	Description	FY 2021 Payment Rate	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$199.25	$136.90	$62.35
651	Routine Home Care (days 61+)	$157.49	$108.21	$49.28
652	Continuous Home Care Full Rate = 24 hours of care Hourly rate= $59.68	$1,432.41	$984.21	$448.20
655	Inpatient Respite Care	$461.09	$249.59	$211.50
656	General Inpatient Care	$1,045.66	$669.33	$376.33

CMS UPDATES FOR HOSPICE FY 2021

Table 2: FY2021 Hospice Payment Rates for Hospices that **DO NOT** Submit the Required Quality Data:

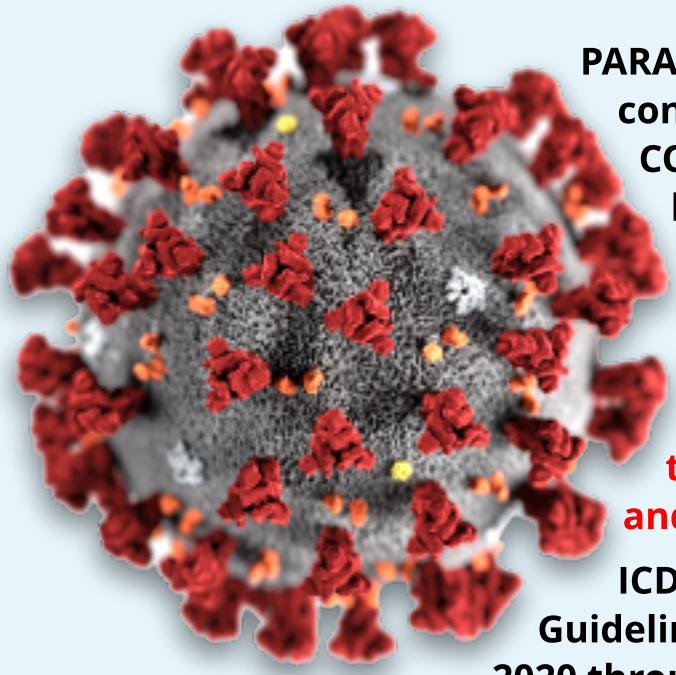
Code	Description	FY 2021 Payment Rate	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$195.36	$134.23	$61.13
651	Routine Home Care (days 61+)	$154.42	$106.10	$48.32
652	Continuous Home Care Full Rate = 24 hours of care Hourly rate= $58.52	$1,404.44	$964.99	$439.45
655	Inpatient Respite Care	$452.08	$244.71	$207.37
656	General Inpatient Care	$1,025.23	$656.25	$368.98

CMS UPDATES FOR HOSPICE FY 2021

Table 3: List of counties that must use 50xxx Codes for FY2021 due to the wage index transition:

FIPS County Code	COUNTY NAME	CBSA FY 2020	CBSA Name FY 2020	Alternative ID	CBSA NAME FY 2021
17039	DE WITT	14010	Bloomington, IL	50001	ILLINOIS
18143	SCOTT	31140	Louisville/Jefferson County, KY-IN	50002	INDIANA
20149	POTTAWATOMIE	31740	Manhattan, KS	50003	Manhattan, KS
20161	RILEY	31740	Manhattan, KS	50003	Manhattan, KS
20095	KINGMAN	48620	Wichita, KS	50004	KANSAS
21223	TRIMBLE	31140	Louisville/Jefferson County, KY-IN	50005	KENTUCKY
25011	FRANKLIN	99922	MASSACHUSETTS	50006	Springfield, MA
26159	VAN BUREN	28020	Kalamazoo-Portage, MI	50007	MICHIGAN
27143	SIBLEY	33460	Minneapolis-St. Paul-Bloomington, MN-W	50008	MINNESOTA
28009	BENTON	32820	Memphis, TN-MS-AR	50009	MISSISSIPPI
30037	GOLDEN VALLEY	13740	Billings, MT	50010	MONTANA
31081	HAMILTON	24260	Grand Island, NE	50011	NEBRASKA
34023	MIDDLESEX	35614	New York-Jersey City-White Plains, NY-	50012	New Brunswick-Lakewood, NJ
34025	MONMOUTH	35614	New York-Jersey City-White Plains, NY-	50012	New Brunswick-Lakewood, NJ
34029	OCEAN	35614	New York-Jersey City-White Plains, NY-	50012	New Brunswick-Lakewood, NJ
36071	ORANGE	35614	New York-Jersey City-White Plains, NY-	50013	Poughkeepsie-Newburgh-Middletown, NY
37051	CUMBERLAND	22180	Fayetteville, NC	50014	Fayetteville, NC
37093	HOKE	22180	Fayetteville, NC	50014	Fayetteville, NC
45087	UNION	43900	Spartanburg, SC	50015	SOUTH CAROLINA
46033	CUSTER	39660	Rapid City, SD	50016	SOUTH DAKOTA
47081	HICKMAN	34980	Nashville-Davidson--Murfreesboro--Fran	50017	TENNESSEE
48007	ARANSAS	18580	Corpus Christi, TX	50018	TEXAS
48221	HOOD	23104	Fort Worth-Arlington, TX	50019	TEXAS
48425	SOMERVELL	23104	Fort Worth-Arlington, TX	50019	TEXAS
51029	BUCKINGHAM	16820	Charlottesville, VA	50020	VIRGINIA
51033	CAROLINE	40060	Richmond, VA	50021	VIRGINIA
51063	FLOYD	13980	Blacksburg-Christiansburg-Radford, VA	50022	VIRGINIA
53051	PEND OREILLE	44060	Spokane-Spokane Valley, WA	50023	WASHINGTON
54003	BERKELEY	25180	Hagerstown-Martinsburg, MD-WV	50024	Hagerstown-Martinsburg, MD-WV
24043	WASHINGTON	25180	Hagerstown-Martinsburg, MD-WV	50024	Hagerstown-Martinsburg, MD-WV
72083	LAS MARIAS	99940	PUERTO RICO	50025	Mayaguez, PR

COVID-19 UPDATED 12/1/2020



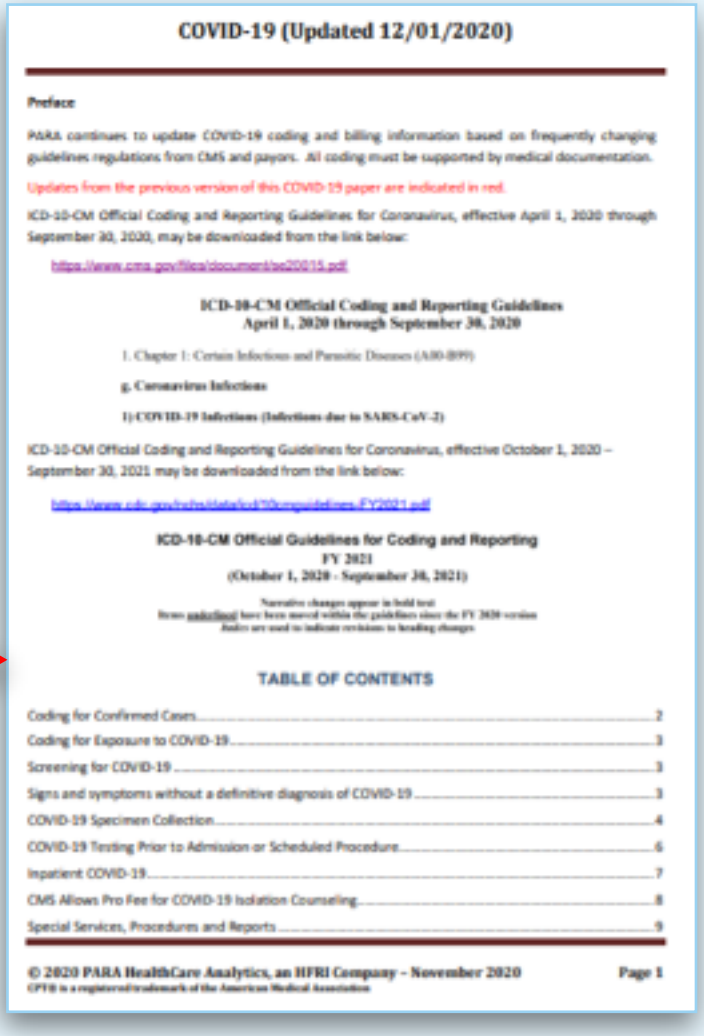
PARA HealthCare Analytics continues to update COVID-19 coding and billing information based on frequently changing guidelines regulations from CMS and payers. All coding must be supported by medical documentation.

Updates from the previous version of this COVID-19 paper are indicated in red, and test tables are updated.

ICD-10-CM Official Coding and Reporting Guidelines for Coronavirus, effective April 1, 2020 through September 30, 2020, may be downloaded from the link below:

https://apps.para-hcfs.com/para/Documents/COVID-19%20(Updated%2012-01-2020).pdf

Download the full 22-page update dated December 1, 2020, by clicking the link above or the document to the right.



COVID-19 (Updated 12/01/2020)

Preface

PARA continues to update COVID-19 coding and billing information based on frequently changing guidelines regulations from CMS and payors. All coding must be supported by medical documentation.

Updates from the previous version of this COVID-19 paper are indicated in red.

ICD-10-CM Official Coding and Reporting Guidelines for Coronavirus, effective April 1, 2020 through September 30, 2020, may be downloaded from the link below:

https://www.cms.gov/files/document/se20015.pdf

ICD-10-CM Official Coding and Reporting Guidelines
April 1, 2020 through September 30, 2020

1. Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)

g. Coronavirus Infections

1) COVID-19 Infections (Infections due to SARS-CoV-2)

ICD-10-CM Official Coding and Reporting Guidelines for Coronavirus, effective October 1, 2020 – September 30, 2021 may be downloaded from the link below:

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2021
(October 1, 2020 - September 30, 2021)

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 Page 1

RACS TO AUDIT INPATIENT DEFIBRILLATOR IMPLANT CLAIMS

On October 6, 2020, CMS approved a new nationwide Recovery Audit Contractor issue to examine whether medical necessity documentation requirements were met for inpatient implantable defibrillator claims.Since many providers remain unaware of the special restrictions placed on coverage of ICD implant procedures, hospitals may be blindsided by the impending audits and resulting recoupments.

RAC auditors will focus on inpatient defibrillator cases performed after a new National Coverage Determination became effective on February 15, 2019.The NCD requires a formal "shared decision making visit" between the patient and the physician prior to the procedure.If that visit was not conducted, reimbursement will be recouped in full.Since inpatient ICD cases are typically reimbursed at between $30,000 and $90,000, the threat is significant.

A link and an excerpt from the approved issue announcement on the CMS website:

https://www.cms.gov/node/1439781

Issue Name: 0195-Implantable Automatic Defibrillator- Inpatient Procedure: Medical Necessity and Documentation Requirements

Date: 2020-10-06

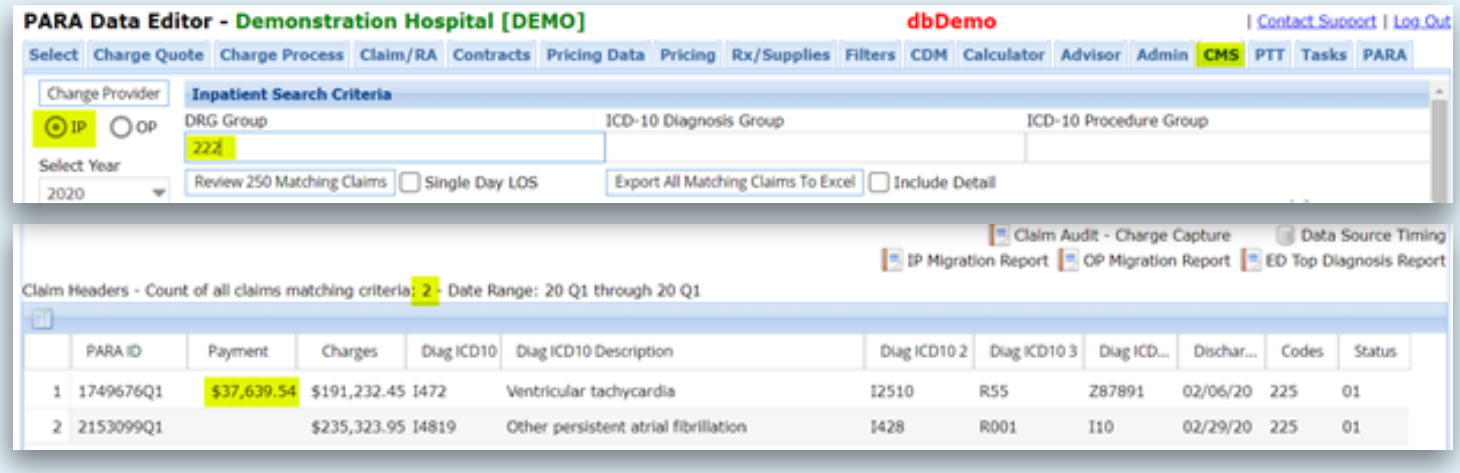
Review Type: Complex

Provider Type: Inpatient Hospital

MAC Jurisdiction: All A/B MACs

Description: The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.

