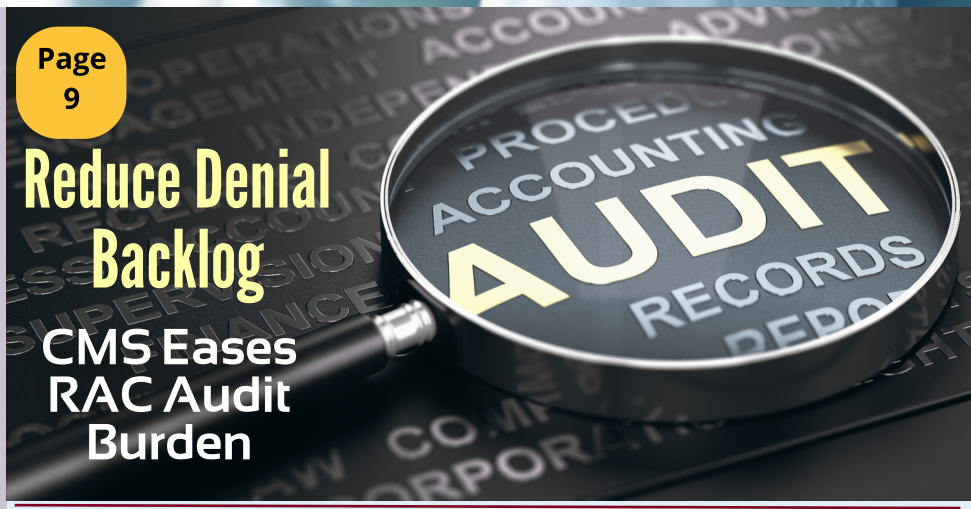
PARA
HealthCare Analytics
an HFRI Company

December 4, 2019

Weekly eJOURNAL

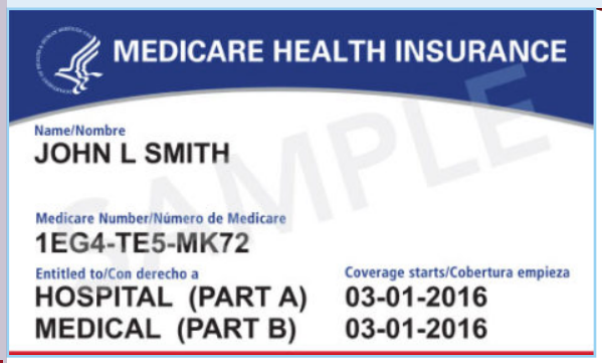
NEWS FOR HEALTHCARE DECISION MAKERS

IN THIS ISSUE



1 The number of new or revised Med Learn articles released this week.

3 The number of new or revised Transmittals released this week.



NEW

Medicare Beneficiary Identifier Reminder

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PARA

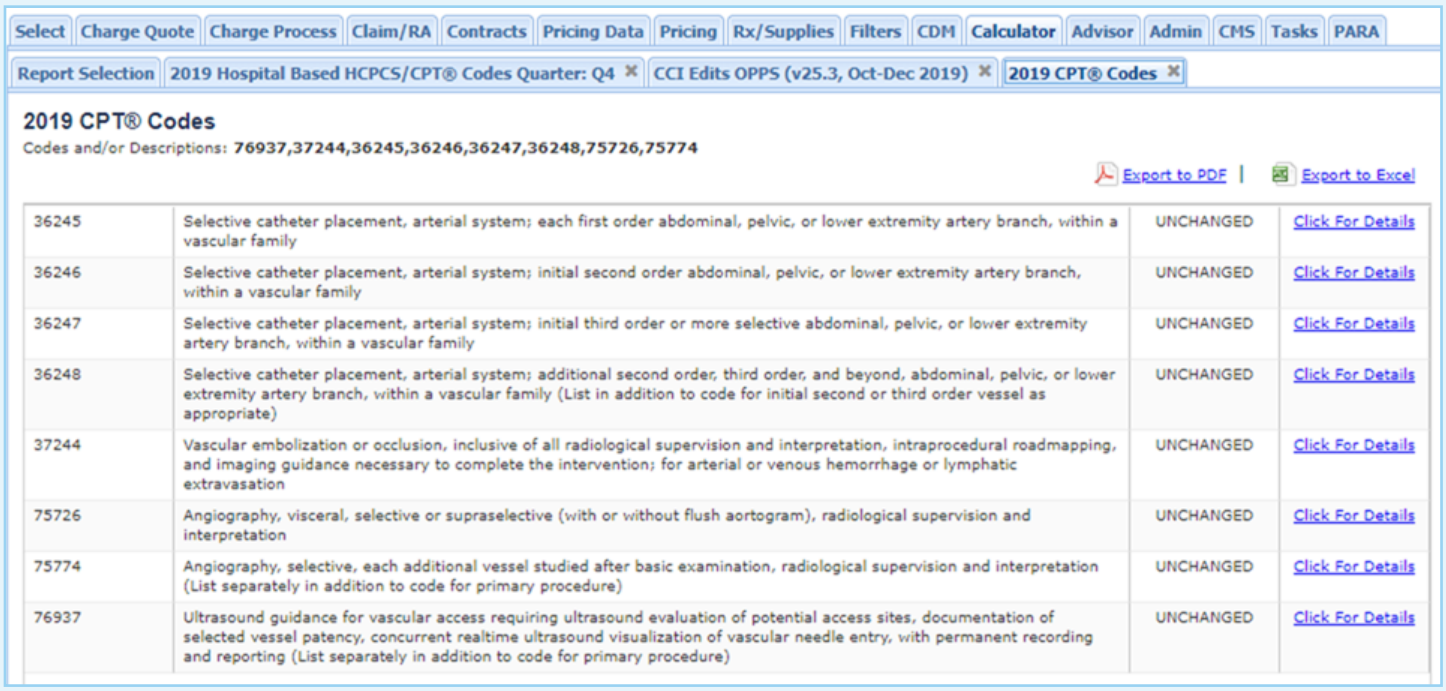
FAST LINKS

IR MESENTERIC ANGIOGRAM

Q. Please review the operative note for an IR Mesenteric Angiogram, Uterine Artery Embolization and provide the appropriate codes. We are considering the following codes: 76937, 36247, 36248 x 3, 75726-XU, 37243.

A. **Answer:** Report CPT© codes 76937, 37244, 36245-59, 36246-59 x2, 36247x2, 36248 x4, 75726-59 x4 and 75774-59 x4. The physician is attempting to identify active bleeding. After completion of the imaging, the right uterine artery is embolized due to large volume vaginal bleeding. Since there is mention of bleeding and no mention of uterine fibroids/tumor, CPT© code 37244 would be reported rather than 37243. Based on the documentation submitted, four separate vascular families are accessed from a right femoral artery approach, with multiple images taken.

The separate family selections and imaging are as follows: Celiac to left gastric (36246, 75726), SMA (36245,75726), IMA, left colic, sigmoid, superior rectal/hemorrhoidal, (36246, 36248, 36248, 75726, 75774, 75774), Left internal iliac to left inferior vesicle (36247, 36248, 75726, 75774) and Right internal iliac, to pudenal, uterine (36247, 36248, 75726, 75774). Please refer to the **PARA Data Editor** code descriptions.



36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	UNCHANGED	Click For Details
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	UNCHANGED	Click For Details
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	UNCHANGED	Click For Details
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	UNCHANGED	Click For Details
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	UNCHANGED	Click For Details
75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	UNCHANGED	Click For Details
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	UNCHANGED	Click For Details
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	UNCHANGED	Click For Details

IR MESENTERIC ANGIOGRAM

CPT© code 75726 represents the initial visceral imaging in a vascular family. Code 75774 is reported for additional images taken within a vascular family. Please refer to the AHA Coding Clinic for HCPCS - First Quarter 2012 Page: 5 which contains an example of celiac artery imaging, with additional selection of branches with imaging and advises that 75774 is reported "for each vessel and each branch of a vessel that is selectively catheterized and imaged."

Append modifier 59 to 36246 and 36245 to override the CCI edit when reported with 36247. Append modifier 59 to 75726 and 75774 to override the CCI edit when reported with 37244. Documentation supports separate and distinct services since separate vascular families are selected and imaged.

Please refer to the **PARA Data Editor** CCI edits.

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

Report Selection | 2019 Hospital Based HCPCS/CPT® Codes Quarter: Q4 | CCI Edits OPPS (v25.3, Oct-Dec 2019) | 2019 CPT® Codes

CCI Edits OPPS (v25.3, Oct-Dec 2019)

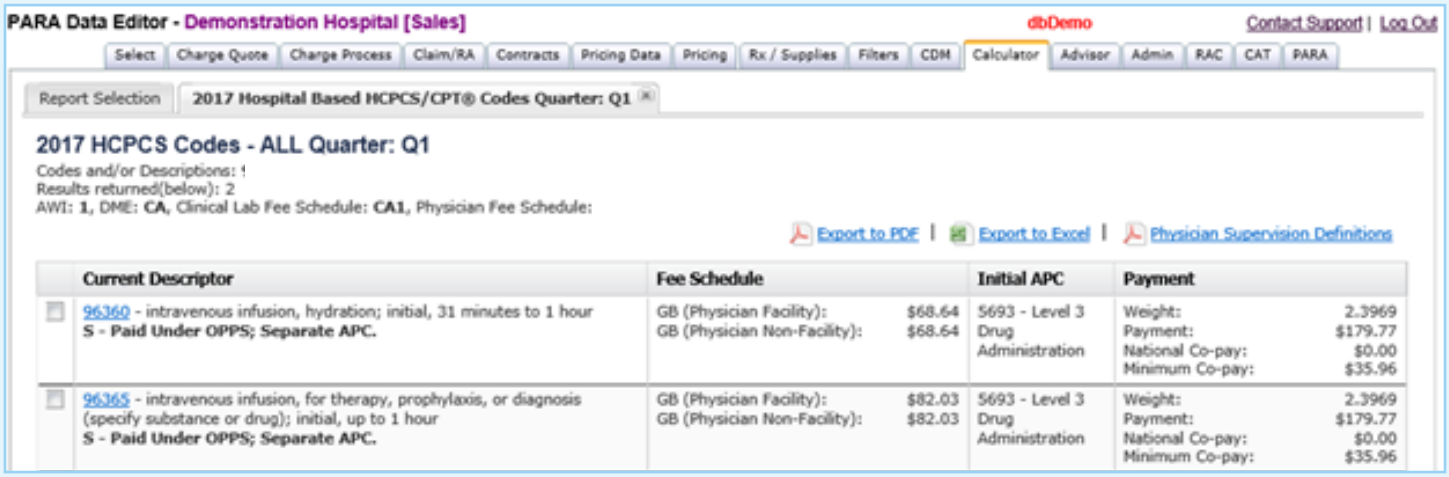
Codes and/or Descriptions: **76937,37244,36245,36246,36247,36248,75726,75774**

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

PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
36246 - SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (Column 1)	36245 - SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
36247 - SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (Column 1)	36245 - SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
36247 - SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (Column 1)	36246 - SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
37244 - VASCULAR EMBOLIZATION OR OCCLUSION, INCLUSIVE OF ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE INTERVENTION; FOR ARTERIAL OR VENOUS HEMORRHAGE OR LYMPHATIC EXTRAVASATION (Column 1)	75726 - ANGIOGRAPHY, VISCERAL, SELECTIVE OR SUPRASELECTIVE (WITH OR WITHOUT FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
37244 - VASCULAR EMBOLIZATION OR OCCLUSION, INCLUSIVE OF ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE INTERVENTION; FOR ARTERIAL OR VENOUS HEMORRHAGE OR LYMPHATIC EXTRAVASATION (Column 1)	75774 - ANGIOGRAPHY, SELECTIVE, EACH ADDITIONAL VESSEL STUDIED AFTER BASIC EXAMINATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill

HYDRATION VS MEDICATION INFUSION (UPDATED)

Q. Regarding hydration vs. an infusion of medication -- does an infusion of potassium qualify as a medication if the medical necessity of potassium is documented? What constitutes a minimum flow rate for hydration therapy?



A. **Answer:** Having researched this in numerous authoritative reference publications, we find:

- No instruction defines a point when the vitamin and mineral additives in a pre-packaged IV solution bag might constitute a medication

- The CPT® manual states: "Codes 96360-96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal salien+30mEq KCl/liter), but are not used to report infusion of drugs or other substances"

- Both CPT®and CMS indicate that fluid with electrolytes does not constitute medication infusion, but hydration. Potassium is an electrolyte; therefore we find that an infusion of IV fluid with potassium qualifies as hydration

- A "banana bag" typically includes thiamine, folic acid, magnesium, and multivitamins. Since this is more than electrolytes, a banana bag infusion meets the definition of a medication infusion per CPT®

- There is no guidance on the rate of flow that qualifies for hydration; however, we found Medicare guidance that providers should not bill hydration for an infusion which addresses an imbalance of less than 500 ml of volume. If the hydration flow rate is 100 ml per hour or less (for an adult patient), **PARA** does not recommend billing either hydration or medication infusion charges; the service should be considered a component of the outpatient room rate or visit charge

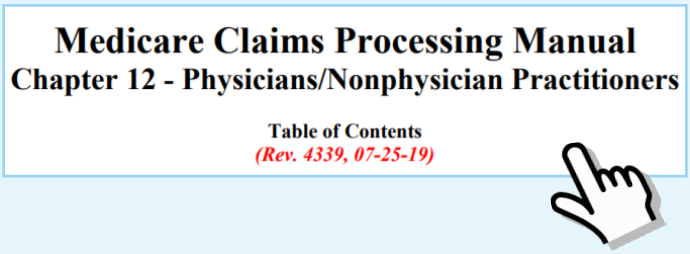
HYDRATION VS MEDICATION INFUSION (UPDATED)

The research supporting these findings is provided below.

1. The 2019 CPT® code book, guideline for Hydration offers the following instruction: "Codes 96360-96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal saline+30mEq KCL/liter) but are not used to report infusion of drugs or other substances. ..."

2. The Medicare Claims Processing Manual -- Chapter 12 - Physicians/Nonphysician Practitioners repeats the CPT® instructions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

   Hydration - The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and/or electrolytes (e.g. normal saline, D5-1/2 normal saline +30 mg EqKC1/liter) but are not used to report infusion of drugs or other substances.


Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

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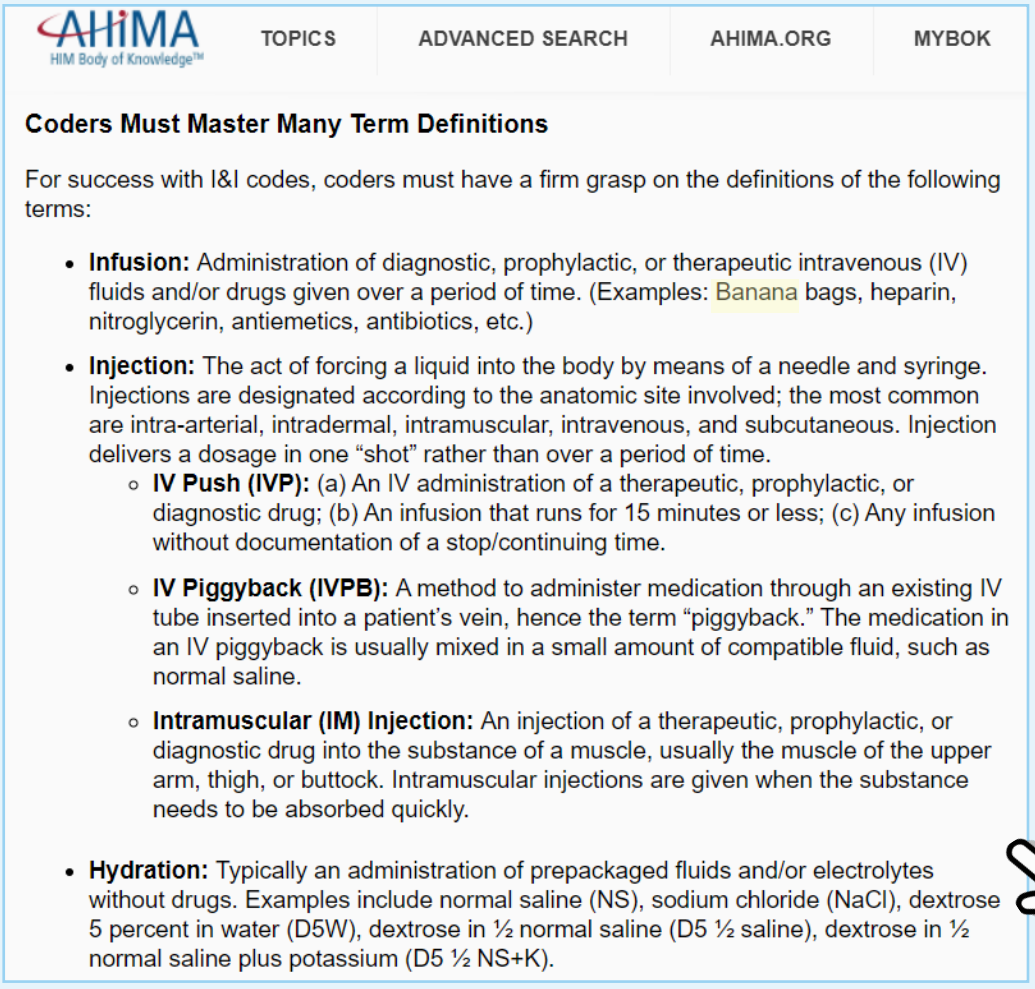
(Rev. 4339, 07-25-19)

3. The article "Injection and Infusion Coding Offers High Stakes: Outpatient Coders Must Play Their Cards Right" – AHIMA: https://bok.ahima.org/doc?oid=107707#.XdwvIl3sZ9A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Coders Must Master Many Term Definitions

For success with I&I codes, coders must have a firm grasp on the definitions of the following terms:

- **Infusion:** Administration of diagnostic, prophylactic, or therapeutic intravenous (IV) fluids and/or drugs given over a period of time. (Examples: Banana bags, heparin, nitroglycerin, antiemetics, antibiotics, etc.)
- **Injection:** The act of forcing a liquid into the body by means of a needle and syringe. Injections are designated according to the anatomic site involved; the most common are intra-arterial, intradermal, intramuscular, intravenous, and subcutaneous. Injection delivers a dosage in one "shot" rather than over a period of time.
  - **IV Push (IVP):** (a) An IV administration of a therapeutic, prophylactic, or diagnostic drug; (b) An infusion that runs for 15 minutes or less; (c) Any infusion without documentation of a stop/continuing time.
  - **IV Piggyback (IVPB):** A method to administer medication through an existing IV tube inserted into a patient's vein, hence the term "piggyback." The medication in an IV piggyback is usually mixed in a small amount of compatible fluid, such as normal saline.
  - **Intramuscular (IM) Injection:** An injection of a therapeutic, prophylactic, or diagnostic drug into the substance of a muscle, usually the muscle of the upper arm, thigh, or buttock. Intramuscular injections are given when the substance needs to be absorbed quickly.
- **Hydration:** Typically an administration of prepackaged fluids and/or electrolytes without drugs. Examples include normal saline (NS), sodium chloride (NaCl), dextrose 5 percent in water (D5W), dextrose in ½ normal saline (D5 ½ saline), dextrose in ½ normal saline plus potassium (D5 ½ NS+K).

HYDRATION VS MEDICATION INFUSION (UPDATED)

1. Novitas LCD L34960 – Hydration Therapy – is instructive:

   https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34960&ver=21&name=331*1&UpdatePeriod=696&bc=AQAAEAAAAAAAAA%3d%3d&

   ...Indications:

   The clinical manifestations of dehydration or volume depletion are related to the volume and rate of fluid loss, the nature of the fluid that is lost, and the responsiveness of the vasculature to volume reduction. Rehydration with fluids containing sodium as the principal solute, preferentially expand the extracellular fluid volume; a 1-liter infusion of normal saline may expand blood volume by about 300 ml. In general, an imbalance of less than 500 ml of volume is not likely to require intravenous rehydration.

   - These CPT® codes require the direct supervision of the physician. Under levels of supervision (see 42 CFR 410.32 (b)(3)(ii)), direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room during the entire time the procedure is performed

   - When performed in conjunction with chemotherapy, these CPT® codes are covered only when infusion is prolonged and done sequentially (done hour(s) before or after administration of chemotherapy), and when the volume status of a beneficiary is compromised or will be compromised by side effects of chemotherapy or an illness

   Limitations:

- Rehydration with the administration of an amount of fluid equal to or less than 500 ml is not reasonable and necessary

- These CPT® codes are not to be used for intradermal, subcutaneous or intramuscular or routine IV drug injections

- Hanging of D5W or other fluid just prior to administration of chemotherapy (minutes) is not hydration therapy and should not be billed with these codes

- These services may not be used in addition to prolonged service codes

- When the sole purpose of fluid administration (e.g. saline, D5W) is to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic; therefore, these infusion CPT® codes should not be billed as hydration therapy

- Administration of fluid in the course of transfusions to maintain line patency or between units of blood product is, likewise, not to be separately billed as hydration therapy

- Administration of fluid to maintain line patency or flush lines between different agents given at the same chemotherapy session is not hydration therapy

- Infusion of saline, an antiemetic, or any other non-chemotherapy when these drugs are administered at the same time as chemotherapy (within minutes) should not be billed as hydration therapy with these CPT® codes

- Fluid used to administer drug(s) is incidental hydration and is not separately payable.

93288 PACEMAKER

Q. We are wondering if we can bill 93288 in our ER when we are retrieving info from the pacemaker on a patient.

A. **Answer:** It depends on the documentation in the medical record. To support 93288, the physician documentation would need to include a face-to-face assessment of all device functions, including the battery, lead(s), capture and sensing function, heart rhythm, and programmed parameters of a single-, dual-, or multiple-lead pacemaker system.

While it would be unusual to report 93288 as an emergency department service, it could be appropriate if the physician's documentation supported this code.

Here's the full code description:

> 93288 - Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system

There is no CCI edit preventing 93288 from being reported with an ED visit code, for either physicians or OPPS facilities:

CCI Edits OPPS (v25.3, Oct-Dec 2019)

Codes and/or Descriptions: **93288,99285**

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

PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
93288 - INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER; SINGLE, DUAL, OR MULTIPLE LEAD PACEMAKER SYSTEM, OR LEADLESS PACEMAKER SYSTEM	99285 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS WITHIN THE CONSTRAINTS IMPOSED BY THE URGENCY OF THE PATIENT'S CLINICAL CONDITION AND/OR MENTAL STATUS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH 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 POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION.		OK to bill

We found only one provider manual reference, from United Healthcare, which mentions 93288, but it isn't quite on point to the question. Here is that reference:
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-guidelines/t/transtelephonic-monitoring-cardiac-pacemakers.pdf

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarifications

- **CPT 93293 is the primary code for transtelephonic monitoring**. Pacemaker monitoring (procedure codes 93279, 93280, 93281, 93288, 93294 and 93724) is covered by pacemaker clinics and may be done in conjunction with transtelephonic monitoring, remote monitoring, or as a separate service. The services rendered by a pacemaker clinic are more extensive than those currently possible by telephone. They include, for example, physical examination of patients and reprogramming of pacemakers.

TRANSPARENCY DURING 2020

Q. With the Price Transparency proposed rule not going into effect till January 2021, are we still required to post our standard charges as we do today?

A. **Answer:** We see no relief from the prior requirements during 2020. Therefore, yes, hospitals are required to post their standard charges in a machine-readable format on the hospital website.

The CMS Fact Sheet does not mention relaxing any current requirements. It says the new requirements will "further advance" the objective.

https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price

CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2)

Nov 15, 2019 | Coverage, Legislation, Quality

Share

CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2)

On November 15, 2019, the Centers for Medicare & Medicaid Services (CMS) finalized policies that follow directives in President Trump's Executive Order, entitled "Improving Price and Quality Transparency in American Healthcare to Put Patients First," that lay the foundation for a patient-driven healthcare system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The policies in the final rule will further advance the agency's commitment to increasing price transparency. It includes requirements that would apply to each hospital operating in the United States. This fact sheet discusses the provisions of the final rule (CMS-1717-F2), which can be downloaded from the *Federal Register* at: https://www.hhs.gov/sites/default/files/cms-1717-f2.pdf.

Furthermore, the unpublished final rule recaps "Current guidance":

https://www.hhs.gov/sites/default/files/cms-1717-f2.pdf

B. Statutory Basis and Current Guidance

Section 1001 of the Patient Protection and Affordable Care Act (ACA) (Pub. L. 111-148), as amended by section 10101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), amended Title XXVII of the PHS Act, in part, by adding a new section 2718(e) of the PHS Act. Section 2718 of the PHS Act, entitled "Bringing Down the Cost of Health Care Coverage," requires each hospital operating within the United States for each year to establish (and update) and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis related groups (DRGs) established under section 1886(d)(4) of the Social Security Act (SSA).

CMS WORKS TO EASE RAC AUDIT BURDEN: REDUCE DENIAL BACKLOG

Long a thorn in the side of hospitals nationwide, the Centers for Medicare and Medicaid Services' (CMS) Recovery Audit Contractor (RAC) program recently underwent substantial changes which CMS say will make the audit process significantly less burdensome for providers.

The RAC program—one of several Medicare payment oversight initiatives—was launched in 2009 and relies on third-party contractors to uncover and correct improper Medicare fee-for-service payments through post-payment claims reviews.

RACs identified approximately $89 million in overpayments and recovered $73 million in FY 2018.[1] Since its inception, the RAC program has returned more than $10 billion in improper payments to the Medicare trust fund and more than $800 million in underpayments to providers.[2]

RAC audits typically involve automated claim reviews utilizing computers to detect improper payments, as well as complex reviews that incorporate human analysis of medical records and other documentation. The process has long been a target of ire for the American Hospital Association (AHA) and others in the industry due to the disruption, cost and uncertainty that can accompany a RAC audit for a target hospital.

Fewer audits, more transparency

In announcing changes to the RAC process earlier this year, CMS Administrator Seema Verma acknowledged the agency had received numerous complaints about the program in the past.[3]

"Providers found the audits time-consuming, necessitating high administrative expenses, and often requiring lengthy appeals," Verma said. "Thanks to recent efforts by this Administration, complaints about RACs have decreased significantly. CMS listened to what providers were telling us and we made meaningful changes."[4]

CMS WORKS TO EASE RAC AUDIT BURDEN: REDUCE DENIAL BACKLOG

Modifications aimed at making the RAC process easier for providers include:[5]

- RACs could previously select a certain type of claim to audit. They must now audit proportionately to the types of claims a provider submits
- Instead of treating all providers the same, RACs are conducting fewer audits of providers with low claims denial rates
- Providers have more time to submit additional documentation before being required to repay a claim. A 30-day discussion period, after an improper payment is identified, means that providers do not have to choose between initiating a discussion and filing an appeal
- CMS is now seeking public comment on newly proposed RAC areas for review before the reviews begin. According to the agency, this allows providers to voice concerns regarding potentially unclear policies that will be part of the review

Among the CMS program changes designed to hold RACs more accountable:[6]

- RAC provider portals are being enhanced to make it easier for providers to understand the status of claims
- RACs that fail to maintain a 95% accuracy score will receive a progressive reduction in the number of claims they're allowed to review
- RACs that fail to maintain an overturn rate of less than 10% will also see a reduction in the number of claims they can review
- RACs will not receive a contingency fee until after the second level of appeals is exhausted. Previously, RACs were paid immediately upon denial and recoupment of the claim. This delay in payment helps assure providers that the RAC's decision was correct before they're paid, according to CMS

Tracking RACs

The AHA closely monitored the RAC program between 2014 and 2016. According to the AHA's final RAC report, 60% of claims reviewed by RACs in the third quarter of 2016 were found not to have an overpayment.[7] Hospitals appealed 45% of all denials, with 27% of hospitals reporting having a denial reversed in the discussion period.[8]

AHA also disclosed that 43% of hospitals spent over $10,000 to manage the RAC process during Q3 2016, while 24% spent more than $25,000 and 4% spent over $100,000.[9]

CMS WORKS TO EASE RAC AUDIT BURDEN: REDUCE DENIAL BACKLOG

Driving down the denial backlog

In recent years, denials initiated due to RAC audits have contributed to a massive backlog of Medicare appeals, the number of which totaled 426,594 in November 2018.[10] In response to a lawsuit brought by AHA and others, the Department of Health and Human Services (HHS) was ordered last year to eliminate the backlog by the end of the 2022 fiscal year.[11]

As a result of the order, the backlog had been reduced by 25%, or 108,340 appeals, by the end of Q3 2019, according to AHA, bringing the total down to 318,254.[12] AHA and others sued HHS in 2012 for noncompliance with a statutory requirement that decisions on appeals at the administrative law judge level be made within 90 days.[13] According to CMS, the average processing time for appeals was 1,361 days in FY 2019, up from 1,193 days in 2018 and 94 days in 2009, the year the RACs program was launched.[14]

RAC tactics

In anticipation of an increase in RAC activity—and because CMS Administrator Verma noted that RACs will henceforth be guided by the volume of claims a provider submits—some experts are zeroing in on claims that may represent large-volume risk areas for hospitals.

Among these, according to the John Hall, MD, writing in RACmonitor publication, are observation claims. "There are two types of potential observation denials," Hall wrote.[15] "The first is denials based on the failure to document the essential elements of observation services. The second is based on observation claims that should have been inpatient."

Hall suggested asking a series of questions about each observation claim in preparation for a possible review:[16]

- Does the documentation indicate what is being treated, assessed and reassessed?
- Is there documentation of ongoing treatment, assessment and reassessment, or is the patient being seen once a day?
- Does the documentation indicate what parameters might trigger admission "for further treatment," or if the patient might be discharged from the hospital?

"Implicit in observation services, for the purposes of reimbursement, is a decision related to admission or discharge," Hall wrote. "If the record does not delineate CMS' criteria, then observation reimbursement might be jeopardized."[17]

Hall suggested asking a series of questions about each observation claim in preparation for a possible review.

CMS WORKS TO EASE RAC AUDIT BURDEN: REDUCE DENIAL BACKLOG

According to Hall, other potential risk areas, based on the new RAC guidance, include:[18]

- Diagnostic or therapeutic services with documentation requirements
- One-midnight inpatient surgical procedures
- Observation services in the perioperative period
- Inpatient care for traditionally outpatient services
- NCD and LCD compliance

1 Seema Verma, "Recovery Audits: Improvements to Protect Taxpayer Dollars and put Patients over Paperwork," CMS.gov, May 2, 2019

2 "A History of the RAC Program," MedicareIntegrity.org,

3 Seema Verma, "Recovery Audits: Improvements to Protect Taxpayer Dollars and put Patients over Paperwork," CMS.gov, May 2, 2019

4 Ibid.

5 Ibid.

6 Ibid.

7 "Exploring the Impact of the RAC Program on Hospitals Nationwide," American Hospital Association, Dec. 5, 2016

8 Ibid.

9 Ibid.

10 Jacqueline LaPointe, "Court Orders HHS to Eliminate Medicare Appeals Backlog by 2022," RevCycle Intelligence, Nov. 13, 2018

11 Ibid.

12 "As a result of AHA lawsuit, HHS continues to reduce appeals backlog," press release, American Hospital Association, Sept. 30, 2019

13 Jacqueline LaPointe, "Judge Asks AHA to Develop Medicare Appeals Backlog Solutions," RevCycle Intelligence, April 4, 2018

14 "Average Processing Time By Fiscal Year," Office of Medicare Hearings and Appeals, HHS

15 John K. Hall, "Level of Concern Rises as RACs are Back," RACmonitor, July 24, 2019

16 Ibid.

17 Ibid.

18 John K. Hall, "Level of Concern Rises as RACs are Back: Part II," RACmonitor, July 31, 2019

MODIFIER REQUIREMENTS FOR PT/OT ASSISTANTS

THIS REVISED DOCUMENT CLARIFIES INFORMATION REGARDING THE MODIFIER REPORTING REQUIREMENTS FOR PHYSICAL AND OCCUPATIONAL THERAPISTS. ACCORDING TO THE MEDICARE PHYSICIAN FEE SCHEDULE FINAL RULE, MODIFIERS CO AND CQ SHOULD BE REPORTED TOGETHER WITH THE EXISTING THERAPY MODIFIERS GP AND GO.

https://www.federalregister.gov/documents/2019/08/14/2019-16041/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

NATIONAL ARCHIVES

FEDERAL REGISTER

The Daily Journal of the United States Government

"In the CY 2019 PFS final rule, we clarified that the CQ and CO modifiers are required to be used when applicable for services furnished on or after January 1, 2020, on the claim line of the service alongside the respective GP or GO therapy modifier to identify services furnished under a PT or OT plan of care."