PARA clients can identify the number of inpatient cases at risk of audit by using the CMS Claims Database on the **PARA Data Editor**. Search inpatient claims for DRG's 222, 223, 224, 225, 226, and 227:



RACS TO AUDIT INPATIENT DEFIBRILLATOR IMPLANT CLAIMS

The National Coverage Determination for Implantable Automatic Defibrillators (NCD 20.4) became effective February 15, 2019.The NCD is available on the CMS Coverage Database at the link below:

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=110&ncdver=4&DocID=20.4&bc=gAAAAAIAAAAA&

The NCD requires that most patients receiving an initial ICD placement must first attend a "formal shared decision making visit" with their doctor prior to the ICD placement procedure.If the ICD is placed without the required prerequisite visit, Medicare will not cover the procedure.Since payment is not predicated upon submitting the visit documentation in advance, many hospitals have been billing ICD cases and receiving substantial payments while unaware that the cases did not meet medical necessity.

Although the documentation of the shared decision making visit may not normally be found in the hospital medical record, hospitals remain fully at risk.Here's an excerpt from the Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

3.2.3.3 - Third-party Additional Documentation Request

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

...

Unless otherwise specified, the MAC, RAC and UPIC shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, RAC and UPIC.

In addition to other coverage requirements, the shared decision-making visit applies to the following categories of patients who may be considering an implantable ICD procedure:

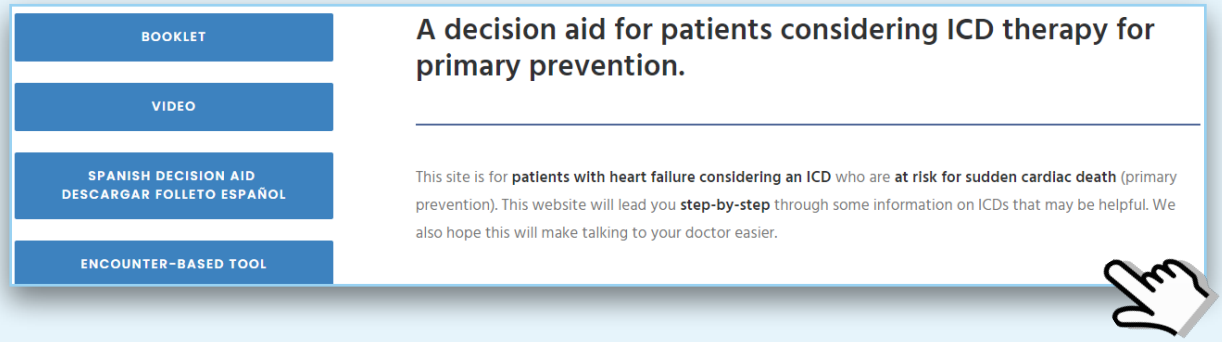
- Patients with a prior MI and a measured Left Ventricular Ejection Fraction (LVEF) < 0.30
- Patients who have severe, ischemic, dilated cardiomyopathy but no personal history of sustained VT or cardiac arrest due to VF, and have NYHA Class II or III heart failure, LVEF < 35%
- Patients who have severe, non-ischemic, dilated cardiomyopathy but no personal history of cardiac arrest or sustained VT, NYHA Class II or III heart failure, LVEF < 35%, been on optimal medical therapy for at least three months
- Patients with documented, familial or genetic disorders with a high risk of life-threatening tachyarrhythmias (sustained VT or VF, to include, but not limited to, long QT syndrome or hypertrophic cardiomyopathy

RACS TO AUDIT INPATIENT DEFIBRILLATOR IMPLANT CLAIMS

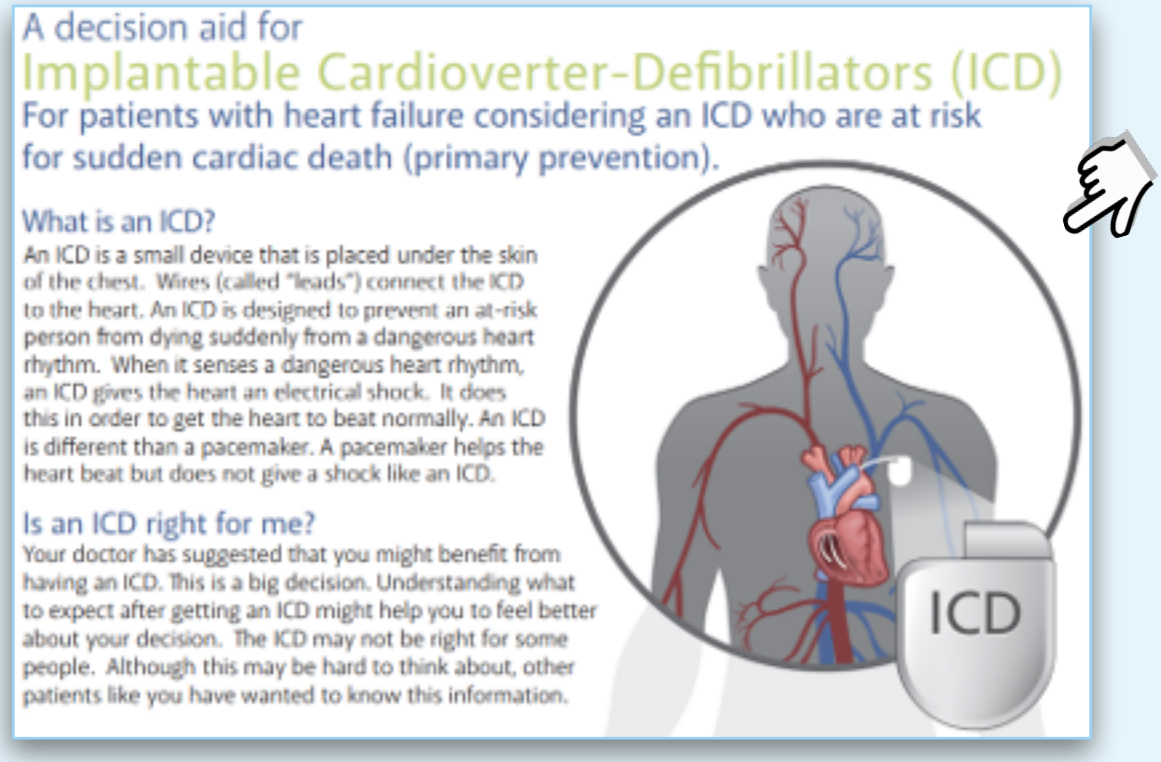
However, the shared decision-making visit is not required for patients with a personal history of sustained Ventricular Tachyarrhythmia (VT) or cardiac arrest due to Ventricular Fibrillation (VF), or patients that have had an ICD previously and require an ICD replacement procedure.

The formal shared decision-making encounter must occur between the patient and a physician or qualified non-physician practitioner using an evidence-based decision tool on ICDs prior to initial ICD implantation. The Colorado Program for Patient Centered Decisions offers such a tool at the following website:

https://patientdecisionaid.org/icd/



https://patientdecisionaid.org/wp-content/uploads/2016/06/ICDInfographic-4.8.19.pdf



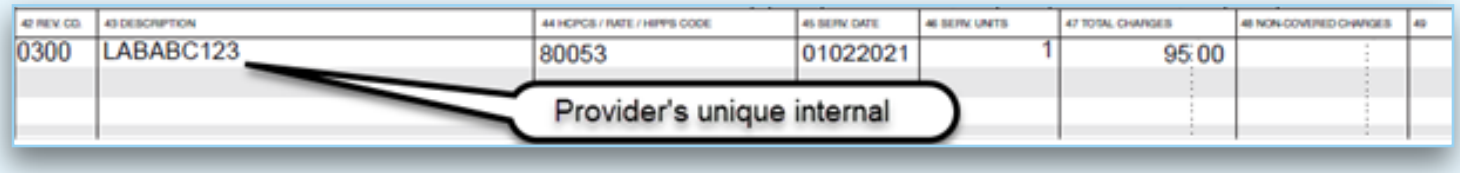
Hospitals would be well served to require evidence of the shared decision-making visit prior to performing an implantable defibrillator procedure for a Medicare beneficiary for both inpatient and outpatient cases.The procedure is costly due to the expensive purchased implants – lost revenue for these procedures is more than benign because the significant cost of the implanted defibrillator device itself is at risk.

UHC POSTPONES LABORATORY REGISTRY PROTOCOL TO JANUARY 1, 2022

United Healthcare has delayed, yet again, its payor-specific requirement for billing laboratory tests.Postponed multiple times due to the COVID-19 Public Health Emergency, UHC updated its website on November 30, 2020. The Laboratory Test Registry Protocol will now go into effect on **January 1, 2022.**

When the protocol becomes effective, claims submitted by an in-network freestanding or outpatient hospital laboratory must include the providing laboratory's **unique test code** for each service.

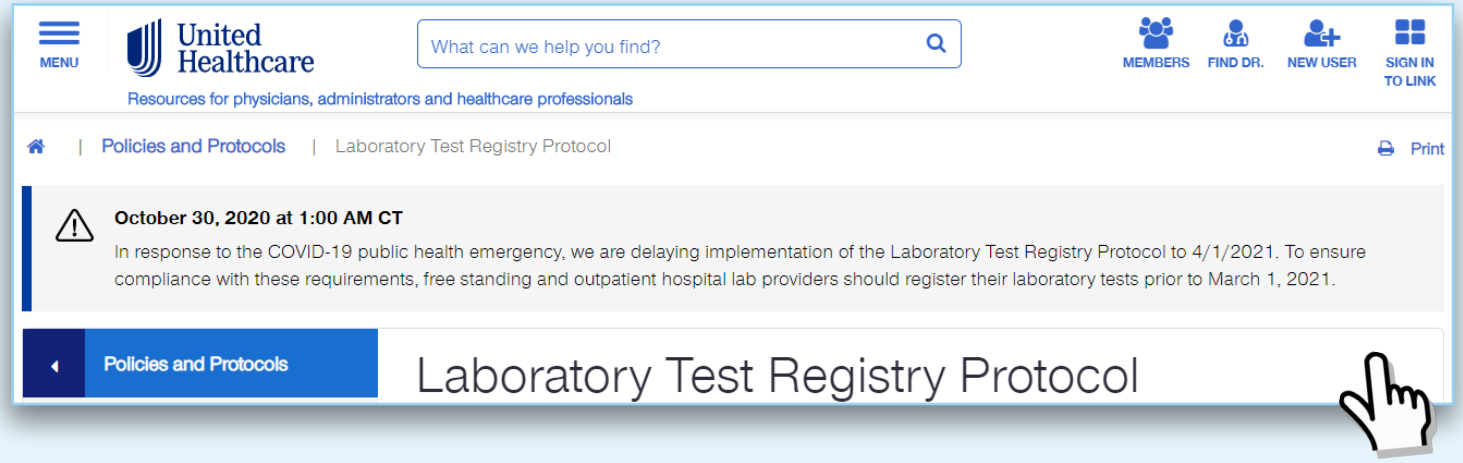
The unique test code is the mnemonic, order code, charge code, or other charge identifier that a physician would use to order a test from the registered laboratory. The unique test codes must match a list of test codes registered in advance with UHC.When a test on the claim does not cross-walk to the registry, UHC will deny the claim. The requirement applies to most UHC commercial, Medicare Advantage, and community plans.



UHC explains in their Test Registry Protocol Frequently Asked Questions that providing these test codes will "improve test transparency."The new billing rules will also serve to reduce provider reimbursement.

United Healthcare recommends that free-standing and outpatient hospital laboratories register no later than December 1, 2021.Testing claim submission using the new code requirements should begin as soon as the laboratory is registered.Laboratory providers can register and seek additional information through the United Healthcare site at the link below:

https://www.uhcprovider.com/en/policies-protocols/lab-test-registry.html



In its Test Registry Protocol Frequently Asked Question link, United Healthcare provided information on where to place the test code on a claim.