The Centers for Medicare and Medicaid Services (CMS) will move forward with their proposal in the 2020 MPFS Proposed Rule to require providers to identify when therapy services are furnished by a Physical Therapy Assistant (PTA) or Occupational Therapy Assistant (OTA). Section 1834 (v)(2)(B) of the Bipartisan Budget Act of 2018 requires that claims submitted on or after January 1, 2020 for outpatient physical therapy or occupational therapy must include the modifiers established by CMS to identify that services were rendered in whole or in part by a PTA or an OTA.

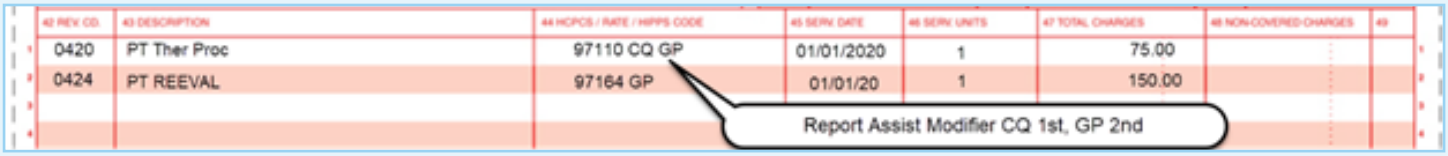
These modifiers will be for reporting and data collection only; payment will not be affected in 2020.

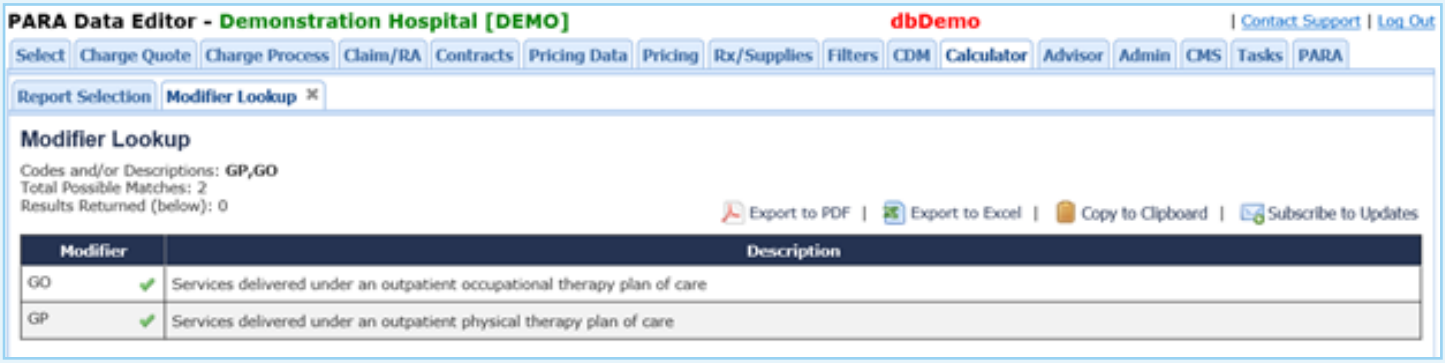
Beginning January 1, 2022 providers will receive payment at 85% of the of the otherwise applicable Medicare Part B payment for services provided by a PTA or OTA. Beginning January 1, 2020 providers will be required to report Modifiers CO and CQ to identify services furnished by a PTA or an OTA respectively.

The use of the CO and CQ modifiers and the subsequent 2022 payment reduction apply to all hospital outpatient departments, SNFs, CORFs, Home Health and Rehabilitation Agencies. Critical Access Hospitals are exempt from these requirements because they are not paid under PFS rates for therapy services.

MODIFIER REQUIREMENTS FOR PT/OT ASSISTANTS

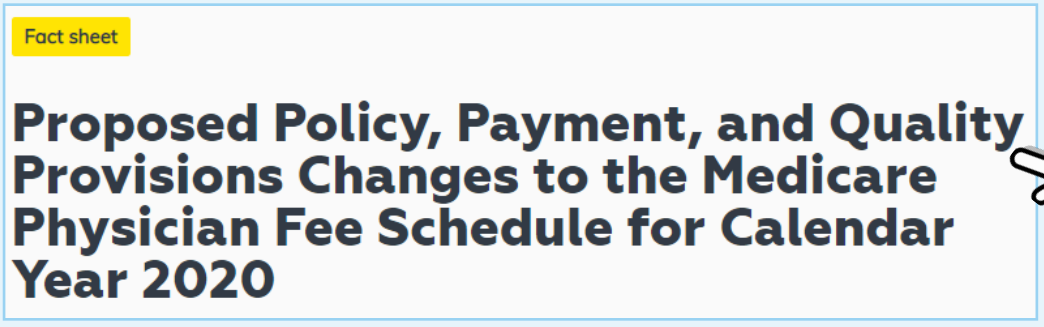
When therapy services are rendered by a PTA or an OTA, the CO and CQ modifiers will be used in addition to the existing GP and GO modifiers that are currently used to identify physical and occupational therapy services. Modifiers GP and GO will also continue to be used to identify services provided by a physical or occupational therapist. Report the CO or CQ modifier in the primary modifier field; report the GO or GP modifier in the second modifier field.





The 2020 MPFS final rule sets a 10 percent minimum standard for when the CO and CQ modifiers will apply. If a PTA or OTA provides more than 10 percent of the care in a treatment session, then the provider would report the services rendered with the CO and CQ modifiers.

https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-2



The final rule provides clarification on how to calculate the 10 percent limit. There are two possible methods that can be used for calculation:

Method 1: Divide the number of minutes of care provided by the PTA/OTA by the total minutes of care provided then multiply by 100. That will give providers the percentage of time of care provided by the PTA/OTA. Providers should round the number to the nearest whole number. Anything equal to or greater than 11 percent requires application of the modifier.

Method 2: Divide the total time of care provided to the patient by 10 (round to the nearest whole number) and add 1 minute to set the minimum time requirement. If the treatment total time was 60 minutes, then 10% is 6 minutes plus 1 minute is 7 minutes. If the PTA/OTA care was 7 minutes or more then the CO/CQ modifier would be added to those line items.

MODIFIER REQUIREMENTS FOR PT/OT ASSISTANTS

The following chart is provided as an example for the Method 2 calculation:

METHOD TWO: Simple Method to apply 10 Percent De Minimis Standard

Total Time* Examples Using Typical Service Total Times	Determine the 10 percent standard by dividing service Total Time by 10	Round 10 Percent standard to Next Whole Integer	PTA/OTA Minutes Needed to Exceed -- Apply CQ/CO
10	1.0	1.0	2.0
15	1.5	2.0	3.0
20	2.0	2.0	3.0
30	3.0	3.0	4.0
45	4.5	5.0	6.0
60	6.0	6.0	7.0
75	7.5	8.0	9.0

Total Time equals total therapist minutes plus any PTA/OTA independent minutes. Concurrent minutes: When PTA/OTA's minutes are furnished concurrently with the therapist, total time equals the total minutes of the therapist's service. Separate minutes: When PTA/OTA's minutes are furnished separately from the minutes furnished by the therapist, total time equals the sum of the minutes of the service furnished by the PT/OT plus the minutes of the service furnished separately by the PTA/OTA.

https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-2

Also, it is important to note that there are documentation requirements included in the MPFS final rule.

Since modifiers are applied on a per code basis, documentation would need to state the code, modifier applied or not applied, and the amount of time services were provided by the PTA/OTA to justify appending or omitting the CO/CQ modifiers.

Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2020.

The calendar year (CY) 2020 PFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation.

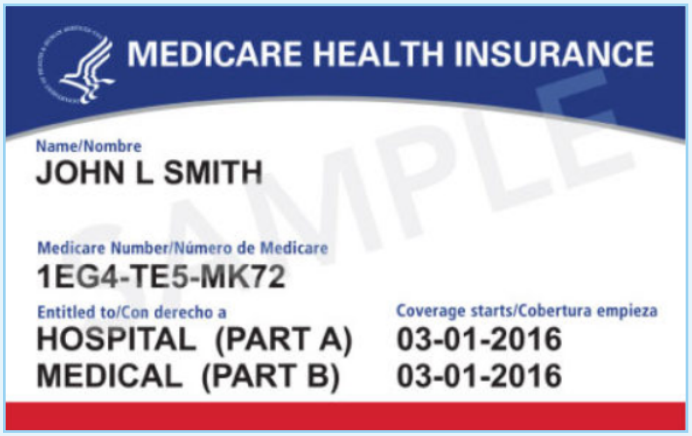
Background on the Physician Fee Schedule

Payment is made under the PFS for services furnished by physicians and other practitioners in all sites of service. These services include, but are not limited to, visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.

In addition to physicians, payment is made under the PFS to a variety of practitioners and entities, including nurse practitioners, physician assistants, and physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

Payments are based on the relative resources typically used to furnish the service. Relative Value Units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor. Payment rates are calculated to include an overall payment update specified by statute.

MEDICARE BENEFICIARY IDENTIFIER (MBI) REMINDER

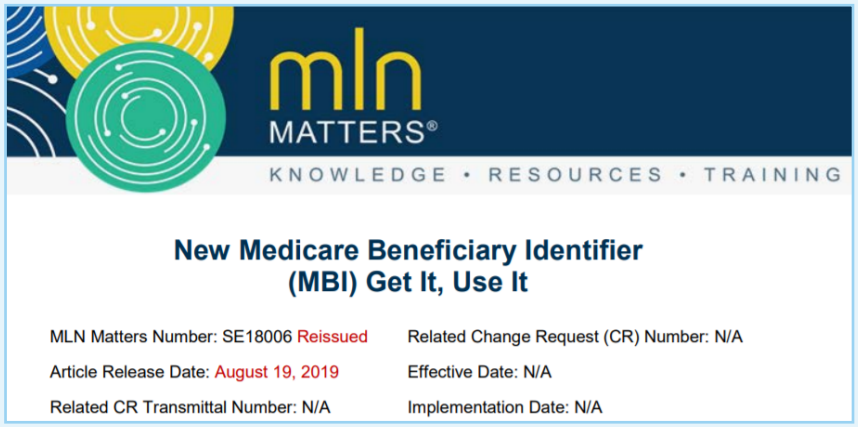


In preparation for the new year, CMS has re-issued MLN SE18006, as a reminder to providers to convert using the new Medicare Beneficiary Identifier (MBI) at the claim level. The Centers for Medicare and Medicaid (CMS) has completed mailing all new Medicare cards. The new cards are designed to enhance protection for Medicare Beneficiaries personal identities.

The re-issuing of the August 19, 2019 MLN SE18006, was completed by CMS to serve as a reminder to providers to implement this change starting now.

Effective January 01, 2020, CMS will reject claims that do not have the MBI number on the claim. Further CMS, will begin rejecting all eligibility transactions submitted that reflect the old HICNs.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18006.pdf



Currently CMS has identified three exceptions to this new implementation requirement:

1. **Appeals**: When filing an appeal, providers have the option to either use the HICN or MBI

2. **Claim status query**: This depends on the date of service on the claim when the provider is performing this process.
   - If the earliest date of service on the claim is before January 01, 2020, providers have the option to use either the HICN or MBI
   - If the date of service on the claim is after January 01, 2020, the MBI must be used

3. **Span-date claims**: Providers have the option during the transition period to use the HICNs or MBIs for bill types:
   - Inpatient Hospital (11X)
   - Home Health Claims including Request for Anticipated Payments (RAPs)
   - Religious Non-Medical Health Care Institution

If the "From Date" is before the end of the transition period (December 31, 2019.) If a Medicare Beneficiary begins services in an Inpatient Hospital, Home Health, or Religious Non-Medical Health Care Institution before December 31, 2019, but is discharged after December 31, 2019, providers have the option to submit a claim using either the HICN or MBI.

Home Health providers: If the patient is admitted for services prior to December 31, 2019, the RAP may be submitted using either the HICN or MBI, however the MBI will be required on the End of Episode (EOE) claim if services continue after January 01, 2020.

HOME HEALTH CY 2020 FINAL RULE

On October 26, 2019, the Centers for Medicare and Medicaid (CMS) issued the Final Rule (CMS-1689-F) for Calendar Year (CY) 2019.

This issue finalized:

- Payment updates
- Quality reporting changes for home health agencies (HHAs)
- Finalized case-mix methodology refinements
- Change in the home health unit of payment from 60 days to 30 days for CY 2020
- The rule discusses the implementation of temporary transitional payments for home infusion therapy services to begin on January 01, 2019 and summarizes public comments related to the full implementation of the new home infusion therapy benefit to begin in CY 2021

A copy of the final rule can be reviewed at the following link on the Federal Register website:

https://www.federalregister.gov/public-inspection/current

Medicare and Medicaid Programs:

CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; etc.

Filed on: 10/31/2019 at 4:15 pm
Scheduled Pub. Date: 11/08/2019
FR Document: 2019-24026

PDF 511 Pages (2.3 MB)
Permalink

The following paragraphs summarize the highlight targets of the Final Rule impacts:

1. Payment Rate Changes under the HH PPS for CY 2019: CMS is projecting Medicare payments to HHA's in CY 2019 will increase by 2.2 percent (%), based on the finalized policies. CMS arrived on this estimate based on:

- A 0.1 percent (%) increase in payments due to decreasing the fixed-dollar-loss (FDL) ratio to pay no more than 2.5 percent (%) of total payment as outlier payments, and
- A 0.1 percent (%) decrease in payments due to the new rural add-on policy that is being mandated by the Bipartisan Budget Act of CY2018 for CY 2019. The new rural add-on policy requires CMS to

HOME HEALTH CY 2020 FINAL RULE

classify rural counties (and equivalent areas) into one (1) of three (3) categories which are based on:

- High home health utilization
- Low population density
- All others

- Because of this, rural add-on payments for CY 2019 through CY 2022 will vary based on counties (or equivalent areas) category classification

2. Modernizing the HH PPS Case-Mix Classification System and Promoting Patient-Driven Care: Under the Bipartisan Budget Act of CY 2018, it requires a change in the unit of payment under the HH PPS, from 60-day episodes of care to 30-day periods of care, to be implemented in a budget neutral manner on January 01, 2020.

- In addition, for CY 2020, the Bipartisan Budget Act of CY 2018 mandated that Medicare stop using the number of therapy visit provided to determine home health payment

- Therapy thresholds encourage volume over value and do not acknowledge that all patients do not respond the same, with some patients having complex needs that do not involve a lot of therapy

CMS is finalizing the implementation of the Patient-Driven Groupings Model, also known as PDGM. This change will apply to home health periods of care beginning on or after January 01, 2020. Under PDGM methodology CMS is intending to:

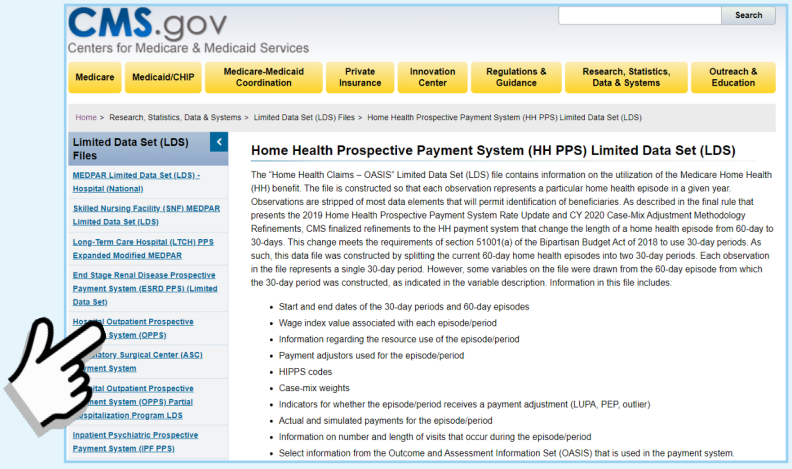
- Remove the current incentive to overprovide therapy

- Instead, PDGM is designed to reflect CMS focus on relying more heavily on clinical characteristics and other patient clinical information to allow reimbursement to reflect more to the needs of the patient

- The improved structure of the case-mix system will move Medicare towards a more value-based payment system that puts patient needs first

To support an assessment of the effects of the PDGM, CMS will provide, upon request, a Home Health Claims-OASIS Limited Data Set (LDS) file to accompany the CY 2019 HH PPS Final Rule. This request may be accessed at the link below:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/Home_Health_PPS_LDS.html



HOME HEALTH CY 2020 FINAL RULE

In addition, CMS will make available agency-level impacts, as well as an interactive Grouper Tool that will allow HHAs to determine case-mix weights for their specific patient populations. The web link has been inserted below:

https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

- CY 2020 HH PPS Wage Index [ZIP, 105KB]
- CY 2019 HH PPS Case Mix Weights for 60-day episodes into CY 2020 [ZIP, 13KB]
- CY 2020-CY 2022-Rural-Add-On-Payment Designations [ZIP, 154KB]
- CY 2020 PDGM Case Mix Weights and LUPA Thresholds [ZIP, 27KB]
- CY 2020 PDGM Interactive Grouper Tool [ZIP, 1MB]
- CY 2020 PDGM Agency Level Impacts [ZIP, 1MB]

3. The use of Remote Patient Monitoring (RPM) under the Medicare Home Health Benefit:

CMS finalized the definition remote patient monitoring (RPM) in regulation for the Medicare home health benefit. Agencies will be allowed to report the program implementation on the agency cost report.

CMS is allowing this benefit due to previous study findings show that RPM services have a positive impact on the patients, as it allows patients to hare more live-in data with their providers and care-givers. CMS is encouraging HHAs to participate and offer these services to their patients. For more information regarding this service, please visit the link below:

https://apps.para-hcfs.com/para/Documents/PARA%20FAQ%20Remote%20Patient%20Monitoring%20March%202019.pdf

FAQ Remote Patient Monitoring (RPM)

With the passage of the final rule, CMS implemented 3 new codes that became effective as of January 01, 2019. These codes are intended to incentivize providers to effectively and efficiently use RPM technology to monitor and manage patient care needs.

Question: Does Medicare already cover remote patient monitoring? Yes, prior to the creation of the newly defined codes, monitoring services were reported by providers under 99091. This code was implemented by CMS beginning January 01, 2018.

Question: So why did CMS create additional codes for this service? 99091 proved to fail to optimally describe how RPM services are furnished using the current technology and staffing models. The failure being this code has an N status payment indicator which means it is not separately payable.

The new codes (99453, 99454 and 99457) accurately reflect RPM services

PARA HealthCare Financial Services / Analytics – March 2019

HOME HEALTH CY 2020 FINAL RULE

4. New Home Infusion Therapy Services Temporary Transitional Payment and Home Infusion Therapy Benefit: In accordance to the mandates in section 50401 of the Bipartisan Budget Act of CY 2018, for CY 2019 and CY 2020 CMS is implementing a temporary transitional payment for home infusion therapy services that will reimburse eligible home infusion therapy suppliers for associated professional services for administering certain drugs and biologicals infused through

- A durable medical equipment (DME) pump
- Training and education
- Remote Patient Monitoring (RPM)
- In-home monitoring

Section 50401 of the Bipartisan Budget Act of 2018

On February 9, 2018, the Bipartisan Budget Act of 2018 was signed into law. Section 50401 amended section 1834(u) of the Act, by adding a new paragraph (7) that establishes a home infusion therapy services temporary transitional payment for eligible home infusion suppliers for certain items and services furnished in coordination with the furnishing of transitional home infusion drugs beginning January 1, 2019. This temporary payment covers the cost of the same items and services, as defined in section 1861(iii)(2)(A) and (B) of the Act, related to the administration of home infusion drugs. The temporary transitional payment would begin on January 1, 2019 and end the day before the full implementation of the home infusion therapy benefit on January 1, 2021, as required by section 5012 of the 21st Century Cures Act.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.html

In addition, Section 5012 of the 21st Century Cures Act creates a new permanent Medicare benefit for home infusion therapy services beginning January 01, 2021. As a result, this final rule finalizes the elements of the permanent home infusion benefit including:

- Health and safety standards for home infusion therapy
- The accreditation process for qualified home infusion therapy suppliers
- Approval and oversight process for the organizations that accredit qualified home infusion therapy suppliers

CMS is still seeking comments from stakeholders regarding the CMS interpretation of the phase "infusion drug administration calendar day" and on its potential effects on access to care. This is the reason for only a partial implementation of this benefit begins on January 01, 2019.

5. Home Health Quality Reporting Program (HH QRP) Provisions: In this final rule for Home Health, CMS is finalizing Meaningful Measures Initiative which will result in further alignment with CMS policies of other CMS quality programs. The provisions being finalized are:

- CMS policy for removing previously adopted HH QRP measures to be based on eight (8) measure removal factors

HOME HEALTH CY 2020 FINAL RULE

- Removal of seven quality measures based on one of these eight finalized measure removal factors
- Final update to regulations to clarify not all OASIS data is used to determine whether an HHA has met reporting requirements for the HH QRP program year

6. Home Health Value-Based Purchasing Model: The last target of this final rule for Home Health, CMS is finalizing the following changes to the HHVBP Model:

- Beginning with Performance Year 4 there will be a removal of two (2) Outcome and Assessment Information Set (OASIS)- based measures:
  - Influenza Immunization Received for Current Flu Season, and
  - Pneumococcal Polysaccharide Vaccine Ever Received
- These measures will be replaced with three (3) OASIS-based measures with two new composite measures related to total change in self-care and mobility

Reference for this article:

https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

UNDER THE MICROSCOPE

Clearing Up Confusion On 14x TOB

For Non-Patient Specimens

In the course of educating hospitals on the new PAMA private payer lab reporting requirements for hospital "outreach" lab services, PARA has encountered several facilities which may have misunderstood a 2014 Medicare transmittal which, among other things, informed hospitals to discontinue reporting outpatient hospital lab testing on the non-patient Type of Bill (TOB) 014x.

MLN Matters article SE1412 reversed a short-lived Medicare instruction to report lab testing performed on an outpatient of the hospital (as opposed to a non-patient), when the testing was unrelated to an encounter on the same day, on the 014x type of bill.

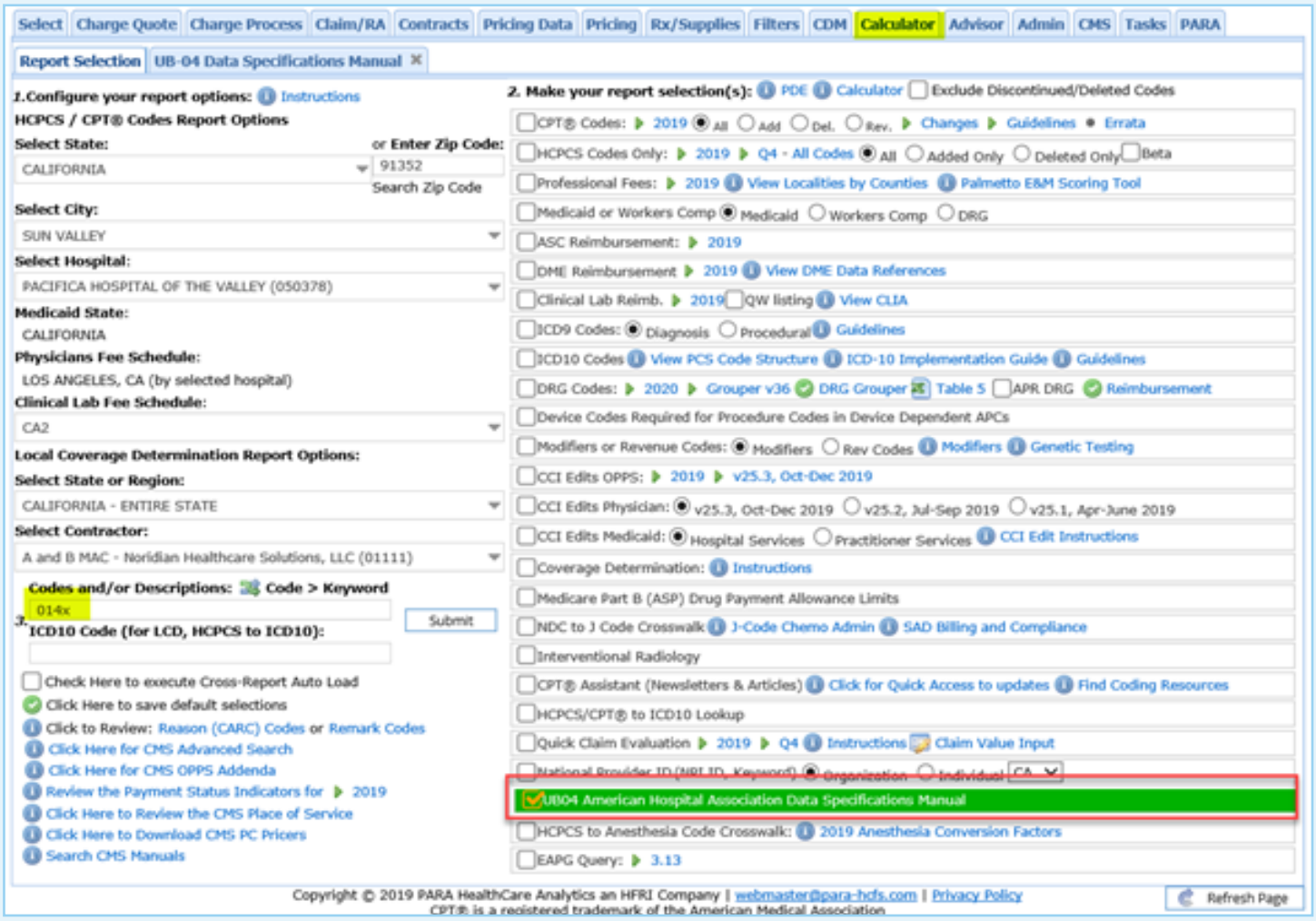
CMS explained that reporting outpatient services on the 014x TOB was not compliant with HIPAA standard transaction data set rules, and told hospitals to stop using the 141 TOB for those circumstances. At the end of the transmittal, CMS reminded hospitals to use the 014x TOB for non-patient services:

MLN Matters® Number: SE1412 **Related Change Request Number: 8572**

As a reminder, for claims received on or after July 1, 2014, OPPS providers are instructed to submit "specimen only" services on the 014x TOB. OPPS providers are instructed not to use the new modifier on 014x TOB.

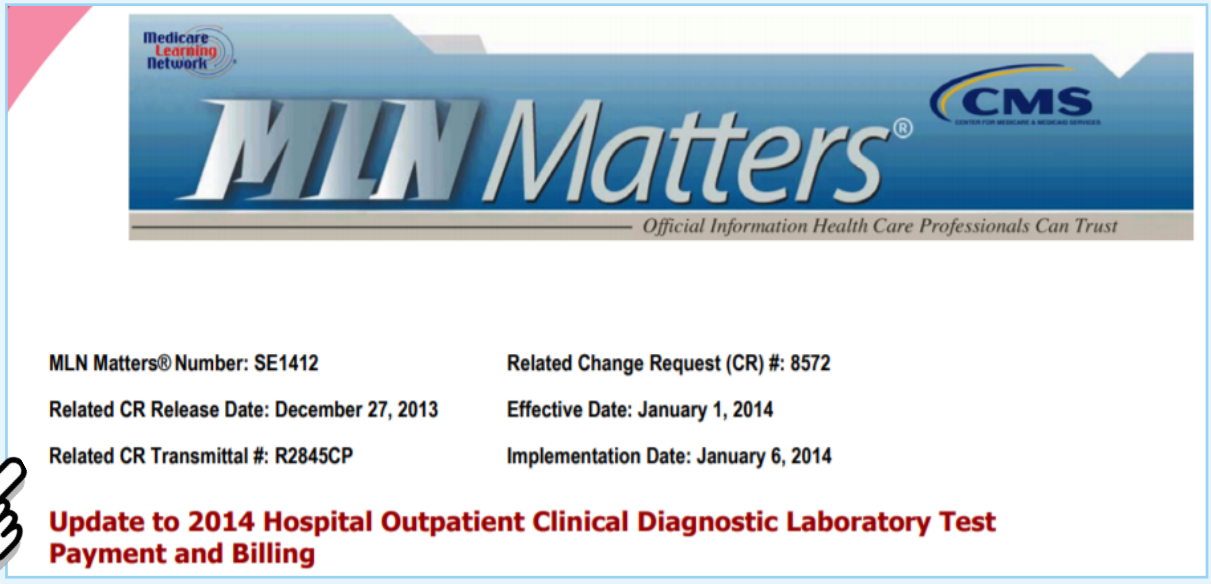
PARA Data Editor users with "UB Data Specifications" access can view the American Hospital Association type of bill indicators on the Calculator tab by entering "04x" in the search function and selecting the UB Data Specifications report (see next page):

UNDER THE MICROSCOPE



A larger excerpt from the transmittal follows:

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE1412.pdf



UNDER THE MICROSCOPE

"As per the OPPS final rule, CMS created very limited exceptions to the packaging policy and instructed hospitals to use the 014X TOB (Hospital Non-Patient) to obtain separate payment only in the following circumstances:

(1) Non-patient (referred) specimen;

(2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or

(3) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

...

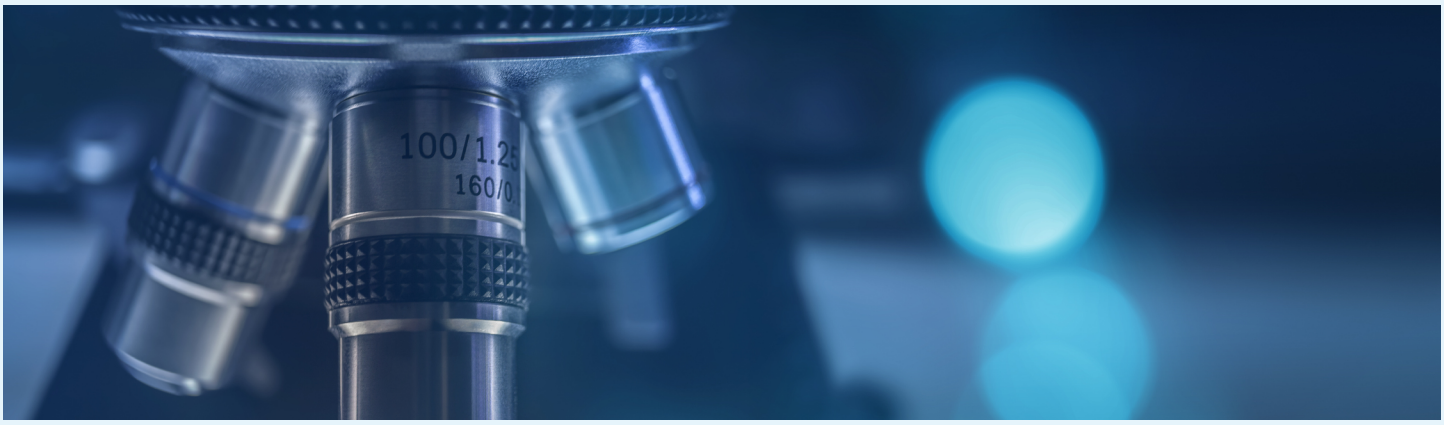
"Since publication of the final rule and the January release of CR 8572, some hospitals expressed concern that submitting a 014x TOB in this manner may violate the Health Insurance Portability and Accountability Act. The National Uniform Billing Committee (NUBC) definition approved in 2005 for the 014x TOB for billing of laboratory services provided to "Non-Patients," means referred specimen, where the patient is not present at the hospital.

"To alleviate this concern, for CY 2014 a new modifier will be used on the 013X TOB (instead of the 014X TOB) when non-referred lab tests are eligible for separate payment under the CLFS for exceptions (2) and (3) listed above. The 014x will only be used for non-patient (meaning referred) laboratory specimens (exception 1 above) and will not include this new modifier. The new modifier will be effective for claims received on or after July 1, 2014, and retroactive for dates of service on or after January 1, 2014. Please note that CMS views this new modifier as an immediate solution to hospitals' concern for CY 2014 and that we may evaluate better means to bill for laboratory services next year."

Medicare did not instruct hospitals to stop using the 014x TOB for all circumstances. The 014x TOB remains the appropriate billing form for hospitals to report charges for laboratory processing of specimen-only, non-patient services. It is inappropriate for hospitals to report non-patient services on the 013x TOB.