UHC POSTPONES LABORATORY REGISTRY PROTOCOL TO JANUARY 1, 2022

Preferred Laboratory UniqueTest Code Claim Locations

Claim	Lab CPT®/HCPCS Code Field	Unique Test Code Field (preface with the word "LAB")*
UB04 (CMS 1450)	Field Location 44	Field Location 43
837 Institutional	Loop 2400 SVV202-2	Loop 2400 SV202-7
837 Professional	Loop 2400 SVV101-2	Loop 2400 SV101-7
CMS-1500	Number 24D	Shaded Section above Number 24A thru 24G

Alternately (UHC states "For the Time Being")
Unique Test Codes Claim Locations

Claim	Lab CPT®/HCPCS Code Field	Unique Test Code Field *
837 Institutional	Loop 2400 SVV202-2	Service Line Number (NTE-Notes Section) Example: "NTE *TPO*LAB(unique test code)
837 Professional	Loop 2400 SVV101-2	Service Line Number (NTE-Notes Section) Example: "NTE *ADD*LAB(unique test code)

**** Do not place a space or special characters following the word LAB***

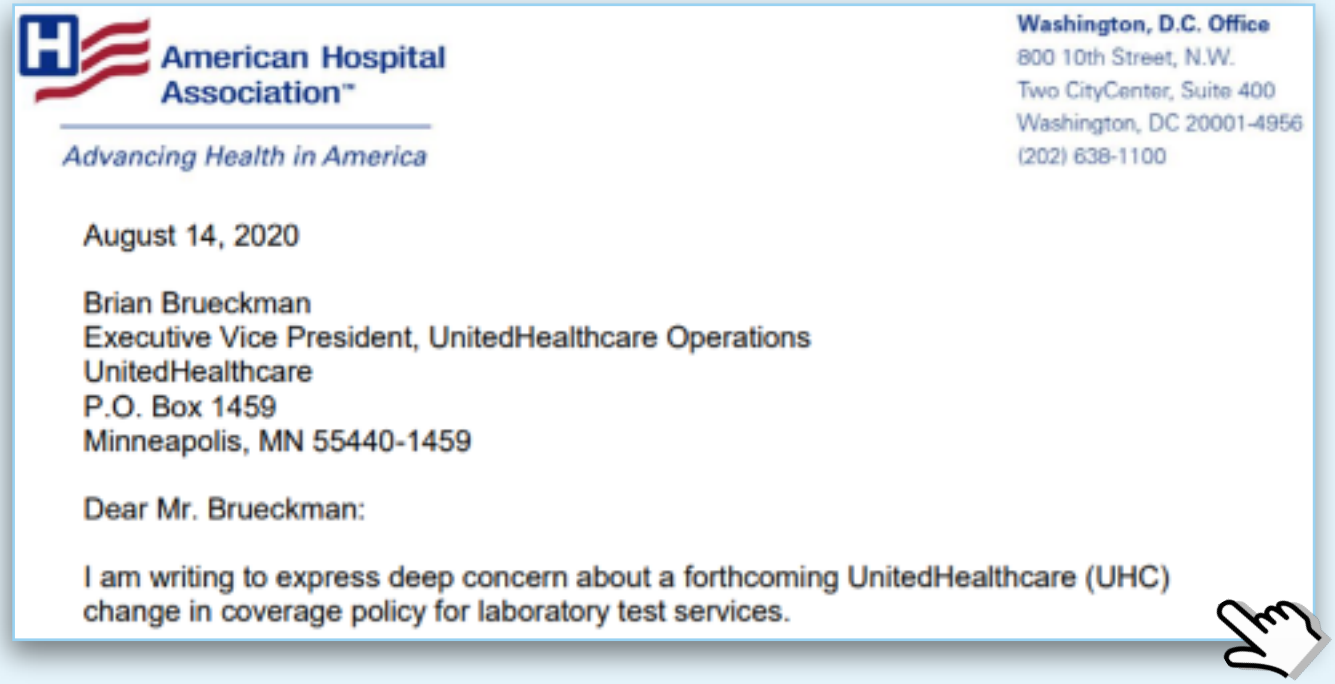
Molecular-Genetic Laboratory tests, which require may require a Genetic Testing Registry Identifier (GTR ID) depending whether they are included in the Genetic and Molecular Lab Testing Notification/Prior Auth Program, are excluded from this unique test code protocol.

A list of plans that are excluded from this requirement are listed on the UHC website.United Healthcare offers Live Training sessions as well as a reference guide.

UHC POSTPONES LABORATORY REGISTRY PROTOCOL TO JANUARY

In a letter to United Healthcare dated August 14, 2021, the American Hospital Association urged the payer to reconsider this requirement citing undue burden to hospitals already tasked with issues related to COVID-19.

https://www.aha.org/system/files/media/file/2020/08/aha-expresses-concern-forthcoming-unitedhealthcare-change-coverage-policy-laboratory-test-services-8-14-20.pdf



American Hospital Association™

Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

August 14, 2020

Brian Brueckman
Executive Vice President, UnitedHealthcare Operations
UnitedHealthcare
P.O. Box 1459
Minneapolis, MN 55440-1459

Dear Mr. Brueckman:

I am writing to express deep concern about a forthcoming UnitedHealthcare (UHC) change in coverage policy for laboratory test services.

The Hospital Healthsystem Association of Pennsylvania also included 25 other state Hospital Associations in a letter sent to United Healthcare dated September 22, 2020. In their letter Association expressed concerns about United Healthcare not meeting the requirements of HIPAA with this new protocol.

https://www.haponline.org/Resource-Center?resourceid=505

HAP The Hospital + Healthsystem Association of Pennsylvania

Advocacy | Public Health | Quality & Safety | News | Education | HAPevolve

Resource Center

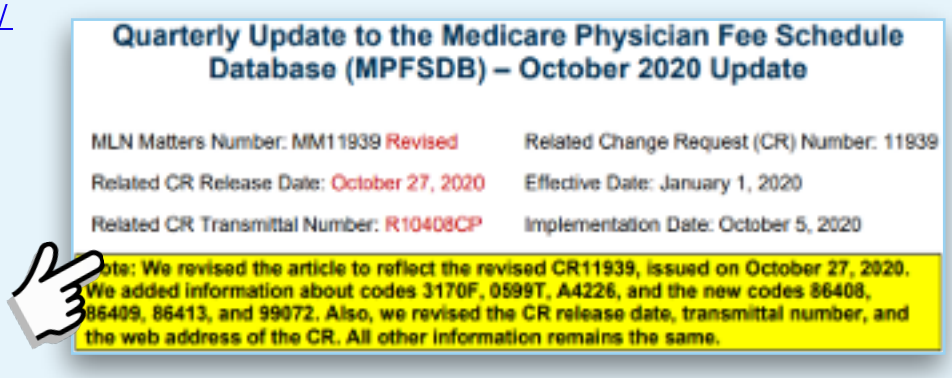
HAP Resource Center

Advocacy Correspondence: Joint Letter to UnitedHealthcare, Concerns about Change in Coverage Policy for Laboratory Test Services

LATE OCTOBER 2020 MEDICARE PHYSICIAN FEE SCHEDULE UPDATE

CMS issued a revised update to the Medicare Physician Fee Schedule on October 27, 2020, addressing several new CPT® codes released in October, 2020 by the American Medical Association.

https://www.cms.gov/files/document/mm11939.pdf



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

MLN Matters Number: MM11939 Revised	Related Change Request (CR) Number: 11939
Related CR Release Date: October 27, 2020	Effective Date: January 1, 2020
Related CR Transmittal Number: R10408CP	Implementation Date: October 5, 2020

Note: We revised the article to reflect the revised CR11939, issued on October 27, 2020. We added information about codes 3170F, 0599T, A4226, and the new codes 86408, 86409, 86413, and 99072. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

Of particular interest, CMS will accept CPT® 99072 on professional fee claims on or after September 8, 2020, although this code will not generate additional reimbursement. The MPFS Status indicator assigned to 99072 is B, "**Bundled code. Payment for covered services are always bundled into payment for other services not specified.**"

99072 - Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease

The following new CPT®s for lab codes were assigned MPFS Status Indicator X effective August 10, 2020 – status X means they are not payable under the MPFS, but payable under another fee schedule (i.e. Clinical Laboratory Fee Schedule):

86408 - Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-COV-2) (coronavirus disease [COVID-19]); screen

86409 - Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-COV-2) (coronavirus disease [COVID-19]); titer

86413 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative

Medicare also assigned MPFS status indicator I (Not valid for Medicare purposes) to A4226 effective September 15, 2020:

A4226 - Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week

REVISED: HOME HEALTH PENALTY FOR DELAYED RAP

CMS recently revised MLN Matters Article MM11855. This Transmittal advises Home Health Agency (HHA) providers about the CY 2021 Home Health (HH) Request for Anticipated Payment (RAP) payment policies.

These payment policies will be implemented as of January 4, 2021.

Beginning in CY2021, the split-percentage payment will be lowered to zero (0) percent for all HHAs (includes newly enrolled and existing). However, all HHAs would still be required to submit a RAP at the beginning of each 30-day period of care (84FR60548). Since no payment will be associated with the submission of the RAP in CY2021, HHAs are to submit a RAP when:

- The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented as required in accordance with 4.2 Code of Federal Regulations (CFR) Sections 484.60(b) an 409.43(d); and
- The initial visit within the 60-day certification period has been made and the individual is admitted to HHA care (84 FR 60548)

The information needed for submission of the RAP in CY 2021 will mirror the one (1) time Notice of Admission (NOA) process, also finalized in the CY 2020 HH PPS Final Rule with comment period, starting CY 2022 (84 FR 60549).

In scenarios where the plan of care dictates multiple 30-day periods of care will be required to effectively treat the beneficiary, HHAs will be allowed to submit RAPs for both the first and second 30-day periods of care (for a 60-day certification) at the same time to help further reduce provider administrative burden (84 FR 60549).

In addition, beginning CY2021, there will be a non-timely submission payment reduction when the HHA does not submit the **RAP within 5 calendar days from the start of care date** (admission date and from date on the claim will match the start of care) for the first 30-day period of care in a 60-day certification period and within 5 calendar days of the from date for the second 30-day period of care in the 60-day certification period.

This penalty reduction in payment will be equal to a 1/30th reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the HH start of care date/admission date, or from date for subsequent 30-day period payment amount, including any outlier payment, that the HHA otherwise would have received absent any reduction.

For Low Utilization Payment Adjustment (LUPA) 30-day periods of care in which an HHA fails to submit a timely RAP, no LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP. The penalty payment reduction cannot exceed the total payment of the claim. The penalty payment reduction for the late submission of a RAP can be waived for exceptional circumstances as outlined in regulations at 42 CFR 484.205(i)(3).

MACs will accept the KX modifier when reported with the Health Insurance Prospective Payment System (HIPPS) code on the revenue code 0023 claim line of Type of Bill (TOB) 032x (except 0322 and 0320) as an indicator that an HHA requests an exception to the late RAP penalty.

REVISED: HOME HEALTH PENALTY FOR DELAYED RAP

In addition, the HHA should provide sufficient information in the Remarks section of its claim to allow the MAC to research the exception request. However, if the remarks are not sufficient the MAC will request additional documentation from the HHA.

There are four circumstances that may qualify the HHA for an exception to the consequences of filing the RAP more than five (5) calendar days after the HH period of care "From" date:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate

2. An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond the control of the HHA

3. A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC

4. Other circumstances determined by the MAC or CMS to be beyond the control of the HHA

Revision: Service Date Reporting:

Currently, for initial episodes/periods of care, HHAs report 0023 revenue code at the claim level, to associate the first covered visit provided during the episode/period. For all subsequent episodes, the HHA reports 0023 revenue code at the claim level, the date that associates the first visit date provided during the episode/period, regardless of whether the visit was covered or non-covered, unless an exception applies. (exceptions 1-4 outlined above)

On implementation of this Transmittal, a new exception applies when submitting RAPs for all subsequent periods of care for CY2021. The HHA may submit RAPs with the first day of the period of care as the service date on the revenue code claim line 0023. This will allow for the submission of RAPs for two 30-day periods of care immediately after the start of a 60-day certification period. In doing this, it will also prevent delaying the submission of the RAP for subsequent periods when the first visit in that period would be beyond the 5-day timeframe for a timely-filing RAP.

Remarks: Conditional: If the RAP that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty, enter the information supporting the exception category that applied to the RAP.

If the RAP that corresponds to a claim was originally received timely but the RAP was cancelled and resubmitted to correct a claim error, enter remarks to indicate the condition. Example: Timely RAP, cancel and rebill).

Append modifier KX to the HIPPS code reported on the revenue code 0023 claim line. It is recommended by CMS, HHA providers should resubmit corrected RAPs generally within 2 business days of canceling the original RAP.

Remarks are otherwise required on a claim only when cases involving claim cancelling or adjustments (bill types 327 or 328).

REVISED: HOME HEALTH PENALTY FOR DELAYED RAP

Other items of note from this Transmittal update are:

1. Value codes 61 and 85 are optional for RAPs with "From" dates on and after January 01, 2021.

61 Place of Residence Where Service Is Furnished (HHA and Hospice)

This code indicates the MSA or CBSA number (or rural state code) of the place of residence where the home health or hospice service is delivered. Effective July 1, 2018, this field should be left-justified.

- This code is required for Medicare home health and hospice billing, when applicable.
- Home health episode payments are based upon the site at which the beneficiary is served. RAPs and claims will not be processed without this value code. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 10, sec. 40.2)
- Enter the MSA or CBSA number where care is being rendered, not the agency location.
- Hospices must report value code 61 when RC 0651 or 0652 is reported in FL 42. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 11, sec. 30)
- When home hospice services are provided in more than one CBSA during the billing period, report the CBSA that applies at the end of the billing period. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 11, sec. 30.3)

85 County where Service is Rendered (effective January 1, 2019)

Report the Federal Information Processing Standards (FIPS) state and county codes when required by law or regulation. There should be no space between the state and county code.

2. Other Diagnosis Codes are optional for RAPs with "From" dates on and after January 01, 2021.

Reference for this article can be found at:

https://www.cms.gov/files/document/mm11855.pdf

Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation

MLN Matters Number: MM11855 Revised	Related Change Request (CR) Number: 11855
Related CR Release Date: September 24, 2020	Effective Date: January 1, 2021
Related CR Transmittal Number: R10369CP	Implementation Date: January 4, 2021

Note: We revised this article to reflect the revised CR 11855 issued on September 24, 2020. The CR revision changed Service Date reporting instructions in Chapter 10, section 40.1 and instructions for Remarks in section 40.2 of the manual attachment of the CR. We included those instructions in this article. We also changed the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

HIGH THROUGHPUT COVID-19 TEST CODING UPDATE

Medicare will change how it reimburses high-throughput COVID-19 testing on 1/1/2021. High-throughput laboratory equipment is capable of automated processing of more than 200 specimens a day. Operators must have specialized technical training to operate the equipment properly.In April, 2020, Medicare created two HCPCS which represent high-throughput testing, which CMS will reimburse at $100 per test through December 31, 2020:

HCPCS	Description	Effective Date
U0003	Infectious agent detection by nucleic acid (DNA or RNA) severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique), making use of high throughput technologies as described by CMS-2020-01-R	04/14/2020
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R	04/14/2020

Report **U0003** in place of tests that were reported as **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) when high-throughput technology is used.