Another MLN Matters article repeats the direction from Medicare to stop using the 14x TOB when a lab service was rendered the same day as another outpatient service:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8776.pdf [excerpt provided is on page 8]



UNDER THE MICROSCOPE

MLN Matters® Number: MM8776 **Related Change Request Number: 8776**

Operational Change to Billing Lab Tests for Separate Payment

As delineated in MLN Matters Special Edition Article (SE)1412, issued on March 5, 2014, (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticles/Downloads/SE1412.pdf), effective July 1, 2014, OPPS hospitals should begin using modifier L1 on type of bill (TOB) 13X when seeking separate payment for outpatient lab tests under the Clinical Laboratory Fee Schedule (CLFS) in the following circumstances:

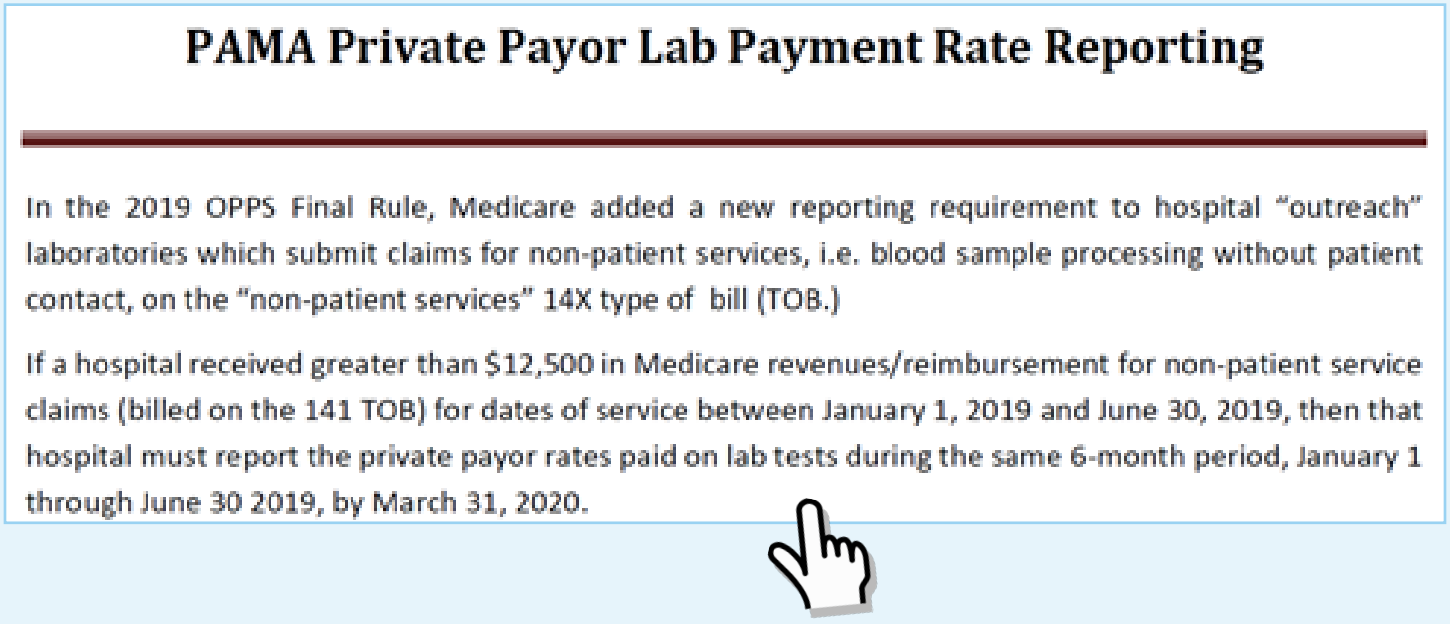
1) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or

2) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day.

"Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Hospitals should no longer use TOB 14X in these circumstances.

PARA offers guidance to hospitals in the new PAMA private-payer payment rate reporting requirements at the following link:

https://apps.para-hcfs.com/para/Documents/PAMA%20Private%20Payor%20Lab %20Payment%20Rate%20Reporting%20(Nov%208%202019)%20-%20Final.pdf



PAMA Private Payor Lab Payment Rate Reporting

In the 2019 OPPS Final Rule, Medicare added a new reporting requirement to hospital "outreach" laboratories which submit claims for non-patient services, i.e. blood sample processing without patient contact, on the "non-patient services" 14X type of bill (TOB.)

If a hospital received greater than $12,500 in Medicare revenues/reimbursement for non-patient service claims (billed on the 141 TOB) for dates of service between January 1, 2019 and June 30, 2019, then that hospital must report the private payor rates paid on lab tests during the same 6-month period, January 1 through June 30 2019, by March 31, 2020.

CMS: WHAT'S NEXT?

CMS started introducing pricing transparency guidelines in 2015 when it required hospitals to provide a list of standard charges upon request. However, it wasn't until the 2019 final rule that they required hospitals to publish standard charges in a frequently updated, machine-readable format, online.

The President's Executive Order in June 2019 promoted increased availability of meaningful pricing information for patients.

Therefore, CMS' FY2020 Proposed Rule (https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-25011.pdf) attempted to further define hospitals, standard charges, and items and services. Although it continues to call for standard charges in a machine-readable format, it also requested payer-negotiated rates for charges and a separate list of "shoppable" services including 230 hospital-selected and 70 CMS-selected services.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB93

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147 and 158

[CMS- 9915 -P]

RIN 0938-AU04

Transparency in Coverage

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rule.

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). For example, states like California, Colorado, and North Carolina, among others, have required annual posting of chargemasters, a selection of hospital financial reports, and a listing of common procedures, for years.

CMS: WHAT'S NEXT?

The American Hospital Association (AHA) soundly opposed the rule as it was written - (https://www.aha.org/news/headline/2019-09-27-aha-comments-opps-proposed-rule-cy-2020). In fact, of the 66 pages of comments on the proposed rule, 20 pages were devoted to the proposed Pricing Transparency guidelines outlined in the rule. 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 AHA mentions many legal and operational challenges, even citing First Amendment rights and anti-trust, anti-competition challenges. We know that hospitals are operating on very thin margins and that threatening health plan competition in the marketplace may be detrimental to providers. Additionally, operationalizing this request is a sizable ask of the Finance and IT teams at hospitals.

In the originally released Final Rule, CMS postponed a response/decision on this component of the proposed rule.

However, on November 15th, they released comments and final action which is expected to be implemented on January 1, 2021. (https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24931.pdf)

The CMS Fact Sheet regarding the new rule (https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price) highlights the following information: Hospital price transparency final rule for FY2021 includes the following components:

1) **Hospitals** post the "standard charges" online in a machine-readable file.

According to the updated definition outlined by CMS, standard charges include all items and services, including supplies, facility fees and professional charges for employed physicians and other practitioners.

The following data points are required:

- gross charges – chargemaster price
- discounted cash prices – self-pay/cash price
- payer-specific negotiated charges – hospital-negotiated price by third party payer
- de-identified minimum negotiated charges – lowest third-party payer negotiated price
- de-identified maximum negotiated charges – highest third-party payer negotiated price

2) **Hospitals** publish 230 hospital-selected and 70 CMS-selected "shoppable services" including payer-specific negotiated rates online in a searchable and consumer-friendly manner.

3) **Hospitals** that fail to publish the negotiated rates online could be fined up to $300 per day.

The positive news from the November 15th announcement is that CMS is now planning to hold health insurance companies responsible for providing a level of transparency to pricing, as well.

According to the proposed rule:

- **Health insurance** companies and group health plans required to disclose on a public website their negotiated rates for in-network providers and allowed amounts paid for out-of-network providers. Focused on promoting competition, driving innovation and supporting price-conscious decision-making, according to the CMS fact sheet on the proposed rule
- **Health insurers** required to offer a transparency tool to provide members with personalized out-of-pocket cost information for all covered services in advance.

For more information on how **PARA Solutions** can support your journey to Pricing Transparency, please contact your **PARA Account Executive**.

APPROPRIATE USE HCPCS AND MODIFIERS RELEASED

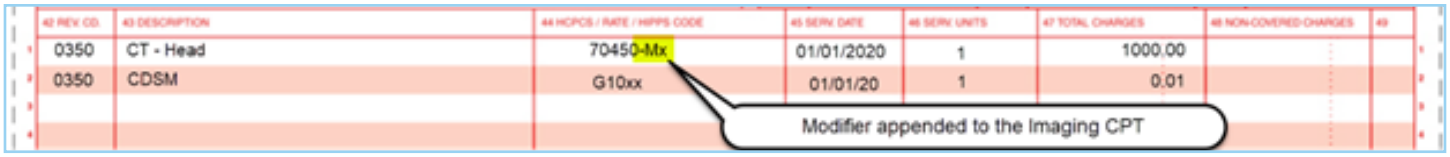
NEW

THIS REVISED DOCUMENT CORRECTS INFORMATION REGARDING THE NEW CDSM MODIFIERS, WHICH SHOULD BE APPENDED TO THE IMAGING HCPCS RATHER THAN THE INFORMATIONAL G-CODE.

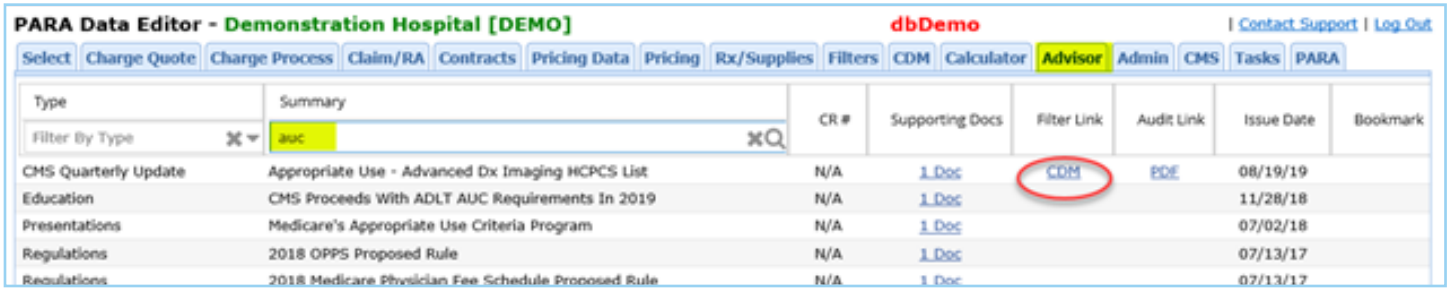
The long-awaited CMS plan to require additional HCPCS to claims for Advanced Diagnostic Imaging has been unveiled. CMS will begin an "Educational and Operations Testing Period", expected to last for one year (January 1, 2020 – December 31, 2020). No denials for lack of CDSM reporting will occur during the "Education and Testing Phase" in 2020. (The requirement does not apply to Critical Access Hospitals.)

While reporting in 2020 is "encouraged", it appears that in 2021 reporting will be mandatory, although CMS has not committed to that date yet. Eventually, "rendering providers" i.e. hospitals and independent imaging centers, as well as interpreting radiologists, will be required to report an informational G-code, along with a modifier appended to the imaging exam HCPCS, to obtain payment for an Advanced Diagnostic Imaging Study.

The excerpt below illustrates the mandatory reporting for a CT of the head billed to Medicare on a UB04:



The list of imaging HCPCS which will require CDSM reporting is available on the **PARA Data Editor**; search the Advisor tab with the keyword "AUC" in the summary field, then click on the "CDM" link to the right of that Advisor:



The MLN Matters article describing the new requirements is available at the link below:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements

MLN Matters Number: MM11268

Related Change Request (CR) Number: 11268

Related CR Release Date: July 26, 2019

Effective Date: January 1, 2020

Related CR Transmittal Number: R2323OTN

Implementation Date: January 6, 2020

APPROPRIATE USE HCPCS AND MODIFIERS RELEASED

During the 2020 "Education and Testing phase", CMS indicates that claims will not be denied for failing to include AUC-related information or for misreporting AUC information on non-imaging claims, but inclusion is encouraged.

The reporting requirement is challenging, in that hospitals and radiologists will require the CDSM information from the ordering provider. Since ordering providers are not accustomed to consulting CDSMs, and may or may not have access to a CDSM, compliance with the new requirements will require considerable organization and teamwork.

Beginning in 2020, CMS claims processing systems will accept eleven new informational HCPCS, which identify by name each qualified CDSM programs. In addition, eight new modifiers to be appended to the HCPCS for Advanced Diagnostic Imaging services have been released. Each advanced diagnostic imaging service billed to Medicare after 1/1/2020 should list one informational G-code, and a CDSM modifier should be appended to the imaging exam HCPCS.

In 2019, reporting was both voluntary and fairly simple – if the ordering practitioner consulted a CDSM when ordering an advanced diagnostic imaging exam, the billing provider supplying the technical component or the professional interpretation appends modifier QQ (Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional) to the imaging code HCPCS. There was no second line HCPCS which identified the CDSM consulted. While the QQ modifier was not deleted in 2020, Medicare has instructed rendering providers to use the new modifier set after 1/1/2020.

Medicare created ten new HCPCS G-codes, G1000-G1010, to identify "qualified" CDSM programs by name, plus G1011 for "NOS" – not otherwise specified.

Each HCPCS long description includes "as defined by the Medicare Appropriate Use Criteria Program", which we have omitted for the sake of brevity in the list below:

- G1000 - Clinical Decision Support Mechanism Applied Pathways
- G1001 - Clinical Decision Support Mechanism eviCore
- G1002 - Clinical Decision Support Mechanism MedCurrent
- G1003 - Clinical Decision Support Mechanism Medicalis
- G1004 - Clinical Decision Support Mechanism National Decision Support Company,
- G1005 - Clinical Decision Support Mechanism National Imaging Associates
- G1006 - Clinical Decision Support Mechanism Test Appropriate
- G1007 - Clinical Decision Support Mechanism AIM Specialty Health
- G1008 - Clinical Decision Support Mechanism Cranberry Peak
- G1009 - Clinical Decision Support Mechanism Sage Health Management Solutions
- G1010 - Clinical Decision Support Mechanism Stanson
- G1011 - Clinical Decision Support Mechanism, qualified tool not otherwise specified

APPROPRIATE USE HCPCS AND MODIFIERS RELEASED

Medicare also released eight new modifiers to be appended to the imaging exam HCPCS if an Advanced Diagnostic Imaging is billed. The modifiers indicate the clinician's use (or non-use) and compliance with a Clinical Decision Support Mechanism (CDSM) when ordering Advanced Imaging Studies. The list of modifiers appears below.

Modifiers to be appended to Advanced Diagnostic Imaging HCPCS on Medicare Outpatient Claims		
Modifier	**Short Descriptor**	**Long Descriptor**
MA	Emer med cond susp/confirm	Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition
MB	AUC hardship, insuf internet	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access
MC	AUC hardship, vendor issues	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues
MD	AUC hardship, extreme circ	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances
ME	Order adheres to AUC	The order for this service adheres to appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
MF	Order does not adhere to AUC	The order for this service does not adhere to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
MG	AUC not applicable to order	The order for this service does not have applicable appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional
MH	AUC consult not provided	Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

On October 24, 2018, President Trump signed into law the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L., (115-271).

The law was adopted in response to growing concerns nationwide about the increasing numbers of drug overdose deaths. The numbers, specifically Opioid overdoses, have significantly been on the increase since CY 2002.

The Support Act consists of eight titles. Among the significant Medicare changes, the law creates a Medicare bundled payment for an incident of medication-assisted treatment (MAT), which combines medications with counseling and behavioral therapies to provide a holistic approach to treating Opioid Use Disorder (OUD) and makes federally registered opioid treatment programs (OTPs) approved Medicare providers.

In addition, under the Act private insurers will be required to offer Medicare Part D prescription drug plans to implement "lock-in" programs. This requirement is scheduled to be implemented in CY 2022, that limit the number of pharmacies and prescribers used by enrollees that are identified as at risk of opioid abuse.

https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf

TITLE II—MEDICARE PROVISIONS TO ADDRESS THE OPIOID CRISIS

SEC. 2001. EXPANDING THE USE OF TELEHEALTH SERVICES FOR THE TREATMENT OF OPIOID USE DISORDER AND OTHER SUBSTANCE USE DISORDERS.

(a) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

Medicare Coverage of Opioids and OUD Treatment:

Currently, Medicare benefits are provided through Part A, which covers hospital (inpatient) services and skilled nursing care; Part B, which covers physician services, other outpatient services and physician-administered prescription drugs; Part C Medicare Advantage (MA), a managed care option that offers Part A and Part B benefits (except hospice care); and Part D, a voluntary program that provides coverage of outpatient prescription drugs through private health plans.

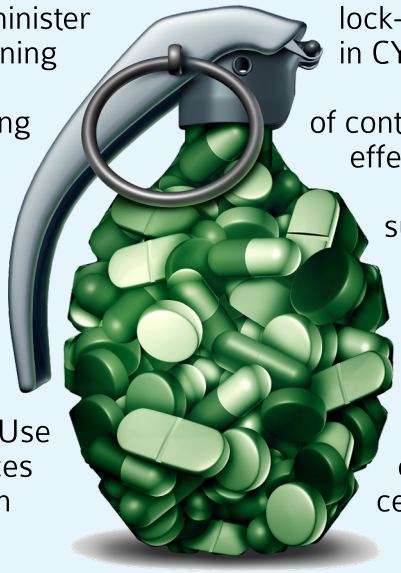
Medicare may provide coverage for opioids prescribed by approved providers in a variety of settings including outpatient care, a hospital, a skilled nursing facility, or a hospice.

Medicare does not currently have a distinct benefit category for Substance Use Disorder (SUD) treatment, although the program will reimburse for certain services, such as psychiatric care and prescription drugs, that are deemed reasonable and necessary for treatment of alcoholism and opioid abuse when provided in settings certified by HHS.

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Medicare Provisions of the SUPPORT Act:

- Creates a new Medicare bundled payment for MAT, effective in CY 2022. The payment covers MAT services provided in federally registered OTPs, including dispensing of methadone.
- Requires Part D plans to administer lock-in programs for enrollees identified as at risk of opioid abuse, beginning in CY 2022.
- Requires electronic prescribing of controlled substances in Medicare Part D to reduce errors and fraud, effective CY 2021.
- Allows Part D plans to suspend payments to pharmacies in cases where there are credible allegations of fraud, beginning in CY 2020.



Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders: Under the current general provisions of CMS, telehealth services can be provided to Medicare beneficiaries under Parts A and B, in certain situations, separate payment for telehealth services will apply.

Under Part B, payments for telehealth services are required to follow the provisions outlined in the Social Security Act (SSA) Section 1834(m), which places the restrictions on the location, provider, telehealth technology, and certain other parameters.

Beginning January 01, 2020, The Bipartisan Budget Act of CY2019 (BBA 18; P.L. 115-123) expands telehealth under Medicare in four ways:

1. Increasing the opportunities for certain accountable care organization (ACO) and Medicare shared savings plans models to receive telehealth payments
2. Eliminating the originating site restrictions for telehealth services for acute stroke evaluation, beginning January 01, 2019
3. Allowing MA plans to provide additional telehealth benefits, which are treated as if they are benefits required under original Medicare (Parts A and B) for payment purposes starting in CY 2020
4. By permitting Medicare patients with end-stage renal disease on home dialysis to receive monthly clinical assessments at home or at freestanding dialysis facilities via telehealth beginning January 01, 2019.

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Medicare provisions of the SUPPORT Act:

Section 2001 of the SUPPORT Act amends SSA Section 1834(m) to eliminate the geographic originating site requirements listed in the above paragraph for telehealth services furnished for the treatment of SUD and co-occurring mental health disorders.

For providers to receive reimbursement for the facility fee for SUD telehealth services, the originating site must be one of the qualifying originating sites listed in the telehealth requirements, (excluding freestanding dialysis facilities). The provision also adds the home as a permissible originating site for SUD telehealth services, however, facility fees would not apply when the originating site is the beneficiary home. The amendments of this provision are to become effective beginning July 01, 2019.

Comprehensive Screenings for Seniors: Currently under Medicare, beneficiaries are entitled to annual "well" visits with the first being furnished within the first year of Medicare enrollment (IPPE). Visits following are considered annually (AWV) and personalized prevention plan services. For each visit, the provision of a health assessment, a suite of physical measurements, education and counseling, and referral for additional preventive services that are covered separately. Consultative services that must be furnished include, among others, end-of-life planning and screenings for depression and alcohol misuse.

Medicare provisions of the SUPPORT ACT:

Section 2002 amends the IPPE authority in SSA Section 1861(ww) to include a review of the beneficiary's current opioid prescriptions and should be defined in the patient medical records:

- Complete review of potential risk factors for OUD
- Evaluation of pain severity and the treatment plan
- The provision of information on non-opioid treatment options
- Referral to a specialist, as the physician/clinician deems appropriate

In addition, the provision adds to the required elements of the IPPE, screening for potential substance use disorders.

The provision also amends the AWV authority in SSA Section 1861(hhh) to include the same review of the beneficiary's current opioid prescription (s) as for the IPPE requirements.

The tables on the following pages outline all provisions that are contained within this Act, along with the scheduled implementation dates. It is recommended all providers review the tables, as the Act's provisions will impact across all providers, including FQHC and RHC.

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Enactment Dates and Deadlines for SUPPORT Act Medicare Provisions			
Provision Number	Title	Brief Description	Implementation/Reporting Deadline
2001	Expanding the use of telehealth services for the treatment of opioid use disorder and other substance use disorders	Eliminates originating site geographic requirements for telehealth services for treating substance use disorders and co-occurring mental health disorders, among other modifications. HHS Secretary to report to Congress on the impact of these modifications on health care utilization and health outcomes related to substance use disorders, including emergency room visits	July 01, 2019 No later than five (5) years after enactment (CY 2023)
2002	Comprehensive screenings for seniors	Requires that Medicare Annual Wellness visits include a review of a beneficiary's opioid prescription(s).	For dates of service on or after January 01, 2020
2003	Every prescription conveyed securely	Requires prescription(s) for Part D controlled substances to be transmitted by a health care practitioner electronically in accordance with an approved electronic prescription drug program Requires the U.S. attorney general to update requirements for the biometric component of multi-factor authentication with respect to electronic prescriptions of controlled substances.	January 01, 2021 No later than one (1) year after enactment October, 2019
2004	Requiring prescription drug plan sponsors under Medicare to establish drug management programs for at-risk beneficiaries	Requires Part D plans to implement lock-in provisions for at-risk beneficiaries.	For plan years on or after January 01, 2022
2005	Medicare coverage of certain services furnished by opioid treatment programs	Creates Medicare bundled payment for items and services provided by outpatient treatment programs for opioid use disorder, including methadone	For services rendered on or after January 01, 2020
2006	Encouraging appropriate prescribing under Medicare for victims of opioid overdose	Requires Part D-eligible individual identified as having a history of opioid-related overdoses be included as a potentially at-risk beneficiary under a drug management program	For plan years no later than January 01, 2021

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Enactment Dates and Deadlines for SUPPORT Act Medicare Provisions			
Provision Number	Title	Brief Description	Implementation/Reporting Deadline
2007	Automatic escalation to external review under a Medicare Part D drug management program for at-risk beneficiaries	Provides expedited appeals process for Part D enrollees determined to be at risk of opioid abuse	No later than January 01, 2021
2008	Suspension of payments by Medicare prescription drug plans and MA-PD plans pending investigations of credible allegations of fraud by pharmacies	Authorizes Medicare Part D plan sponsors to suspend payments to pharmacies in the plan's networks.	Applies to Part D plan years beginning January 01, 2020
4002	Requiring reporting by group health plan of prescription drug coverage information for purposes of identifying primary payer situations under the Medicare program	Adds Medicare Secondary Payer (MSP) requirement that group health plans identify situations in which a plan should be the primary payer with respect to benefits relating to Medicare Part D coverage	January 01, 2020
6012	Study on abuse-deterrent opioid formulations access barriers under Medicare	Requires the Secretary to send a study to Congress determining whether Part D enrollees with chronic pain have adequate access to abuse-deterrent opioids	No later than one (1) year after enactment of this provision
6021	Medicare opioid safety education	Requires the Secretary to compile and provide educational resources in the Medicare annual notice of benefits covering topics of opioid use, pain management, and alternative pain management treatments	January 01, 2019
6032	Action plan on recommendations for changes under Medicare and Medicaid to prevent opioids addictions and enhance access to medication-assisted treatment	Directs the Secretary to collaborate with the Pain Management Best Practices Inter-Agency Task Force in developing an action plan on changes to Medicare and Medicaid to prevent opioid addiction and enhance access to medication-assisted treatment No later than three months after enactment, the Secretary is to convene a public stakeholder meeting and request public feedback on ways the Centers for Medicare Services (CMS) can address opioid crisis through development and application of the action plan The Secretary is required to submit a report to Congress that summarizes the action plan review; identifies planned next steps; and evaluates price trends for drugs used to reverse opioid overdoses, including recommendation to lower costs	January 24, 2019 No later than June 01, 2020

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Enactment Dates and Deadlines for SUPPORT Act Medicare Provisions			
Provision Number	Title	Brief Description	Implementation/Reporting Deadline
6042	Opioid use disorder treatment demonstration program	Requires the Secretary to conduct a four (4) year demonstration project on increasing access to opioid use disorder treatment, improving beneficiary outcomes, and reducing Medicare expenditures. Requires the Secretary to consult with addiction specialists, primary care clinicians, and beneficiary groups on demonstration design	No later than January 01, 2021 Within 3 months of the enactment of this provision
6062	Electronic prior authorization for covered Part D drugs	Requires Part D e-prescribing systems to allow for processing of formulary prior authorization requirements	January 02, 2021
6063	Program integrity transparency measures under Medicare Part C and Part D	Requires the Secretary to establish a secure internet website for data sharing and reporting of Medicare Part D waste, fraud, and abuse Requires the Secretary to disseminate quarterly reports to Part D plans on fraud, waste and abuse and suspicious activity trends reported through the website. Requires Part D sponsors to submit information to the Secretary on credible evidence of suspected fraud and other actions related to inappropriate opioid prescribing	Within two (2) years of enactment of this provision January 01, 2021
6064	Expanding eligibility for medication therapy management programs under Part D	Adds Part D enrollees identified as at risk for prescription drug abuse to the list of targeted medication therapy management enrollees	January 01, 2021
6065	Commit to opioid medical prescriber accountability and safety for seniors	Requires the Secretary to establish technical thresholds for identifying Part D opioid prescribers who are outliers compared to other prescribers in a specific practice specialty and geographic area	January 01, 2021 will begin providing annual notices to prescribers identified as outliers
6072	Medicare Payment Advisory Commission (MedPAC) report on opioid payment, adverse incentives, and data under the Medicare program	Requires MedPAC to submit a report to Congress that describes how Medicare pays for pain management treatment, identifies incentive for prescribing opioids and non-opioid treatments, describes how Medicare tracks and monitors beneficiary claims data, and identifies areas in which improvements are needed	No later than March 15, 2019
6083	Expanding access under the Medicare program to addiction treatment in federally qualified health centers (FQHC) and rural health clinics (RHC)	Subject to available funds, the Secretary is authorized to pay training costs for rural physicians and practitioners who want to obtain DATA 2000 waivers to furnish OUD treatment services	January 01, 2019

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Enactment Dates and Deadlines for SUPPORT Act Medicare Provisions			
Provision Number	Title	Brief Description	Implementation/Reporting Deadline
6084	Studying the availability of supplemental benefits designed to treat or prevent substance use disorders under Medicare Advantage (MA) plans	Requires the Secretary to submit a report to Congress on the availability of supplemental benefits designed to treat and prevent substance use disorders under MA plans	No later than two (2) years after enactment of this provision
6085	Clinical psychologist services models under the Centers for Medicare and Medicaid Innovation (CMS); Government Accountability Office (GAO) study and report	Requires the Secretary to educate and inform Medicare beneficiaries about Part B coverage of clinical psychologist services and to explore ways to avoid unnecessary hospitalizations or emergency department services through use of a 24-hours, 7-day-a-week help line. Requires comptroller general to submit a report to Congress on mental and behavioral health services under Medicare to include an examination of: 1. Services furnished by psychiatrists, clinical psychologists and other professionals 2. Ways that Medicare beneficiaries familiarize themselves with the availability of Medicare payment for clinical psychologist services	No later than 18 months following enactment of this provision
6086	Dr. Todd Graham Pain Management Study	Directs the Secretary to conduct a study addressing best practices, payment, and coverage of pain management services under Medicare Parts A and B. Requires the Secretary to submit a report to the congressional committees on options for revising Parts A and B payments to providers and suppliers, as well as Medicare coverage related to multidisciplinary, evidence-based, non-opioid treatments for acute and chronic pain management	To begin no later than one (1) year following enactment of this provision
6092	Developing guidance on pain management and opioid use disorder prevention for hospitals receiving payment under Part A of the Medicare program	Requires the Secretary to develop and publish guidance for hospitals receiving payment under Medicare Part A regarding pain management and opioid use disorder prevention strategies for Medicare beneficiaries	To begin six (6) months following enactment of this provision
6093	Requiring the review of quality measures relating to opioids and opioid use disorder treatments furnished under the Medicare Program and other federal health care programs	Requires the Secretary to establish a technical expert panel to review quality measures related to opioids and opioid use disorder. The established panel will be required to review existing opioid-related quality measures, including those under development; identify gaps and measure development priorities in this area, and recommend quality measures for use under specified Medicare quality programs	To begin no later than six (6) months following enactment of this provision. To begin no later than one (1) year after the panel has been established.

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Enactment Dates and Deadlines for SUPPORT Act Medicare Provisions			
Provision Number	Title	Brief Description	Implementation/Reporting Deadline
6094	Technical Expert Panel on Reducing Surgical Setting Opioid Uses; Data Collection on Perioperative Opioid Use	Requires the Secretary to convene an expert panel to provide recommendations on reducing opioid use in inpatient and outpatient settings and best practices for pain management. Directs the Secretary to report to Congress on the panel's recommendations and an action plan for implementing pain management protocols that limit opioid use in the perioperative setting and at discharge. Requires the Secretary to submit a report to Congress on perioperative opioid use.	Begins no later than six (6) months following enactment of this provision Begins no later than one (1) year following enactment
6102	Requiring MA plans and Part D prescription drug plans to include information on risks associated with opioids and coverage of non-pharmacological therapies and non-opioid medications or devices used to treat pain	Requires Part D plans must provide enrollees with information regarding the treatment of pain, including the risks of prolonged opioid use and coverage of non-pharmacological therapies, devices and non-opioid medications	Begins January 01, 2021
6103	Requiring MA plans and prescription drug plans to provide information on the safe disposal of prescription drugs	Requires MA plans to provide enrollees with information on the safe disposal of controlled substances. MA or MA-PD plans must ensure that in-home health risk assessments provided on or after January 01, 2021 include information on safe disposal of prescription drugs that are controlled substances.	Begins January 01, 2021
6104	Revising measures used under Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey related to pain management	Requires that any HCAHPS survey conducted as part of the Medicare Hospital IQR program, may not include questions regarding communication about pain between hospital staff and patients unless the questions take into account whether the patient experiencing the pain was informed about the risks associated with opioid use as well as non-opioid alternatives for treating pain. Further, prohibits the Secretary from including on Hospital Compare any measures based on questions in the CY 2018 and CY 2019 HCAHPS survey about communication between hospital staff and patients about the patient's pain Lastly, prohibits the Secretary from including measures based on questions in the CY 2018 or CY 2019 HCAHPS survey about communication by hospital staff with a patient about the patient's pain in the Hospital VBP Program	Begins January 01, 2020

MEDICARE PROVISIONS FOR OPIOID RECOVERY AND TREATMENT

Enactment Dates and Deadlines for SUPPORT Act Medicare Provisions			
Provision Number	Title	Brief Description	Implementation/Reporting Deadline
111	Fighting the opioid epidemic with sunshine	Expands an existing requirement that applicable drug, device, biological or medical supply manufacturers that make a payment or other transfer of value to a Medicare covered recipient annually report information on such transactions to the Secretary. In addition, this provision expands the definition of "covered recipient" to include: 1. Physician assistants (PA) 2. Nurse practitioners (NP) 3. Clinical nurse specialists (CNS) 4. Certified registered nurse anesthetists (CRNA) 5. Certified nurse midwives (CNM) 6. Excludes employees of applicable manufacturers. Lastly, this provision ends the exclusion for National Provider Identifiers (NPI) of covered recipients f or information the Open Payments website.	Begins January 01, 2022

2020 CODING UPDATE -- OPIOID DISORDER TREATMENT HCPCS

In 2020, Medicare will reimburse Opioid Disorder Treatment (ODT) Programs, a new category of provider type. Information regarding enrollment and billing is available on the CMS website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Index.html

Special program enrollment is required to be eligible for reimbursement. Reimbursement for the program is per week of treatment (look for "weekly bundle" in the HCPCS description.) Additional professional and facility fee reimbursement is limited to only G2086, G2087, and G2088; rates for those codes are provided on the last page of this paper.