HCPCS **U0004** should be reported in place of **U0002** (2019-ncov Coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non-cdc.) when high-throughput technology is used.

Effective January 1, 2021 and throughout the Public Health Emergency, Medicare will reduce payment for U0003 and U0004 to $75, but Medicare will pay an additional $25 for new add-on HCPCS code **U0005:**

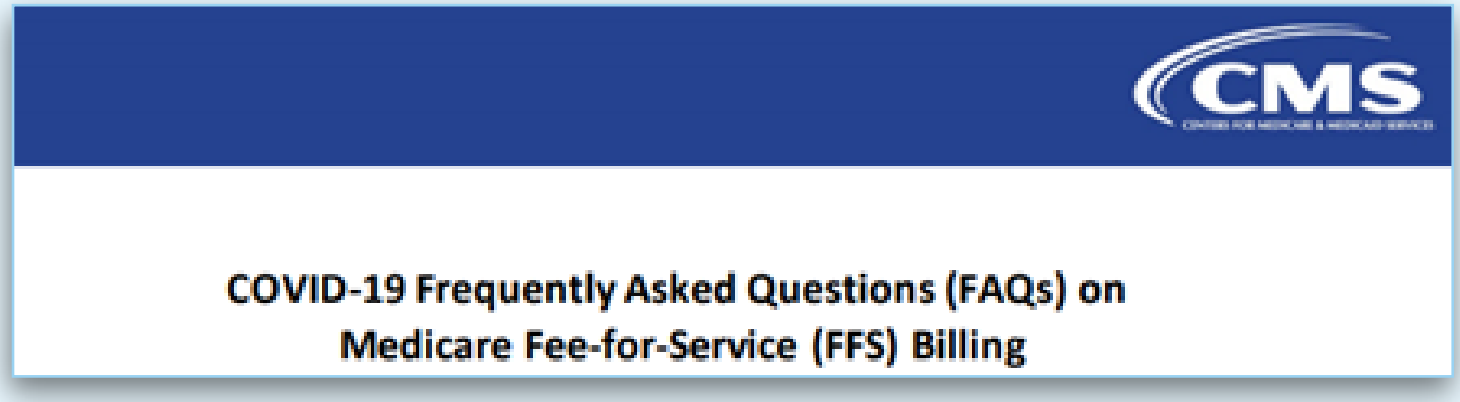
HCPCS	Description	Effective Date
U0005	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within two calendar days from date and time of specimen collection. (List separately in addition to either HCPCS code U0003 or U0004)	01/01-2021

HIGH THROUGHPUT COVID-19 TEST CODING UPDATE

U0005 may be reported if the COVID-19 lab test is completed within two calendar days of the specimen collection AND the laboratory completed 51% of high throughput testing for all patients (not only Medicare beneficiaries) in the previous month within two calendar days. The laboratory must maintain records of its monthly assessments of timely results reporting.CMS instructs MACs to conduct claim reviews and audits to ensure providers are compliant with the Ruling.

This change in reimbursement is addressed in Medicare's Frequently Asked Questions publication regarding Medicare FFS Billing, under D. High Throughput COVID-19 Testing:

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



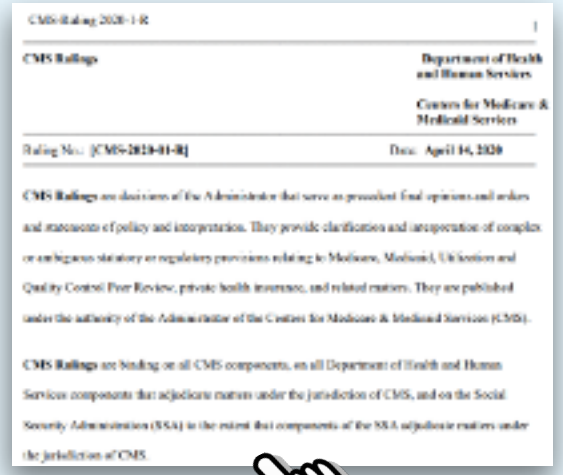
COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

D. High Throughput COVID-19 Testing

1. **Question:** Why did CMS create HCPCS codes U0003, U0004 and U0005?
   Answer: CMS created two new HCPCS codes, effective for dates of service on or after April 14, 2020, specifically for Clinical Diagnostic Laboratory Tests (CDLTs) making use of high throughput technologies, that is, technologies that use a platform that employs automated processing of more than 200 specimens a day, as described in CMS Ruling No. CMS-2020-1-R, available at https://www.cms.gov/files/document/cms-2020-01-r.pdf.

...
CMS provides a partial list of accepted technology high-throughput machines In Ruling2020-1-Rdated April 14, 2020:

https://www.cms.gov/files/document/cms-2020-01-r.pdf



CMS Ruling 2020-1-R

CMS Rulings

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Ruling No.: [CMS-2020-01-R] Date: April 14, 2020

CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters. They are published under the authority of the Administrator of the Centers for Medicare & Medicaid Services (CMS).

CMS Rulings are binding on all CMS components, on all Department of Health and Human Services components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration (SSA) to the extent that components of the SSA adjudicate matters under the jurisdiction of CMS.

Medicare re-evaluated testing resources in Ruling 2020-1-R2 dated January 1, 2021:

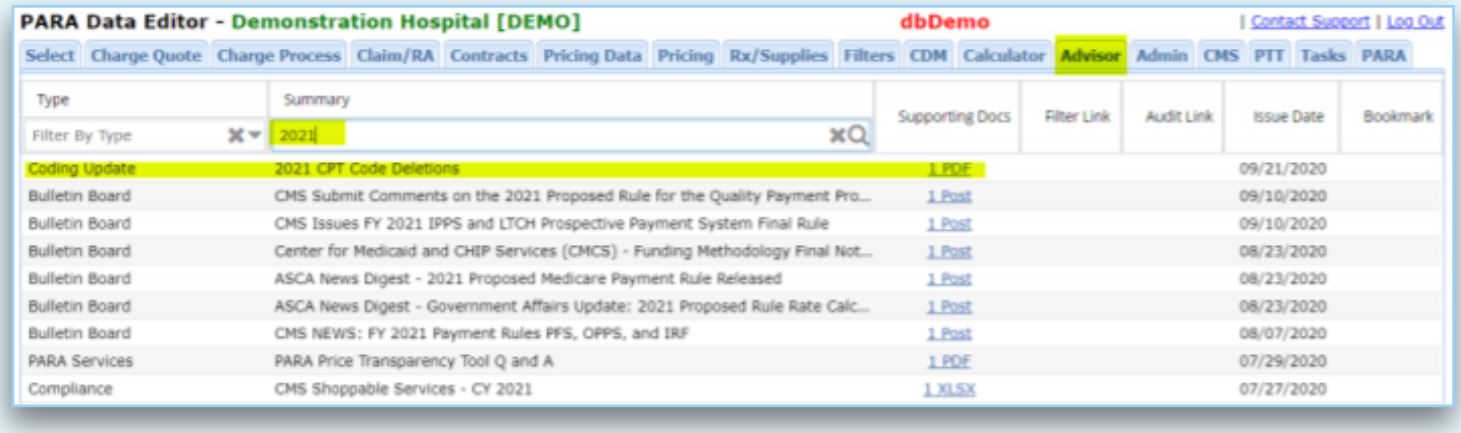
https://www.cms.gov/files/document/cms-ruling-2020-1-r2.pdf

HCPCS U0003 and U0004 should not be used when testing for COVID-19 antibodies.

PREVIEW OF CPT® DELETIONS IN 2021

The CPT® Coding Update for 2021 looks lighter than in recent years, at least as it would impact hard-coded line items in hospital chargemasters.

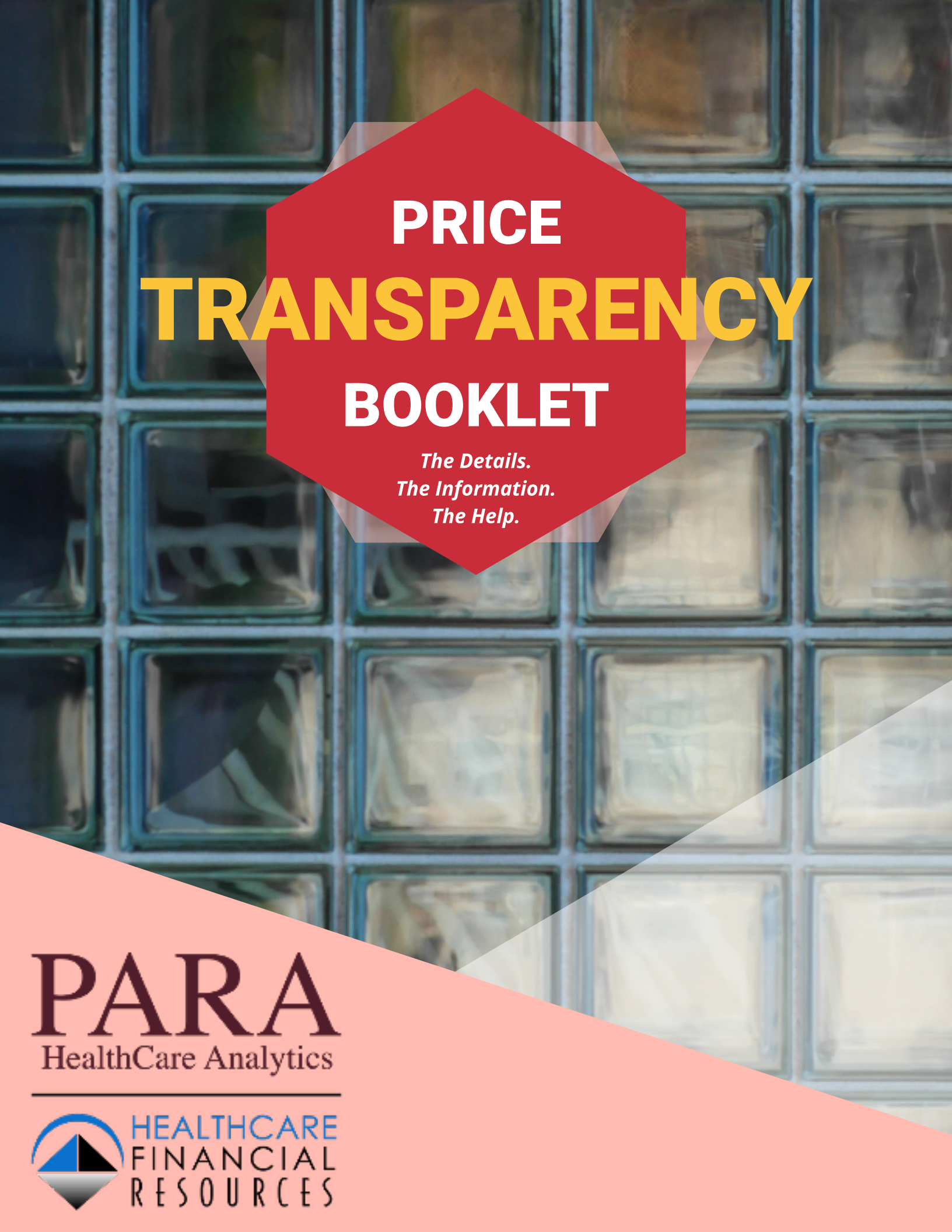
PARA Data Editor (PDE) users who are eager for a preview can access a list of the CPT® codes which will be deleted effective 1/1/21 on the **PARA Data Editor Advisor** tab. Navigate to the Advisor and enter "2021" in the Summary field:



The listing available in the Advisor is informational and carries only the list of CPT® deletions. Additional HCPCS code updates (e.g., J-codes, G-codes, C-codes, etc.) will not be finalized until the release of the OPPS Final Rule, expected in early November.

As usual, **PARA** clients will be guided through the year end CPT®/HCPCS coding update with three editions of a 2021 code map prepared specifically for the client chargemaster.

The first edition of our 2021 code map will be delivered to clients in mid-October, 2020.



PRICE TRANSPARENCY BOOKLET

The Details.
The Information.
The Help.

PARA
HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

CMS began introducing price transparency requirements in 2015 when it first required hospitals to provide a list of standard charges upon request of the patient. However, it was not until the 2019 final rule that they began to require hospitals to publish standard charges in a frequently updated, machine-readable format, online, not just upon request.

The President's Executive Order in June 2019 promoted increased availability of meaningful pricing information for patients.Therefore, CMS' FY2020 Proposed Rule attempted to support this initiative by further defining the requirements for transparency.

It requested payer-negotiated rates for charges and a separate list of "shoppable" services including 230 hospital-selected and 70 CMS- selected services.The rule also outlined monitoring and enforcement including a monetary penalty and corrective action plans from hospitals.

It is important to note that some states have been requiring a version of this rule for many years (except for the payer specific charges component).States' efforts to address surprise billing issues has not gone unnoticed.For example, some states have required annual posting of chargemasters, a selection of hospital financial reports, and/or a listing of common procedures for several years, demonstrating that states have been proactively addressing transparency for a while now. Other states are also beginning to require some form of price transparency in the coming year.

As you can see in the timeline, The American Hospital Association (AHA) opposed the CMS proposed rule as it was written. Their belief is that this approach would only further confuse patients in their search for information and would disrupt contract negotiations between payers and hospitals.