The chart below containing HCPCS and payment rates for weekly services of an ODT Program were obtained from the CMS website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Downloads/CY2020-OTP-Payment-Rates.pdf

CY2020 Final Payment Rates for Opioid Treatment Program (OTP) CMS-1715F

HCPCS	Descriptor	Drug Cost	Non-Drug Cost	Total Cost
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	$35.28	$172.21	$207.49
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	$86.26	$172.21	$258.47
G2069	Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	$1,578.64	$178.65	$1,757.29
G2070	Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	$4,918.98	$407.86	$5,326.84

2020 CODING UPDATE -- OPIOID DISORDER TREATMENT HCPCS

G2071	Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	$0	$427.32	$427.32
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	$4,918.98	$626.97	$5,545.95
G2073	Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	$1,164.02	$178.65	$1,342.67

Intensity Add-on Codes

HCPCS	Descriptor	Drug Cost	Non-Drug Cost	Total Cost
G2076	Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician or qualified personnel that includes preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.	$0	$179.46	$179.46
G2077	Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.	$0	$110.28	$110.28
G2078	Take-home supply of methadone; up to 7 additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.	$35.28	$0	$35.28

Reimbursement outside of the "weekly bundle" program rate is limited to only a few of the new codes.

HCPCS	Description	MPFS	OPPS
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	Non Fac: $413.23 Fac: $301.35	APC Status: S $131.35
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	Non Fac: $368.48 Fac: $293.77	APC Status: S $131.35
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)	Non-Fac: $70.01 Fac: $35.01	APC Status: N (payment packaged)

2020 OPPS FINAL RULE REQUIRING PRIOR AUTHORIZATION

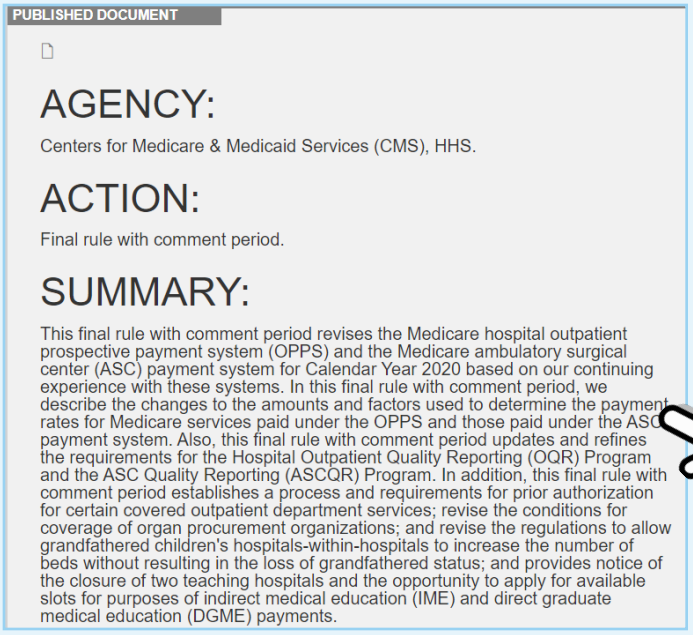
In the 2020 OPPS Final Rule, Medicare firmed up its plan to require hospital outpatients to obtain prior authorization to perform certain services which it deems to have been at risk for incorrect payment due to medical necessity, primarily services that are sometimes performed for cosmetic purposes. The prior authorization process is not required of procedures performed in Ambulatory Surgery Centers.

The regional MACs will be responsible for the nuts-and-bolts authorization process. In theory, the authorization process will take no more than 10 days. Either the physician or the hospital may submit the request for prior authorization, but the hospital will remain ultimately responsible for ensuring that authorization is obtained prior to the surgical procedure.

Eventually, Medicare expects to provide an exemption to the prior authorization process for certain physicians who demonstrate consistent compliance with medical necessity requirements, but the details of this process are not yet available.

The final rule will be published in the Federal Register on 11/12/19; in the meantime, a temporary link has been provided to the unpublished text:

https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center



PUBLISHED DOCUMENT

AGENCY:

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

ACTION:

Final rule with comment period.

SUMMARY:

This final rule with comment period revises the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for Calendar Year 2020 based on our continuing experience with these systems. In this final rule with comment period, we describe the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. Also, this final rule with comment period updates and refines the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program. In addition, this final rule with comment period establishes a process and requirements for prior authorization for certain covered outpatient department services; revise the conditions for coverage of organ procurement organizations; and revise the regulations to allow grandfathered children's hospitals-within-hospitals to increase the number of beds without resulting in the loss of grandfathered status; and provides notice of the closure of two teaching hospitals and the opportunity to apply for available slots for purposes of indirect medical education (IME) and direct graduate medical education (DGME) payments.

"In sum, we are finalizing our proposed prior authorization policy as proposed, including our proposed regulation text, with the following modifications: we are adding additional language at § 419.83(c) regarding the notice of exemption or withdraw of an exemption. We are including in this process the two additional botulinum toxin injections codes, J0586 and J0588. See Table 65 below for the final list of outpatient department services requiring prior authorization. ..."

TABLE 65.--PROPOSED LIST OF OUTPATIENT SERVICES THAT WOULD REQUIRE PRIOR AUTHORIZATION

Code	(i) Blepharoplasty, Eyelid Surgery, Brow Lift, and Related Services
15820	Removal of excessive skin of lower eyelid
15821	Removal of excessive skin of lower eyelid and fat around eye
15822	Removal of excessive skin of upper eyelid
15823	Removal of excessive skin and fat of upper eyelid
67900	Repair of brow paralysis
67901	Repair of upper eyelid muscle to correct drooping or paralysis
67902	Repair of upper eyelid muscle to correct drooping or paralysis
67903	Shortening or advancement of upper eyelid muscle to correct drooping or paralysis

2020 OPPS FINAL RULE REQUIRING PRIOR AUTHORIZATION

Code	(i) Blepharoplasty, Eyelid Surgery, Brow Lift, and Related Services (continued)
67904	Repair of tendon of upper eyelid
67906	Suspension of upper eyelid muscle to correct drooping or paralysis
67908	Removal of tissue, muscle, and membrane to correct eyelid drooping or paralysis
67911	Correction of widely-opened upper eyelid
Code (ii) Botulinum Toxin Injection	
64612	Injection of chemical for destruction of nerve muscles on one side of face
64615	Injection of chemical for destruction of facial and neck nerve muscles on both sides of face
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a
Code	**(iii) Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and Related Services**
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure)
15877	Suction assisted removal of fat from trunk
Code	**(iv) Rhinoplasty, and Related Services**
20912	Nasal cartilage graft
21210	Repair of nasal or cheek bone with bone graft
21235	Obtaining ear cartilage for grafting
30400	Reshaping of tip of nose
30410	Reshaping of bone, cartilage, or tip of nose
30420	Reshaping of bony cartilage dividing nasal passages
30430	Revision to reshape nose or tip of nose after previous repair
30435	Revision to reshape nasal bones after previous repair
30450	Revision to reshape nasal bones and tip of nose after previous repair

2020 OPPS FINAL RULE REQUIRING PRIOR AUTHORIZATION

Code	(iv) Rhinoplasty, and Related Services (continued)
30460	Repair of congenital nasal defect to lengthen tip of nose
30462	Repair of congenital nasal defect with lengthening of tip of nose
30465	Widening of nasal passage
30520	Reshaping of nasal cartilage
Code (v) Vein Ablation and Related Services	
36473	Mechanochemical destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36474	Mechanochemical destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36475	Destruction of insufficient vein of arm or leg, accessed through the skin
36476	Radiofrequency destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36478	Laser destruction of incompetent vein of arm or leg using imaging guidance, accessed through the skin
36479	Laser destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36482	Chemical destruction of incompetent vein of arm or leg, accessed through the skin using imaging guidance
36483	Chemical destruction of incompetent vein of arm or leg, accessed through the skin using imaging guidance

NEW FINAL RULES: GET THE FACTS

Fact sheet

CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)

Nov 01, 2019 | Ambulatory surgical centers, Legislation, Medicare Parts A & B

See full version on next page.

Click Here

Fact sheet

Finalized Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020

ov 01, 2019 | eHealth, Initiatives, Legislation, Physicians

Click Here

NEW FINAL RULES: GET THE FACTS

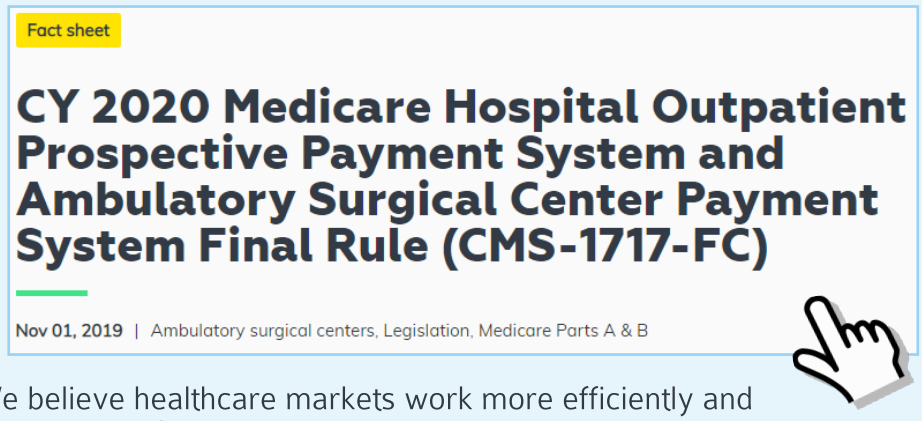
On November 15, 2019, the Centers for Medicare & Medicaid Services (CMS) finalized policies that follow directives in President Trump's Executive Order, entitled "Improving Price Transparency in and Quality to Put Patients First," that lay the foundation for a patient-driven healthcare system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The policies in the final rule will further advance the agency's commitment to increasing price transparency. It includes requirements that would apply to each hospital operating in the United States.

This fact sheet discusses the provisions of the final rule (CMS-1717-F2), which can be downloaded from the Federal Register at: https://www.hhs.gov/sites/default/files/cms-1717-f2.pdf.

Increasing Price Transparency of Hospital Standard Charges

On June 24, 2019, the President signed an Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First noting that it is the policy of the Federal Government to increase the availability of meaningful price and quality information for patients.



The Executive Order directed the Secretary of Health and Human Services (HHS) to propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information.[1] We believe healthcare markets work more efficiently and provide consumers with higher-value healthcare if we promote policies that encourage choice and competition.[2] In short, as articulated by the CMS Administrator, we believe that transparency in health care pricing is "critical to enabling patients to become active consumers so that they can lead the drive towards value."[3]

This final rule implements Section 2718(e) of the Public Health Service Act and improves upon prior agency guidance that required hospitals to make public their standard charges upon request starting in 2015 (79 FR 50146) and subsequently online in a machine-readable format starting in 2019 (83 FR 41144).

Section 2718(e) requires each hospital operating within the United States to establish (and update) and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

NEW FINAL RULES: GET THE FACTS

In the final rule, we finalize the following:

(1) definitions of "hospital", "standard charges", and "items and services";

(2) requirements for making public a machine-readable file online that includes all standard charges (including gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges) for all hospital items and services;

(3) requirements for making public discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 'shoppable' services (70 CMS-specified and 230 hospital-selected) that are displayed and packaged in a consumer-friendly manner; and

(4) monitoring for hospital noncompliance and actions to address hospital noncompliance (including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties), and a process for hospitals to appeal these penalties. CMS is finalizing that these policies would be effective January 1, 2021.

2020 MEDICARE PREMIUM UPDATES

CMS has announced the new updates for the CY2020 premiums and deductibles for Part A and Part B fee for service providers.

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered under Part A.

The standard monthly premium for Medicare Part B enrollees will be $144.60 for CY 2020. This is a slight increase over CY2019, which was $135.50.

The annual deducible for Part B enrollees for CY2020 is $198.00. As with the increase in premiums, this is also a slight increase over CY2019, which was $185.00.

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. Currently, CMS records show about 99% (percent) of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

For CY2020, the Medicare Part A inpatient deductible is $1408.00. This is an increase of $44.00 from the CY2019 deductible amount of $1340.00.

CY2020 Co-insurance rates:

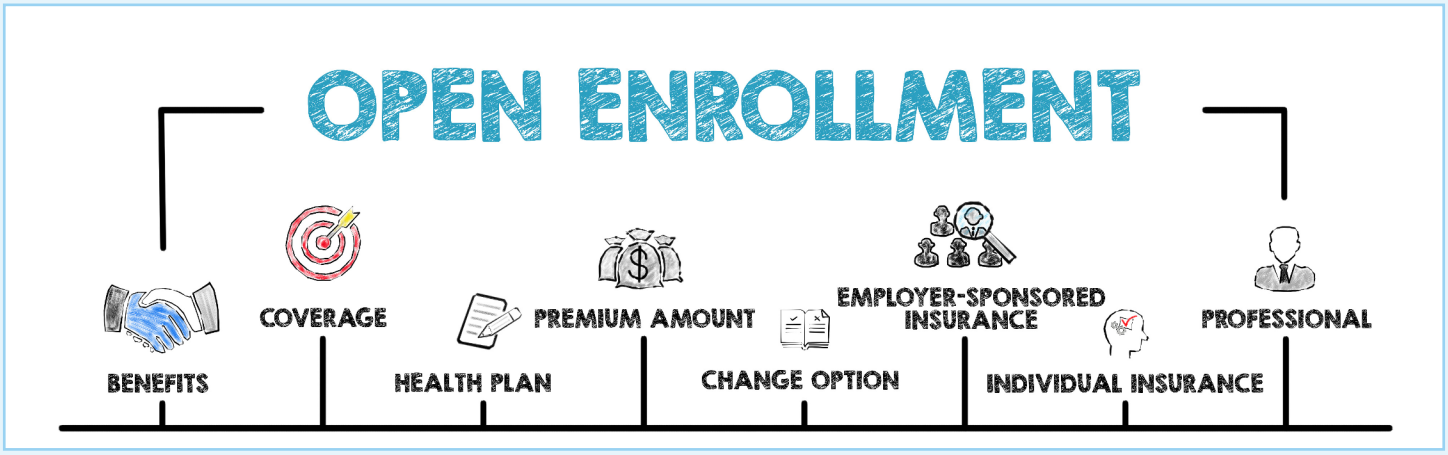
$352.00 – 61st – 90th day

$704.00 – 91st – 150th day for Lifetime reserve days

$176.00 – 21st – 100th day for SNF days

Medicare Advantage Premiums: In CY2019 Medicare Advantage premiums will decline while plan choices and new benefits increase. On average, Medicare Advantage premiums are estimated to decrease by 23% from the CY2018.

Article reference:
https://www.cms.gov/newsroom/fact-sheets/2020-medicare-parts-b-premiums-and-deductibles



2020 CODING UPDATE DOCUMENTS AVAILABLE

In preparation for the year-end CPT®/HCPCS update, **PARA** has prepared eleven brief "2020 Coding Update" documents listing deleted codes and added codes within a particular clinical area or procedure group. The documents are available on the **PARA Data Editor "Advisor"** tab.

The 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.

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:

PARA Data Editor - Demonstration Hospital [DEMO] dbDemo | Contact Support | Log Out

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

Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date	Bookmark
Coding Update							
Coding Update	2020 Coding Update - Autologous Grafting, Fat or Dermis	N/A	1 Doc			10/07/19	
Coding Update	Modifiers CO and CQ for PTA and OTA services in 2020	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update -Therapeutic Drug Lab Testing	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update -Remote Interrogation Device Evals	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update - SPECT Imaging	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update - Radiopharm Loc Inflam Process	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update - Pericardiocentesis, Tube Cardiostomy	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update - Myocardial Imaging (Strain & PET)	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update - Health Behavior and Coaching Codes	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update - GI Tract Imaging	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update – EEG's and Cerebral Seizure Monitoring	N/A	1 Doc			10/07/19	
Coding Update	2020 Coding Update - Cognitive Therapy	N/A	1 Doc			10/07/19	
Coding Update	PARA Year-End HCPCS Update Process	N/A	1 Doc			10/01/19	

Medicare coverage information is not available on all of the new codes at this time. Following the release of the OPPS Final Rule in November, coding update papers will be revised to indicate whether Medicare will accept/cover the new codes that are not clear.