The current healthcare environment is riddled with various pressures in terms of thinning operating margins, health plan competition and a shortage of internal resources, namely IT Resources, to fulfill the requirements.Also, reimbursement methodologies and packaging rules disrupt our ability to provide a true "list" of meaningful prices that would be actionable for patients.

In June 2020, there was a summary judgement against the AHA where a Federal Judge upheld the legality of the rule stating that it would allow patients to make pricing comparisons between hospitals.The AHA is appealing this decision.

INTRODUCTION

However, this may become a moot point because on June 30th, a group of Senators introduced the Healthcare PRICE Transparency Act written to demand transparency through legislation.

The group of Republican Senators behind this legislation built on the president's executive order as it would require hospitals and insurers to reveal cash prices and negotiated rates prior to the receipt of medical care.So, although we've been treating it as a CMS Requirement, chances are good that it could become a Federal Law, which eliminates any chance of challenging the requirements in court.

Based on all of this, we are moving forward with implementing Price Transparency solutions effective January 1, 2021, for hospital clients and assisting in the data mining required to report this information to healthcare consumers.We, as an organization, have supported the idea of pricing transparency and true patient estimator tools for many years now.We are advocates of finding a solution that is capable of providing meaningful price information for patients and have worked to fulfill this need for many of our hospitals for many years.

We believe that facilities must go the extra mile to ensure that the information they are providing to patients is useful and intuitive. While we don't agree with some components of the rule and find issue with how some information is displayed, we realize ultimately, something of this nature will be implemented, so we are working with our clients to get them ahead of the curve.So, what does all of this mean, what are the requirements exactly, and what does this look like?The next few pages are a useful guide to CMS Price Transparency.

THE CLOCK IS TICKING

DATES, RULES & REGS

The CMS final rule (CMS-1717-F2) aims to make hospital price information readily available to patients, so they can compare costs and make more informed healthcare decisions. Meeting the deadline and maintaining compliance will be no small endeavor for providers. Complying with the mandate will be a large undertaking that requires multi-disciplinary coordination. ***PARA HealthCare Analytics and HFRI can help navigate the dates, the rules and the regulations****.*

REQUIREMENT #1

By January 1, 2021, hospitals are required to be in compliance with the Hospital Price Transparency requirements set forth in the CY 2020 Hospital Outpatient PPS Policy Changes (CMS-1717-FS).

REQUIREMENT #2

A comprehensive machine-readable file that includes the specific standard charges for all hospital items and services.

REQUIREMENT #3

A consumer-friendly display that includes the standard charges for at least 300 "shoppable" services that are grouped with charges for ancillary services that ar customarily provided by the hospital.


QUARTZ

SOLUTIONS FOR HOSPITALS

THE PARA PTT

In speaking with hospital associations, clients, and business vendor groups, we are finding that we are one of the only vendors who can completely satisfy, to the letter of the law, both CMS requirements in a fully customizable manner.

Providers will need to publish both machine-readable format files and the patient facing price estimator is a value-add service for enhancing price transparency.

PARA will use the CMS Extract file embedded in the Price Transparency Tool tab via the **PARA Data Editor** to build the shoppable items/bundles. This can be done by the hospital, coupled with **PARA's** guidance to ensure all primary procedures are linked to its customarily paired ancillary services.

Turnaround time for the **Price Transparency Tool** is 60 days from submission of completed data, however subject to change as we get closer to the January 1, 2021 deadline.

There is no limit at this time on how many clients **PARA** can assist with the CMS' 2021 price transparency requirements as we are constantly monitoring workload and innovating our automation to support the data mining need for this initiative.

TAKE A TEST DRIVE

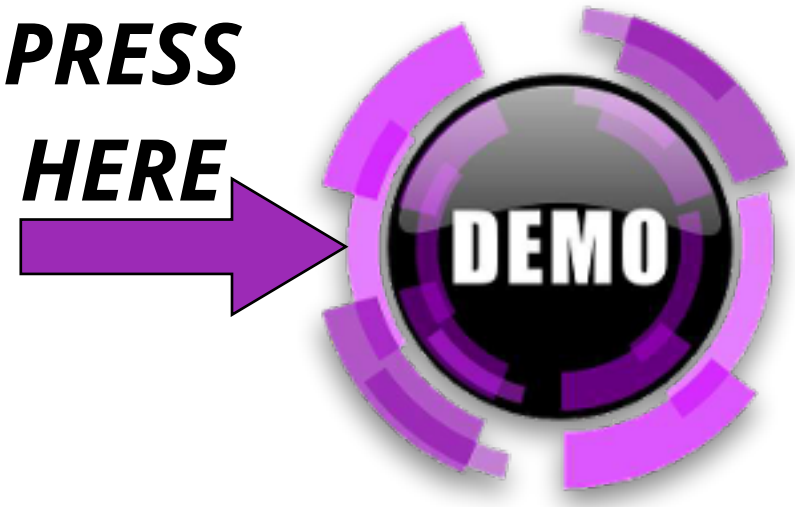
DEMO THE PARA TOOL

It's easy to find out just how the Price Transparency Tool from **PARA HealthCare Analytics** works.

Click on the DEMO button to find out just how your patients can navigate through your installed Price Transparency Tool. They'll be impressed that your hospital has made comparing prices simple, accurate and informative.

Try it out! You'll be impressed. But impressing you isn't our goal. Helping your hospital become compliant is our goal.

Once you've taken the "test drive", contact one of our **PARA Price Transparency** experts to get started on your compliance journey.



PARA'S PRICE TRANSPARENCY TOOL

1. Ensure compliance with the January 1, 2019 and January 1, 2021 CMS mandates for Price Transparency:
    a. Post a listing of all services and prices available at the facility in a machine-readable format
    b. Include payer specific reimbursement information for all services available at the facility

2. Provide customized and meaningful information for patients. Take the guess work out of obtaining an estimate.

3. Improve collections. Patients will know their liability before the service is provided. They can even prepay!

4. Web based solution. Simple implementation. No software to install.

5. Comprehensive tool that pulls
    a. Top services at a facility
    b. User's insurance information via eligibility checking
    c. Registration information to return usage statistics readily available to the facility

TEN REASONS, CONT.

6. Highly customizable

a. The style and functionality of the tool to be directly embedded on the facility website

b. The services available on the Decision Tree and how they are presented (i.e. descriptions, categories)

c. The Prices that are presented (e.g., Average Line Charge, Average Package Charge, Average CDM Charge, etc.)

d. The programming to meet all expectations and functionality

7. Always up to date with the latest information for all users. With no additional work on behalf of the hospital once implemented. Fully serviced and managed on **PARA's** servers with all data and functionality accessible by the facility through the **PARA Data Editor**.

8. Ongoing feature upgrades and improvements that reflect changes in practice, technology, and services.

9. Reporting capabilities to review all activity on hospital website and what services are being shopped.

10. Most cost-effective solution in the industry. **PARA's** cost to deploy its solution is market competitive and in line with what CMS is saying healthcare organizations should pay for to implement a patient price estimator.

10 STEPS TO SUCCESS

1. Take the Price Transparency test drive
2. Contact a **PARA Account Executive** to guide you through the process
3. Identify each hospital location that must make available its list of standard charges
4. Identify all items and services for which your hospital has established a standard charge
5. Gather the required data elements for each item and service
6. Select your file format
7. Name your machine-readable file according to the CMS naming convention
8. Post your machine-readable file prominently on a publicly available website
9. Update your comprehensive machine-readable file annually
10. Double check that you've met the requirements

LET OUR EXPERTS GUIDE YOU

DON'T WAIT!
CONTACT OUR EXPERTS

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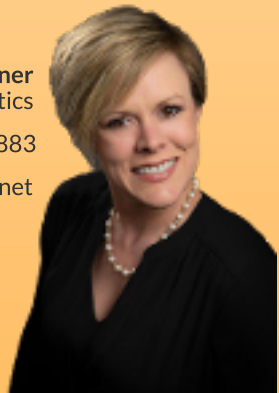
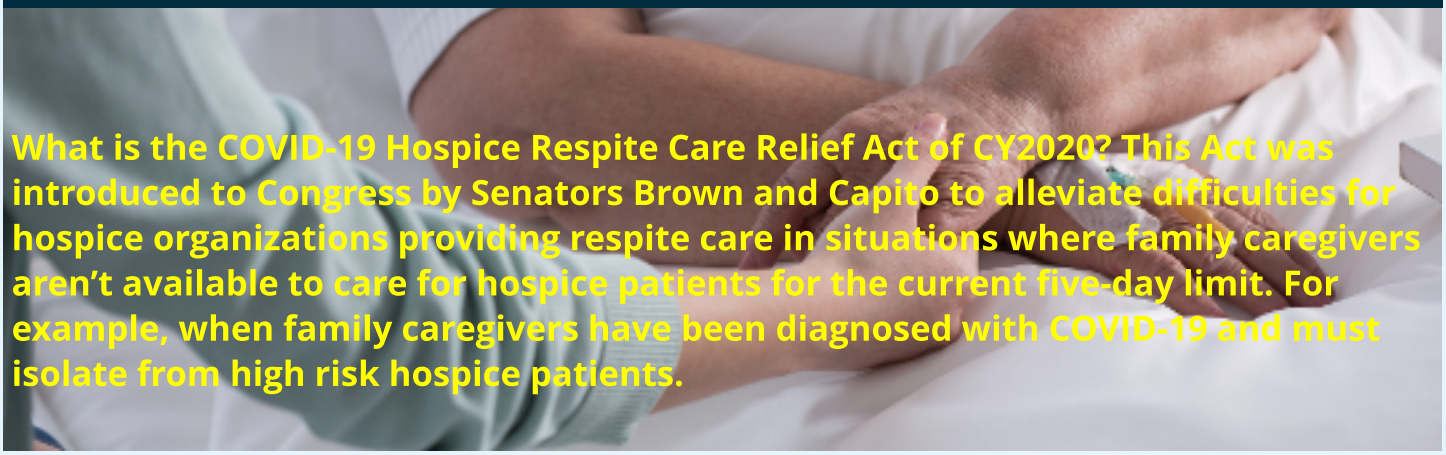


PALLIATIVE CARE AND COVID-19



In addition, adding to the difficulties, there may be patients unwilling to enter a facility due to the potential risk of contracting COVID-19 or there may be no respite beds available.

https://www.congress.gov/bill/116th-congress/senate-bill/4423

116TH CONGRESS
2D SESSION

S. 4423

To amend title XI of the Social Security Act to provide the Secretary of Health and Human Services with the authority to temporarily modify certain Medicare requirements for hospice care during the COVID public health emergency.

IN THE SENATE OF THE UNITED STATES

AUGUST 4, 2020

Mr. BROWN (for himself and Mrs. CAPITO) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XI of the Social Security Act to provide the Secretary of Health and Human Services with the authority to temporarily modify certain Medicare requirements for hospice care during the COVID public health emergency.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "COVID–19 Hospice Respite Care Relief Act of 2020".

Medicare's Hospice Respite Care Benefit enables Medicare beneficiaries receiving hospice services and their caregiver(s) to be eligible for short-term, inpatient, respite care services. Medicare will cover respite care if the hospice beneficiary's primary caregiver is ill, needs rest, or is otherwise unable to care for the hospice patient.

However, there are limitations under the current law which restricts Medicare beneficiaries to access the hospice respite care benefit in an inpatient facility setting only. Examples of facilities could be a hospital, inpatient hospice center or nursing home. The current restrictions are limited to a five-day stay.

With the adoption of this amendment, it will provide the Secretary of Health and Human Services (HHS) with the authority to make the hospice respite care benefit flexible during ANY current public health emergency (PHE), including the current COVID-19 crisis.

PALLIATIVE CARE AND COVID-19

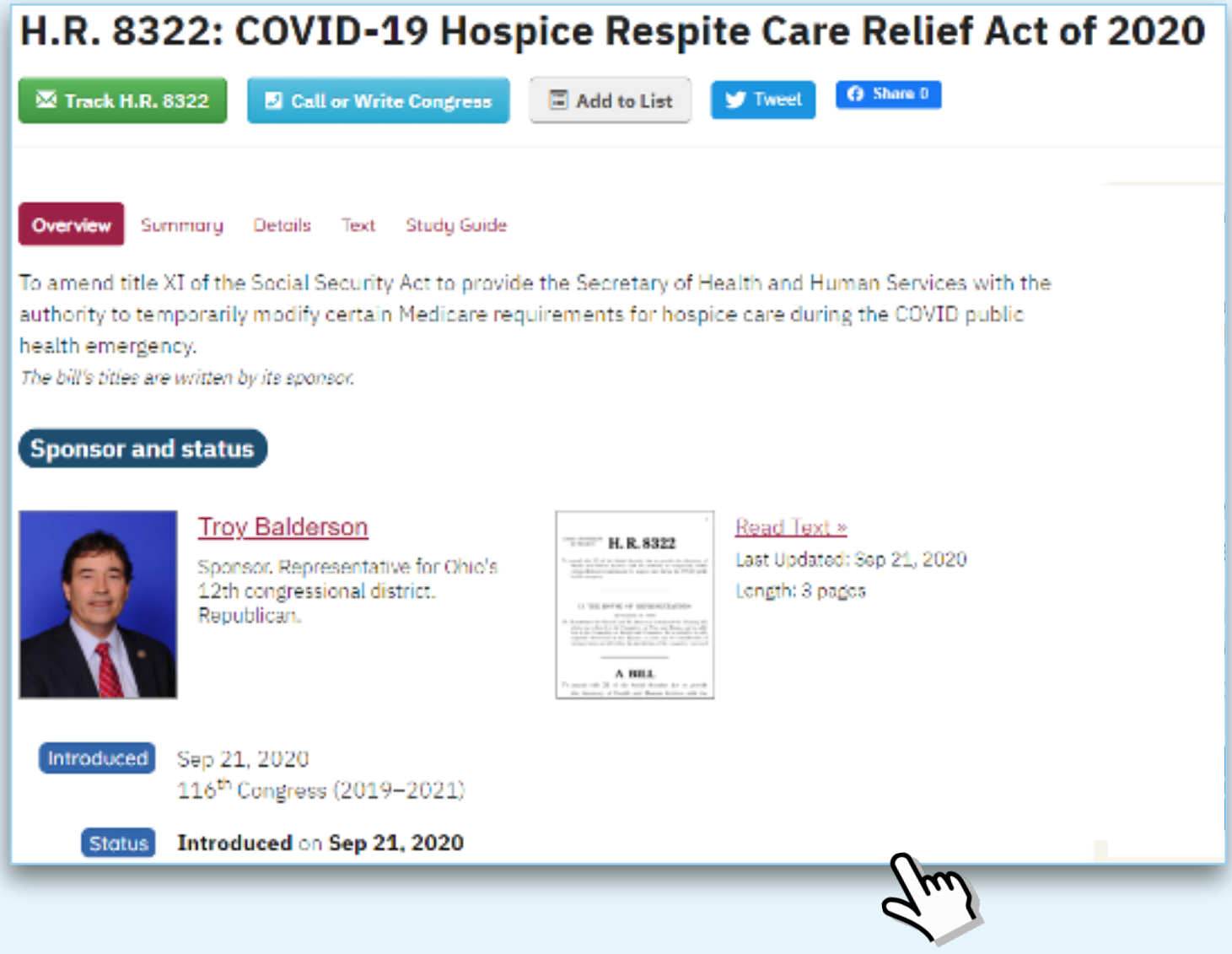
This expanded benefit will open up access for hospice beneficiaries in two (2) ways:

1.Authority to waive the five-day maximum benefit when the caregiver(s) is unable to provide care due to illness or isolation, for up to 15 days.

2.Authority to waive the requirement that respite care only be provided in the inpatient setting, expanding the hospice respite benefit available to hospice patients in their place of residence, protecting and reducing the patient from COVID-19 exposure risks.

This bill is currently still in legislation and the progress can be tracked at the link below:

https://www.govtrack.us/congress/bills/116/hr8322



CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

CMS released details of the October, 2020 OPPS HCPCS Update on August 28, 2020, and added a few points later, on September 24, 2020.

PARA chargemaster clients will be notified by email prior to 10/1/2020 of any required chargemaster updates. Sections with revised information are highlighted.

COVID-19 Testing and Related Services

CMS reaffirmed and updated COVID-19 Lab Testing HCPCS – repeating previously established codes and adding new codes developed since the last quarterly update

Addressed New CPT® 99072 for Additional Practice Expense during a Public Health Emergency

Surgical HCPCS

Three new surgical HCPCS Codes were added:

Drugs, Biologicals, and Radiopharmaceuticals

Two drugs will be newly excluded from OPPS coverage (status E1); both were previously payable.

Fourteen new Drug and Radiopharmaceutical HCPCS Codes and Dosage Descriptors were added.

Three biosimilar drug HCPCS codes will be assigned Pass-Through status (payable statusG):

Pass-through status ends for five drugs on 10/01/2020; they will become status N, not separately paid.

Pass-through status (status G) will be newly assigned to seven HCPCS previously paid as APC status K:

The long descriptors for two HCPCS have been revised:

Updated the quarterly Average Sales Price file, which can change APC rates for status K drugs.

Skin Substitutes

Four new "low cost" skin substitute codes were created and assigned to OPPS status N, payment packaged; Medicare payment under OPPS is packaged to the application procedure C5271-C5278:

Two HCPCS previously paid (pass-through status G) are no longer separately paid under OPPS.

Three skin substitute HCPCS have been reassigned to the "High Cost Skin Substitute Group":

Laboratory

Two new CPT® Codes for Multianalyte Assays with Algorithmic Analyses (MAAA) were added:

Payment policy for twenty new CPT® Proprietary Laboratory Analyses (PLA) Codes was established.

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

COVID-19 Testing and Related Services

CMS reaffirmed and updated COVID-19 Lab Testing HCPCS – repeating previously established codes and adding new codes developed since the last quarterly update

- **U0001** CDC 2019 Novel Coronavirus (2019-nCoV) RealTime RT-PCR Diagnostic Panel; Effective 2/4/2020, OPPS Status A
- **U0002** 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC;Effective 2/4/2020, OPPS Status A
- **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; Effective 3/13/2020, OPPS Status A
- **86328** Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); Effective 4/10/2020; OPPS status A
- **86408** Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen; Effective 8/10/2020, OPPS status A
- **86409** Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer 08/10/2020 A N/A 86769 Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) 04/10/2020 A N/A 87426 Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzymelinked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]); Effective 6/25/2020, OPPS status A
- **86413** (Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative); Effective 9/8/2020, OPPS status A
- **U0003** Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020- 01-R; Effective 4/14/2020, OPPS status A
- **U0004** 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020- 01-R; Effective 4/14/2020, OPPS status A
- **0202U** Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected 05/20/2020 A N/A 0223U Infectious disease(bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA),

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected; Effective 6/25/2020, OPPS status A

- **0224U** Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed; Effective 6/25/2020, OPPS Status A

- **0225U** Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected; Effective 8/10/2020, OPPS status A

- **0226U** Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum ; Effective 8/10/2020, OPPS status A

- **G2023** Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source; Effective 3/1/2020, OPPS status B

- **G2024** Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source; Effective3/1/2020, OPPS status B

- **0014M** Liver disease, analysis of 3 biomarkers (hyaluronic acid [ha], procollagen iii amino terminal peptide [piiinp], tissue inhibitor of metalloproteinase 1 [timp-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years; Effective 4/1/2020, OPPS status Q4

- **C9803** Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sarscov-2) (coronavirus disease [covid-19]), any specimen source; Effective 03/01/2020, OPPS status Q1

Addressed New CPT® 99072 for Additional Practice Expense during a Public Health Emergency

CMS assigned OPPS status B to CPT® 99072 (Reporting of Additional Practice Expenses Incurred During a Public Health Emergency (PHE), Including Supplies and Additional Clinical Staff Time.) Status B HCPCS are not reportable an outpatient hospital claim. Furthermore, this new code has not been added to the Medicare Physician Fee Schedule, and is therefore not reimbursed by Medicare for either professional fees or facility fees in 2020. Commercial payer policies for this new CPT® code may vary.

Surgical HCPCS

Three new surgical HCPCS Codes were added:

- **C9761**, Describing Vacuum Aspiration of the Kidney, Collecting System and Urethra (OPPS status J1)

- **C9768**, Describing Endoscopic Ultrasound-guided Direct Measurement of Hepatic Portosystemic Pressure Gradient (OPPS status N)

- **C9769**, Describing Cystourethroscopy with Insertion of a Temporary Prostatic Implant or Stent with Anchor and Incisional Struts (OPPS status J1)

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

Drugs, Biologicals, and Radiopharmaceuticals

Two drugs will be newly excluded from OPPS coverage (status E1); both were previously payable.

- **J2325** Injection, nesiritide, 0.1 MG (previously status K)
- **J2797** Injection, rolapitant, 0.5 mg (previously status G)

Fourteen new Drug and Radiopharmaceutical HCPCS Codes and Dosage Descriptors were added.

Eight new codes will be assigned Pass-Through Status (separately payable)

- **C9060** Fluoroestradiol F18, diagnostic, 1 mCi
- **C9062** Injection, daratumumab 10 mg and hyaluronidase-fihj
- **C9064** Mitomycin pyelocalyceal instillation, 1 mg
- **C9065** Injection, romidepsin, non-lypohilized (e.g. liquid), 1mg
- **C9066** Injection, sacituzumab govitecan-hziy, 2.5 mg
- **C9067** Gallium ga-68, dotatoc, diagnostic, 0.01 mCi
- **J7351** Injection, bimatoprost, intracameral implant, 1 microgram
- **J9227** Injection, isatuximab-irfc, 10 mg

Two new drug HCPCS will be status E2, excluded because pricing information and claims data are not available

- **J1437** Injection, ferric derisomaltose, 10 mg
- **J9304** Injection, pemetrexed (PEMFEXY), 10 mg

Four J-codes will replace drugs with temporary C-codes, all remain pass-thru status G:

- **J1632** Inj., brexanolone, 1 mg -- replaces C9055
- **J1738** Inj. meloxicam 1 mg – replaces C9059
- **J3241** Inj. teprotumumab-trbw 10 mg – replaces C9061
- **J3032** Inj. eptinezumab-jjmr 1 mg – replaces C9063

(See also Skin Substitutes section for four more new HCPCS)

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

Three biosimilar drug HCPCS codes will be assigned Pass-Through status (payable status G):

- **Q5112** Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg (prior status K)
- **Q5113** Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg (prior status K)
- **Q5121** Injection, infliximab-axxq, biosimilar, (avsola), 10 mg (prior status E2)

Pass-through status ends for five drugs on 10/01/2020; they will become status N, not separately paid.

- **A9586** Florbetapir f18, diagnostic, pre study dose, up to 10 millicuries
- **J1097** phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml
- **Q9950** Injection, sulfur hexafluoride lipid microsphere, per ml
- **Q9982** Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries
- **Q9983** Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries

Pass-through status (status G) will be newly assigned to four HCPCS previously paid as APC status K:

- **J1301** Injection, edaravone, 1 mg
- **J2350** Injection, ocrelizumab, 1 mg
- **J9023** Injection, avelumab, 10 mg
- **J9173** Injection, durvalumab, 10 mg

The long descriptors for two HCPCS have been revised:

- **J9305** changed from "injection pemetrexed, 10 mg"to"Injection, pemetrexed,not otherwise specified, 10 mg"
- **C9066** changed from "Injection, sacituzumab govitecan-hziy, 10 mg" to "Injection, sacituzumab govitecan-hziy, 2.5 mg".The trade name for this medication is Trodelvy; it is supplied in a 180 mg. vial.Providers should note that the change to a smaller mg/unit value increases the billed units

Updated the quarterly Average Sales Price file, which can change APC rates for status K drugs.

Skin Substitutes

Four new "low cost" skin substitute codes were created and assigned to OPPS status N, payment packaged; Medicare payment under OPPS is packaged to the application procedure C5271-C5278:

- **Q4249** Amniply, for topical use only, per square centimeter
- **Q4250** AmnioAMP- MP, per square centimeter
- **Q4254** Novafix dl, per square centimeter
- **Q4255** Reguard, for topical use only, per square centimeter

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

Two HCPCS previously paid (pass-through status G) are no longer separately paid under OPPS.

These HCPCS will be status N, payment packaged (to the skin substitute application procedure 1572x):

- **Q4195** Puraply, per square centimeter
- **Q4196** Puraply am, per square centimeter

Three skin substitute HCPCS have been reassigned to the "High Cost Skin Substitute Group":

- **Q4205** Membrane graft or wrap sq cm
- **Q4226** Myown harv prep proc sq cm
- **Q4234** Xcellerate, per sq cm

Laboratory

Two new CPT® Codes for Multianalyte Assays with Algorithmic Analyses (MAAA) were added:

- **0015M** Adrenal cortical tumor, biochemical assay of 25 steroid markers, utilizing 24-hour urine specimen and clinical parameters, prognostic algorithm reported as a clinical risk and integrated clinical steroid risk for adrenal cortical carcinoma, adenoma, or other adrenal malignancy
- **0016M** Oncology (bladder), mRNA, microarray gene expression profiling of 209 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like)

Both the new MAAA codes will be assigned OPPS status Q4 (payment often packaged.

Payment policy for twenty new CPT® Proprietary Laboratory Analyses (PLA) Codes was established

.

For HCPCS Codes and Description details, please see the TABLE on the next two pages.

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

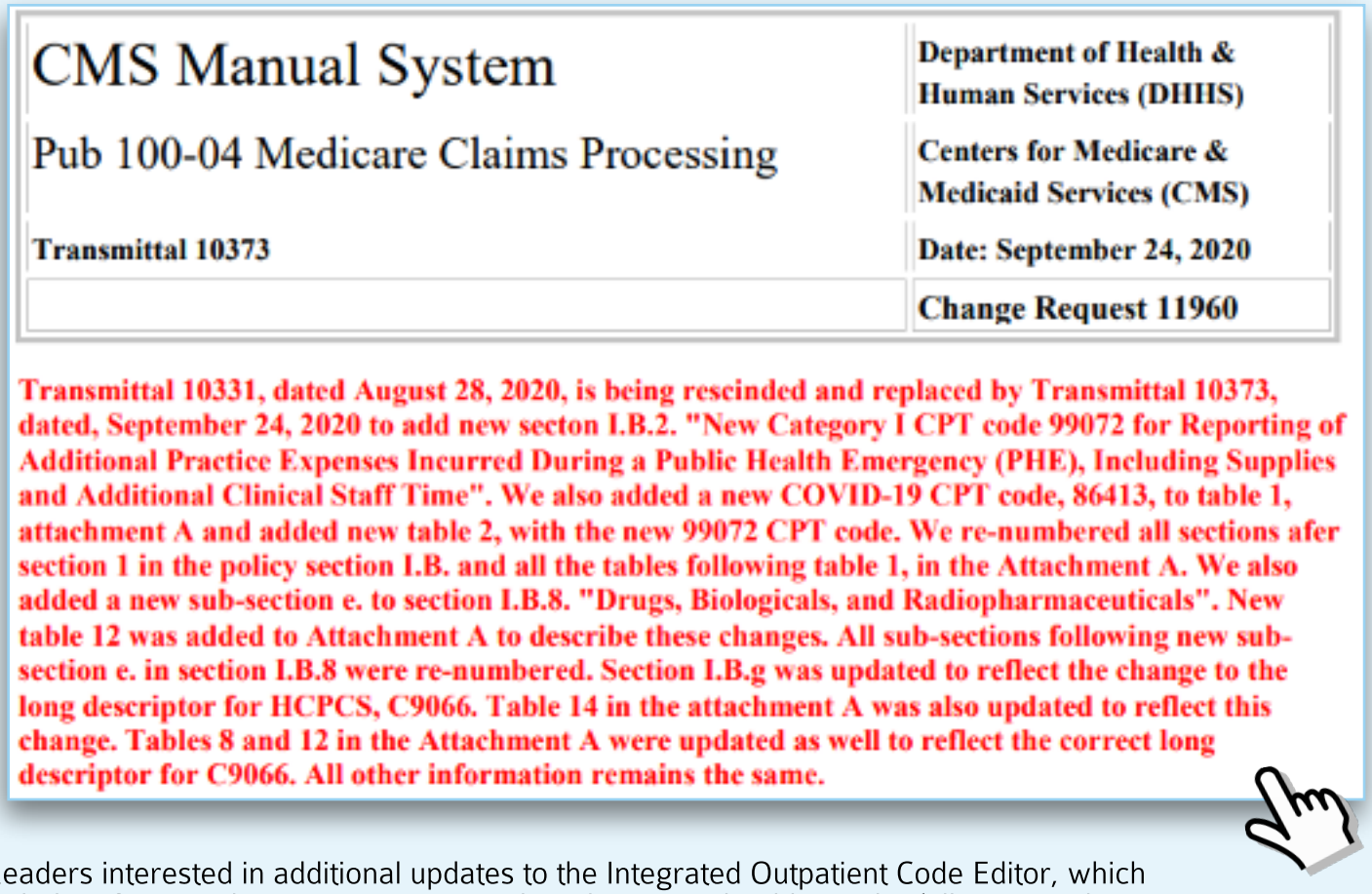
HCPCS/Description	Payment Status Effective 10/1/2020
0202U - Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (sars-cov-2), qualitative rt-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected	Q4 – Paid or packaged
0203U - Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative rt-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness	A – Clinical Lab Fee Schedule or Contractor-Priced
0204U - Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including braf, ras, ret, pax8, and ntrk) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected	A – Clinical Lab Fee Schedule or Contractor-Priced A
0205U - Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 cfh gene, 1 arms2 gene), using PCR and maldi-tof, buccal swab, reported as positive or negative for neovascular age-related macular-degeneration risk associated with zinc supplements	Q4 – Paid or packaged Q4
0206U - Neurology (alzheimer disease); cell aggregation using morphometric imaging and protein kinase c-epsilon (pkce) concentration in response to amylospheroid treatment by elisa, cultured skin fibroblasts, each reported as positive or negative for alzheimer disease	Q4 – Paid or packaged
0207U - Quantitative imaging of phosphorylated erk1 and erk2 in response to bradykinin treatment by in situ immunofluorescence, using cultured skin fibroblasts, reported as a probability index for alzheimer disease (list separately in addition to code for primary procedure)	N – Payment packaged
0208U - Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma	A – Clinical Lab Fee Schedule or Contractor-Priced A
0209U - Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities	A – Clinical Lab Fee Schedule or Contractor-Priced
0210U - Syphilis test, non-treponemal antibody, immunoassay, quantitative (rpr)	Q4 – Paid or packaged Q4
0211U - Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and microsatellite instability, with therapy association	E1
0212U – Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband	A – Clinical Lab Fee Schedule or Contractor-Priced A

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

HCPCS/Description	Payment Status Effective 10/1/2020
0213U - Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent, sibling)	A – Clinical Lab Fee Schedule or Contractor-Priced A
0214U - Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband	A – Clinical Lab Fee Schedule or Contractor-Priced A
0215U - Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (eg, parent, sibling)	A – Clinical Lab Fee Schedule or Contractor-Priced A
0216U - Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants	A – Clinical Lab Fee Schedule or Contractor-Priced A
0217U - Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants	A – Clinical Lab Fee Schedule or Contractor-Priced A
0218U - Neurology (muscular dystrophy), dmd gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants	A – Clinical Lab Fee Schedule or Contractor-Priced
0219U - Infectious agent (human immunodeficiency virus), targeted viral next-generation sequence analysis (ie, protease [pr], reverse transcriptase [rt], integrase [int]), algorithm reported as prediction of antiviral drug susceptibility	A – Clinical Lab Fee Schedule or Contractor-Priced A
0220U - Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score	Q4 – Paid or packaged Q4
0221U - Red cell antigen (abo blood group) genotyping (abo), gene analysis, next-generation sequencing, abo (abo, alpha 1-3-n-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene	A – Clinical Lab Fee Schedule or Contractor-Priced A
0222U - Red cell antigen (rh blood group) genotyping (rhd and rhce), gene analysis, next-generation sequencing, rh proximal promoter, exons 1-10, portions of introns 2-3	A – Clinical Lab Fee Schedule or Contractor-Priced A

CMS LATE ADDITIONS TO OCTOBER 1, 2020 OPPS HCPCS UPDATE

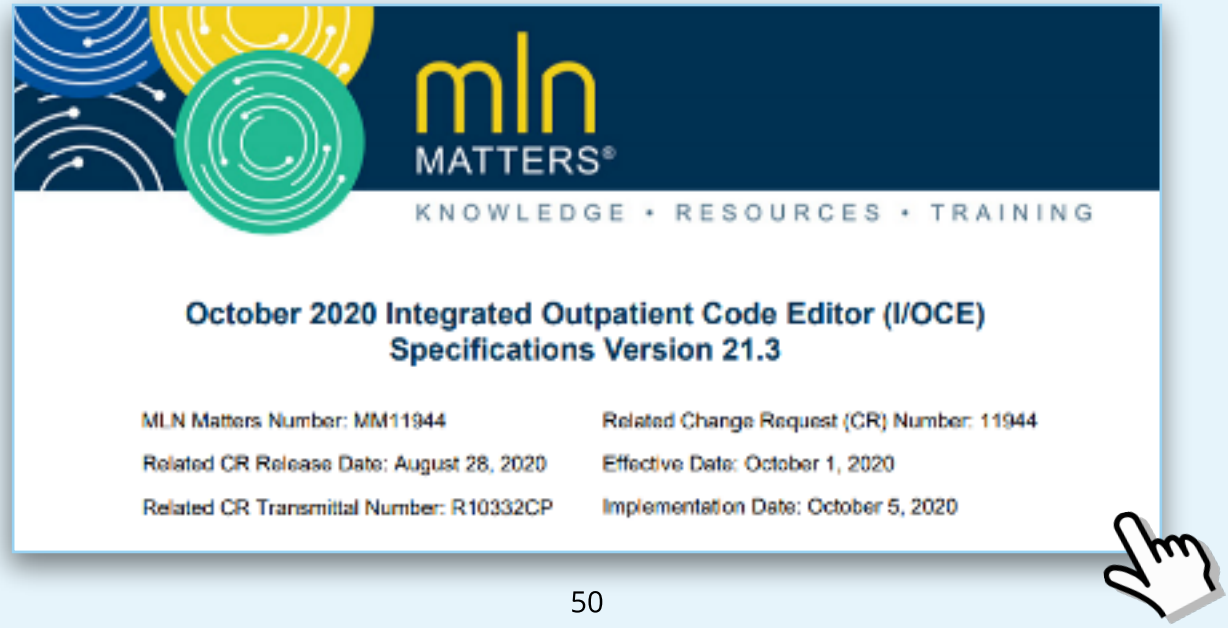
The revised transmittal is found at the following link:
https://www.cms.gov/files/document/r10373cp.pdf



CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10373	Date: September 24, 2020
	Change Request 11960

Transmittal 10331, dated August 28, 2020, is being rescinded and replaced by Transmittal 10373, dated, September 24, 2020 to add new secton I.B.2. "New Category I CPT code 99072 for Reporting of Additional Practice Expenses Incurred During a Public Health Emergency (PHE), Including Supplies and Additional Clinical Staff Time". We also added a new COVID-19 CPT code, 86413, to table 1, attachment A and added new table 2, with the new 99072 CPT code. We re-numbered all sections afer section 1 in the policy section I.B. and all the tables following table 1, in the Attachment A. We also added a new sub-section e. to section I.B.8. "Drugs, Biologicals, and Radiopharmaceuticals". New table 12 was added to Attachment A to describe these changes. All sub-sections following new sub-section e. in section I.B.8 were re-numbered. Section I.B.g was updated to reflect the change to the long descriptor for HCPCS, C9066. Table 14 in the attachment A was also updated to reflect this change. Tables 8 and 12 in the Attachment A were updated as well to reflect the correct long descriptor for C9066. All other information remains the same.

Readers interested in additional updates to the Integrated Outpatient Code Editor, which includes ICD10 updates (among many other changes), should visit the following webpage:
https://www.cms.gov/files/document/mm11944.pdf



mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM11944	Related Change Request (CR) Number: 11944
Related CR Release Date: August 28, 2020	Effective Date: October 1, 2020
Related CR Transmittal Number: R10332CP	Implementation Date: October 5, 2020

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!**

mlnconnects
Official CMS news from the Medicare Learning Network

Thursday, November 25, 2020

News

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

Compliance

- Polysomnography Services: Bill Correctly

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Long-Term Services and Supports Open Door Forum — December 1
- Hospital Price Transparency Webcast — December 8
- Interoperability and Patient Access Final Rule Call — December 9

Publications

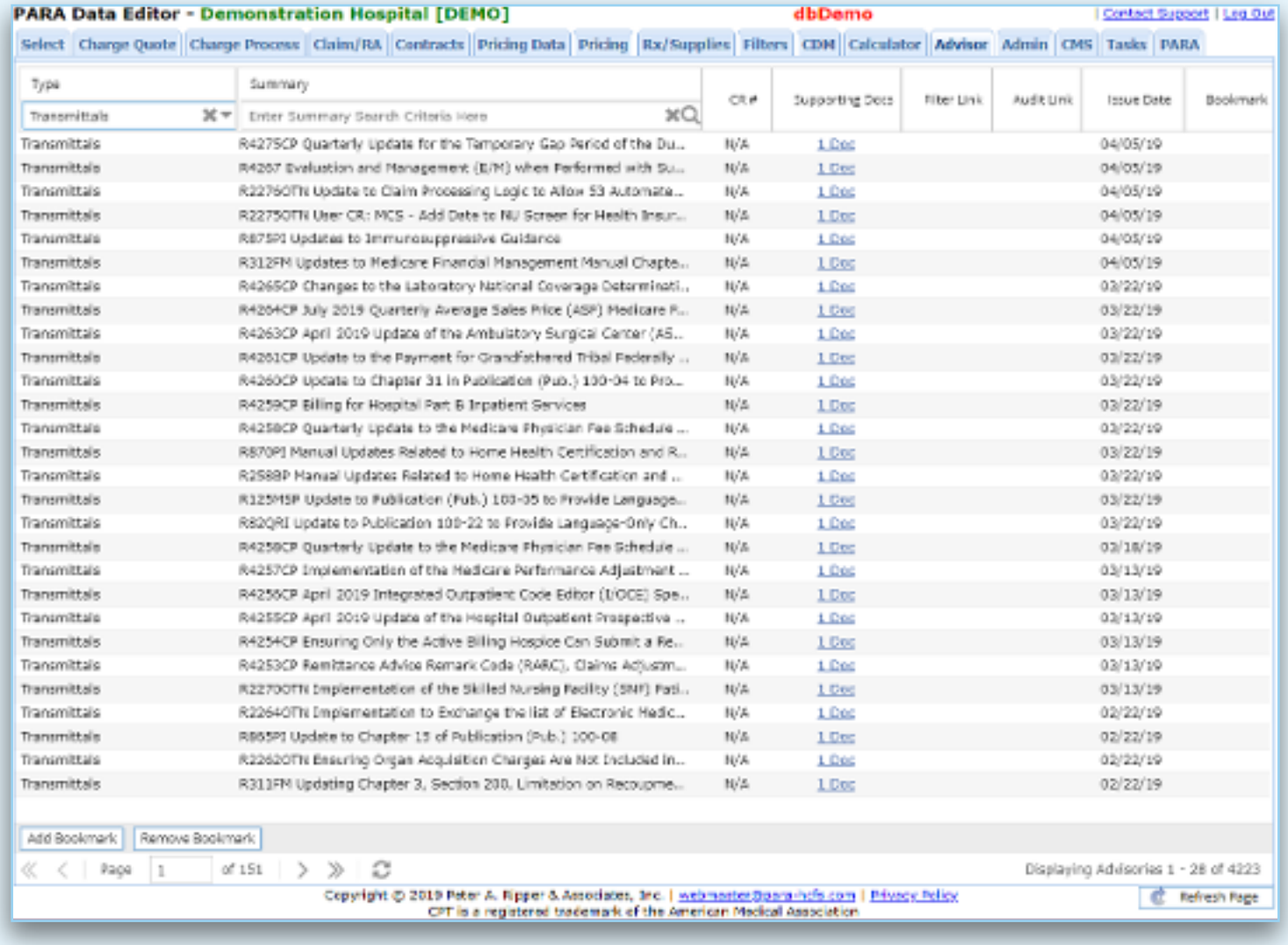
- DMEPOS Information for Pharmacies — Revised
- DMEPOS Quality Standards — Revised
- Advance Care Planning — Revised

View this edition as a PDF (PDF)

There was ONE 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**



The link to this MedLearn MM12011

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021

MLN Matters Number: MM12011 Revised | Related Change Request (CR) Number: 12011

Related CR Release Date: November 23, 2020 | Effective Date: January 1, 2021

Related CR Transmittal Number: R10490BP | Implementation Date: January 4, 2021

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

PROVIDER TYPES AFFECTED

This MLN Matters® Article is for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you about changes to the Calendar Year (CY) 2021 rate updates and policies for the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and changes to the payment for renal dialysis services provided to Medicare beneficiaries with Acute Kidney Injury (AKI) in ESRD facilities. Make sure your billing staffs are aware of these changes.

BACKGROUND

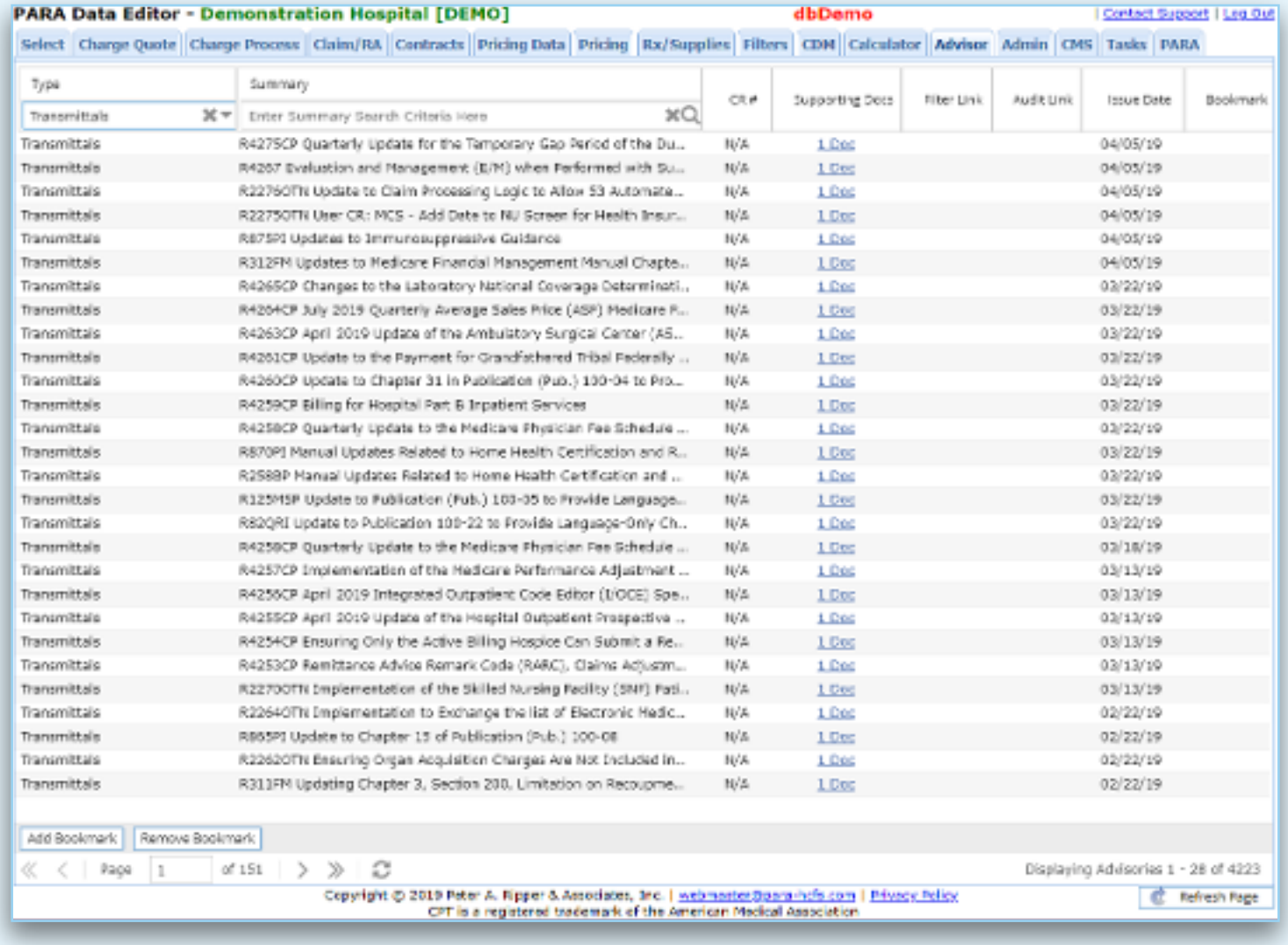
Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS based on the requirements of Section 1881(b)(14) of the Social Security Act (the Act). The ESRD PPS provides a single per treatment payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment. The ESRD PPS base rate is adjusted to reflect patient and facility characteristics that contribute to higher per treatment costs. Section 1881(b)(14)(F) of the Act requires an annual increase to the ESRD PPS base rate by an ESRD market basket increase factor, reduced by the productivity adjustment described in Section 1886(b)(3)(B)(xi)(II) of the Act. That is, the ESRD bundled (ESRDB) market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.

CMS Medicare Learning Network

There were EIGHT new or revised Transmittals released this week.

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

FIND ALL THESE TRANSMITTALS 8
IN THE **ADVISOR** TAB OF THE **PDE**



The link to this Transmittal R10501OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10501	**Date: December 1, 2020**
	Change Request 12039

Transmittal 10478, dated November 20, 2020, is being rescinded and replaced by Transmittal 10501, dated, December 1, 2020 to provide some further edit requests to BRs 12039.2.1 and 12039.3 as follows: remove FISS and MCS from BR 12039.2.1 and to remove the reference to EMED from BR 12039.3. All other information remains the same.

SUBJECT: Shared Systems Report of Medicare Summary Notice (MSN) Counts by Type

I. SUMMARY OF CHANGES: In order to track the number of eMSNs and paper MSNs sent to Medicare FFS beneficiaries, CMS is requiring the Shared Systems to create a file of total MSNs produced per quarter, broken out month and by each MSN type. CMS will use this information to track the use of eMSNs and paper MSNs by beneficiaries in each Jurisdiction and by Shared System over time.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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 R10499OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10499	Date: December 1, 2020
	Change Request 11850

Transmittal 10283, dated August 7, 2020, is being rescinded and replaced by Transmittal 10499, dated, December 1, 2020 to correct the July implementation date from July 5, 2021 to July 6, 2021. All other information remains the same.

SUBJECT: COBOL Version 6.2 Upgrade - Phased Implementation for ViPS Medicare System (VMS) and the Common Working File (CWF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is for the contractors to implement changes in phases in preparation for the migration to Enterprise COBOL 6.2 for z/OS.

EFFECTIVE DATE: January 4, 2021 - Effective date is the date claims are processed; April 5, 2021 - Effective date is the date claims are processed; July 1, 2021 - Effective date is the date claims are processed
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021 - VMS only - BRs 1, 1.1, 2, and 3; April 5, 2021 - CWF - BRs 1 and 1.1; VMS - BR 4; July 6, 2021 - CWF only - BRs 2 and 5

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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):
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IV. ATTACHMENTS:
One Time Notification

The link to this Transmittal R10496CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10496	**Date: November 25, 2020**
	Change Request 12062

SUBJECT: April 2021 Update to the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS)

I. SUMMARY OF CHANGES: This recurring change request provides an update to the FY 2021 IPPS PPS Pricer to allow for up to 10 National Drug Codes to be passed to the IPPS PPS Pricer for payment consideration of New Technologies and emerging medical services. This recurring update notification applies existing policy as stated in publication 100-04, chapter 3, sections 20.2.3 and 160.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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	

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

The link to this Transmittal R10494CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10494	**Date: November 25, 2020**
	Change Request 12052

SUBJECT: Shared System Support Hours for Application Programming Interfaces (APIs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide hours for the Fiscal Intermediary Shared System (FISS) and Multi-Carrier System (MCS) Maintainers to support maintenance, enhancements, and MAC onboarding of the existing APIs in the FISS and MCS using Agile development practices.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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 R10492PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10492	**Date: November 25, 2020**
	Change Request 11997

SUBJECT: Clarifying The Use of As-Needed/PRN Orders for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise section 5.11 in Chapter 5 of Publication (Pub.) 100-08 to account for a recent regulatory change that removed frequency as a required element of the Standard Written Order for DMEPOS.

EFFECTIVE DATE: January 1, 2020 - The effective date is 1-1-2020 to align with the effective date of CMS Regulation 1713-F.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 29, 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
R	5/5.11/Evidence of Medical Necessity

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:

Business Requirements
Manual Instruction

The link to this Transmittal R10495OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10495	**Date: November 24, 2020**
	Change Request 12038

Transmittal 10430, dated October 30, 2020, is being rescinded and replaced by Transmittal 10495, dated, November 24, 2020 to revise the ETC Model end date in the CR summary section of the transmittal. All other information remains the same.

SUBJECT: ESRD Treatment Choices (ETC) Model Implementation: Home Dialysis Payment Adjustment (HDPA) & Waiver of the Kidney Disease Education (KDE) Benefit

I. SUMMARY OF CHANGES: Section 1115A of the Social Security Act (the Act) authorizes the Innovation Center to test innovative payment and service delivery models expected to reduce Medicare, Medicaid, and Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care furnished to the beneficiaries of such programs. The End-Stage Renal Disease (ESRD) Treatment Choices Model (ETC Model) will be a mandatory payment model focused on encouraging greater use of home dialysis and kidney transplants, in order to preserve or enhance the quality of care furnished to Medicare beneficiaries while reducing Medicare expenditures. The ETC Model adjusts Medicare payments on certain dialysis and dialysis-related claims for participating ESRD facilities and clinicians caring for beneficiaries with ESRD—or Managing Clinicians—based on their rates of home dialysis transplant waitlisting, and living donor transplants. We believe that these two models will test ways to further our goals of reducing Medicare expenditures while preserving or enhancing the quality of care furnished to beneficiaries.

The ETC Model will begin January 1, 2021, and end June 30, 2027

The purpose of this CR is to inform Medicare Administrative Contractors (MACs) and all stakeholders that CMS has released the Final Rule (Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures) for the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model and will begin January 1, 2021. This CR updates any relevant BRs in (CR) 11390 and CR 11409 based on final Rule, and requires the MACs to perform any set up and testing to ensure the model is live on January 1, 2021.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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The link to this Transmittal R10500OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10500	**Date: December 1, 2020**
	Change Request 11851

Transmittal 10252, dated July 31, 2020, is being rescinded and replaced by Transmittal 10500 dated, December 1, 2020 to correct the July implementation date from July 5, 2021 to July 6, 2021. All other information remains the same.

SUBJECT: COBOL Version 6.2 Upgrade - Phased Implementation for Fiscal Intermediary Shared System (FISS) and Multi Carrier System (MCS)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is for the contractors to implement changes in phases in preparation for the migration to Enterprise COBOL 6.2 for z/OS.

EFFECTIVE DATE: January 4, 2021 - Effective date is the date claims are processed; April 5, 2021 - Effective date is the date claims are processed; July 5, 2021 - Effective date is the date claims are processed
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021 - BRs 1 thru 6; April 5, 2021 - BRs 4 thru 6; July 6, 2021 - BRs 5.1 and 7

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N/A	N/A

III. FUNDING:
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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10490BP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10490	**Date: November 23, 2020**
	Change Request 12011

Transmittal 10451, dated November 6, 2020, is being rescinded and replaced by Transmittal 10490, dated, November 23, 2020 to revise the CY 2021 AKI dialysis payment rate for renal dialysis services reported in the policy section of this CR. All other information remains the same.

SUBJECT: Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021

I. SUMMARY OF CHANGES: This Change Request (CR) implements the CY 2021 rate updates and policies for the ESRD PPS and implements the payment for renal dialysis services furnished to beneficiaries with AKI in ESRD facilities. This Recurring Update Notification applies to Publication 100-02, Medicare Benefit Policy Manual, Chapter 11, section 50.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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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

Get power on your side and maintain your cash flow.

As provider staffing issues arise it can seem like you're holding back everything you've built.

When you need extra strength, **PARA /HFRI** remote services can step in to continue seamless insurance accounts receivable collections.

BE EMPOWERED

PARA HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

- **Staffing Shortages**
- **Recent Legacy Conversion**
- **Write-offs Over 2.5%**
- **Small Balance Accounts That Are Untouched For 30 Days**
- **Net A/R Days Greater**

WHAT WE OFFER

- Guaranteed Results
- Improved Insurance Collections
- Contingency-Based Flat Rate Fee Schedule
- 25% Reduction In Account Lifecycle

CONTACT OUR EXPERTS

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