PARA Data Editor users can identify updated papers by the word "Revised" in the title and the date issued will be updated.

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

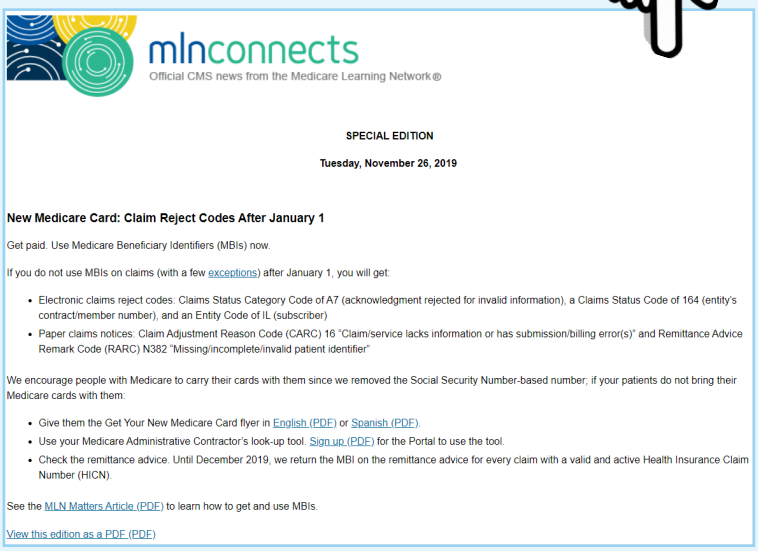
Special Edition: **Thursday, November 26, 2019**

New Medicare Card: Claim Reject Codes After January 1

Get paid. Use Medicare Beneficiary Identifiers (MBIs) now.

If you do not use MBIs on claims (with a few exceptions) after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"


mlnconnects
Official CMS news from the Medicare Learning Network®

SPECIAL EDITION

Tuesday, November 26, 2019

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We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in English (PDF) or Spanish (PDF).
- Use your Medicare Administrative Contractor's look-up tool. Sign up (PDF) for the Portal to use the tool.
- Check the remittance advice. Until December 2019, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN).

See the MLN Matters Article (PDF) to learn how to get and use MBIs.

View this edition as a PDF (PDF)

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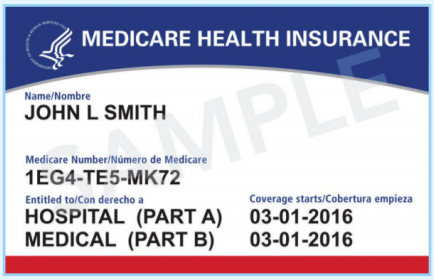

See the MLN Matters Article (PDF) to learn how to get and use MBIs.

View this edition as a PDF (PDF)

There was ONE new or revised Med Learn (MLN Matters) article released this week.

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

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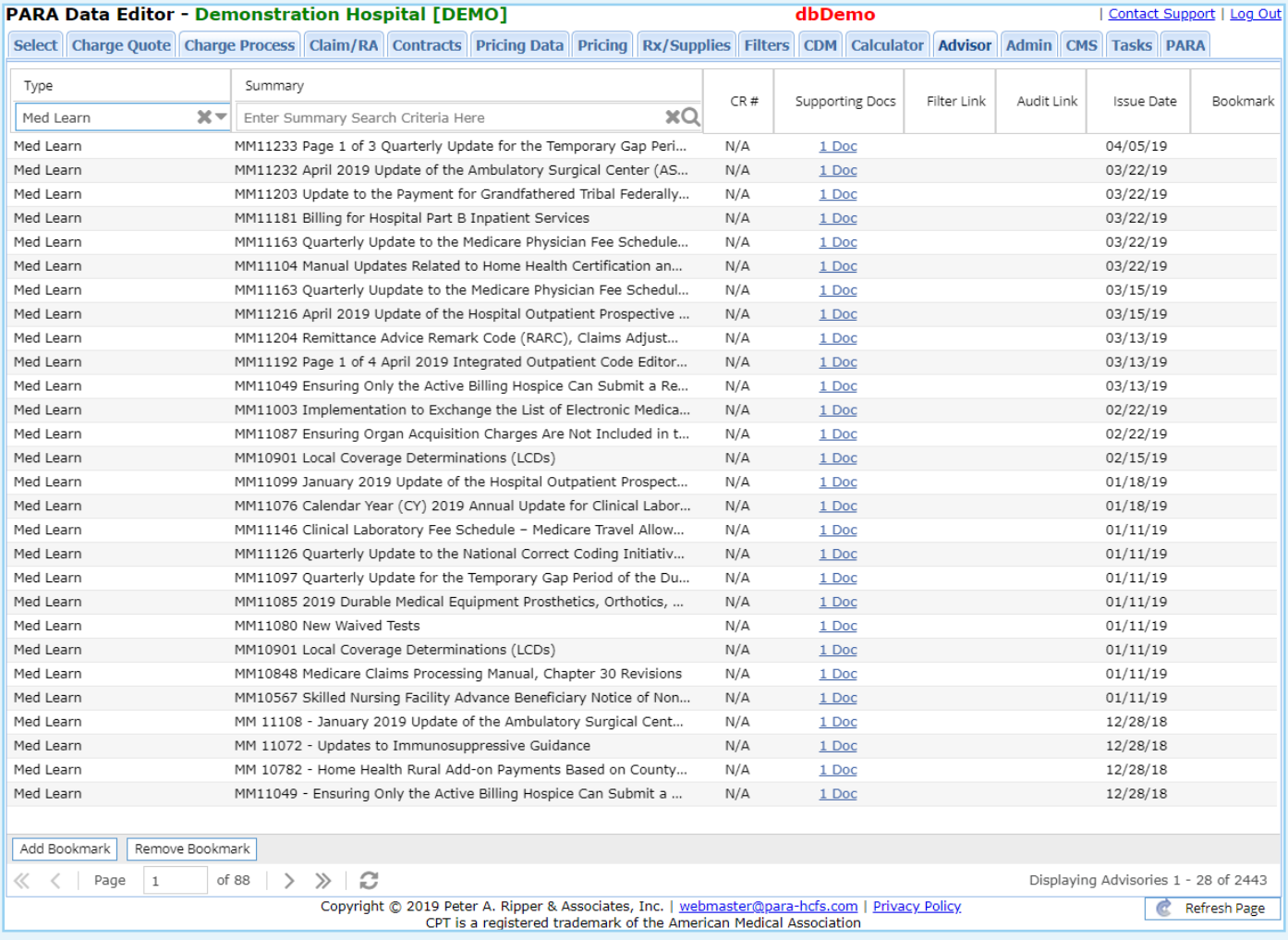

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Med Learn	Enter Summary Search Criteria Here						
Med Learn	MM11233 Page 1 of 3 Quarterly Update for the Temporary Gap Peri...	N/A	1 Doc			04/05/19	
Med Learn	MM11232 April 2019 Update of the Ambulatory Surgical Center (AS...	N/A	1 Doc			03/22/19	
Med Learn	MM11203 Update to the Payment for Grandfathered Tribal Federally...	N/A	1 Doc			03/22/19	
Med Learn	MM11181 Billing for Hospital Part B Inpatient Services	N/A	1 Doc			03/22/19	
Med Learn	MM11163 Quarterly Update to the Medicare Physician Fee Schedule...	N/A	1 Doc			03/22/19	
Med Learn	MM11104 Manual Updates Related to Home Health Certification an...	N/A	1 Doc			03/22/19	
Med Learn	MM11163 Quarterly Uupdate to the Medicare Physician Fee Schedul...	N/A	1 Doc			03/15/19	
Med Learn	MM11216 April 2019 Update of the Hospital Outpatient Prospective ...	N/A	1 Doc			03/15/19	
Med Learn	MM11204 Remittance Advice Remark Code (RARC), Claims Adjust...	N/A	1 Doc			03/13/19	
Med Learn	MM11192 Page 1 of 4 April 2019 Integrated Outpatient Code Editor...	N/A	1 Doc			03/13/19	
Med Learn	MM11049 Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
Med Learn	MM11003 Implementation to Exchange the List of Electronic Medica...	N/A	1 Doc			02/22/19	
Med Learn	MM11087 Ensuring Organ Acquisition Charges Are Not Included in t...	N/A	1 Doc			02/22/19	
Med Learn	MM10901 Local Coverage Determinations (LCDs)	N/A	1 Doc			02/15/19	
Med Learn	MM11099 January 2019 Update of the Hospital Outpatient Prospect...	N/A	1 Doc			01/18/19	
Med Learn	MM11076 Calendar Year (CY) 2019 Annual Update for Clinical Labor...	N/A	1 Doc			01/18/19	
Med Learn	MM11146 Clinical Laboratory Fee Schedule – Medicare Travel Allow...	N/A	1 Doc			01/11/19	
Med Learn	MM11126 Quarterly Update to the National Correct Coding Initiativ...	N/A	1 Doc			01/11/19	
Med Learn	MM11097 Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			01/11/19	
Med Learn	MM11085 2019 Durable Medical Equipment Prosthetics, Orthotics, ...	N/A	1 Doc			01/11/19	
Med Learn	MM11080 New Waived Tests	N/A	1 Doc			01/11/19	
Med Learn	MM10901 Local Coverage Determinations (LCDs)	N/A	1 Doc			01/11/19	
Med Learn	MM10848 Medicare Claims Processing Manual, Chapter 30 Revisions	N/A	1 Doc			01/11/19	
Med Learn	MM10567 Skilled Nursing Facility Advance Beneficiary Notice of Non...	N/A	1 Doc			01/11/19	
Med Learn	MM 11108 - January 2019 Update of the Ambulatory Surgical Cent...	N/A	1 Doc			12/28/18	
Med Learn	MM 11072 - Updates to Immunosuppressive Guidance	N/A	1 Doc			12/28/18	
Med Learn	MM 10782 - Home Health Rural Add-on Payments Based on County...	N/A	1 Doc			12/28/18	
Med Learn	MM11049 - Ensuring Only the Active Billing Hospice Can Submit a ...	N/A	1 Doc			12/28/18	

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The link to this MedLearn MM11560

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KNOWLEDGE • RESOURCES • TRAINING

Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

MLN Matters Number: MM11560 | Related Change Request (CR) Number: 11560

Related CR Release Date: November 27, 2019 | Effective Date: January 1, 2020

Related CR Transmittal Number: R4468CP | Implementation Date: January 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11560 provides a summary of the policies in the CY 2020 MPFS Final Rule, announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2020. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish, by regulation, a fee schedule of payment amounts for physicians' services for the subsequent year.

The Centers for Medicare & Medicaid Services (CMS) final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2020, went on display on November 1, 2019. The final rule also addresses public comments on Medicare payment policies CMS proposed earlier this year. You can find the final rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html.

Medicare Telehealth Services

For CY 2020, CMS is finalizing the proposals to add HCPCS codes G2086, G2087, and G2088 (which describe a bundled episode of care for treatment of opioid use disorders) to the list of telehealth services:

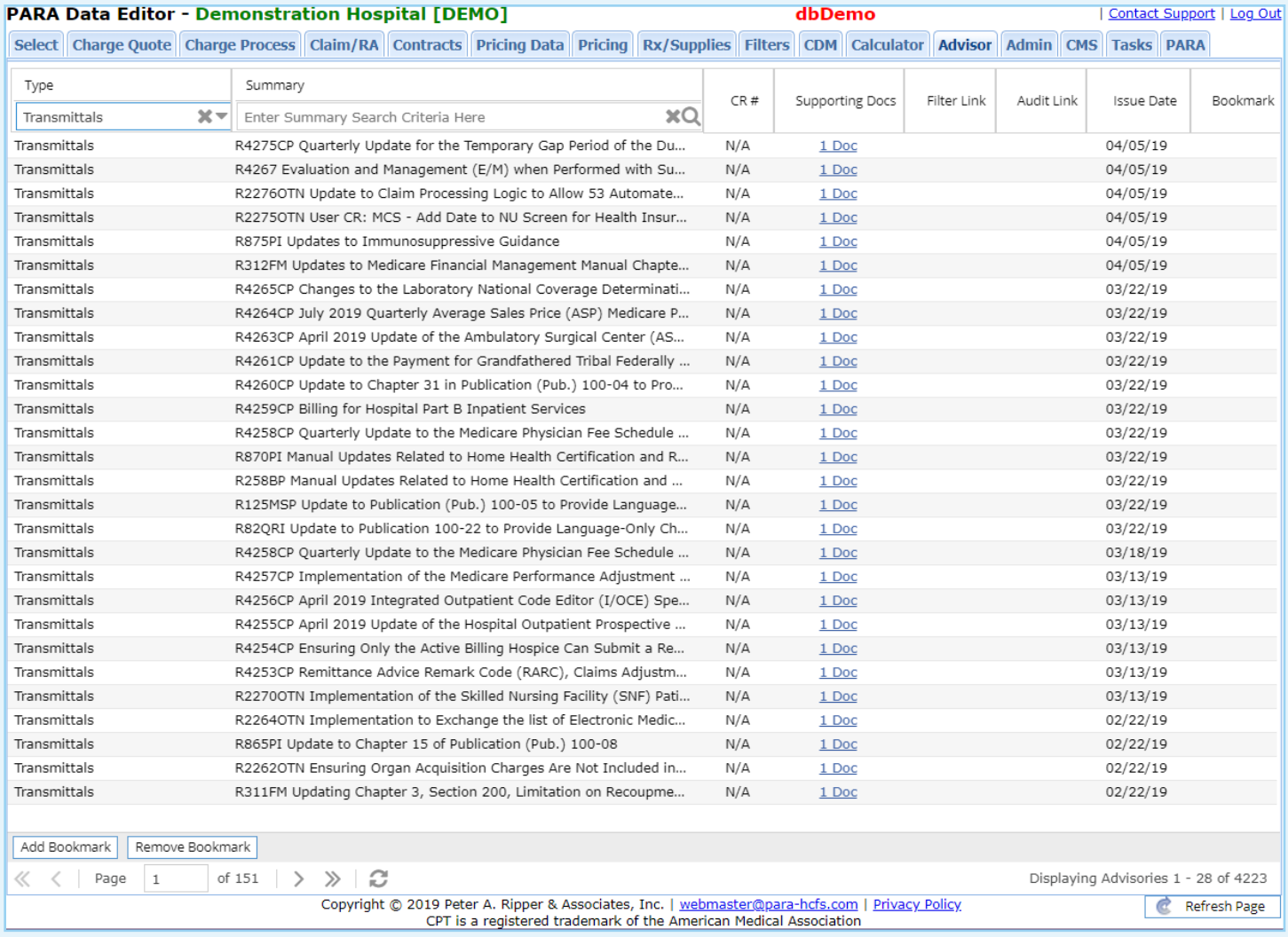
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

There were THREE new or revised Transmittals released this week.

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

FIND ALL THESE TRANSMITTALS IN THE **ADVISOR** TAB OF THE **PDE** 3



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

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The link to this Transmittal R2402OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2402	**Date: November 27, 2019**
	Change Request 11474

SUBJECT: Implementation to Adopt the Document Codes into the Post-Pay Electronic Medical Documentation Requests (eMDR) to Participating Providers via the Electronic Submission of Medical Documentation (esMD) System

I. SUMMARY OF CHANGES: CR 11003 implemented the changes required to receive and process the eMDR Registered Provider File. This file contains the latest status of the providers who have registered to receive eMDR. This was the first step required in order to exchange eMDR letters to registered Providers via the esMD system. CR 11142 implemented the changes required to generate and send the post pay eMDR Letter Package information to the Review Contractors who conduct the reviews via esMD. This CR is the last step in the process to implement the changes required to populate the appropriate/Standardized Document Codes while generating and sending the eMDR Letter Package information, by the Review Contractor to esMD.

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020 - Analysis, Design, Coding; July 6, 2020 - Testing and Implementation

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	

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 R4468CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4468	**Date: November 27, 2019**
	Change Request 11560

SUBJECT: Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of the policies in the CY 2020 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

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

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

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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IV. ATTACHMENTS:
Recurring Update Notification

The link to this Transmittal R2403OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2403	**Date: November 27, 2019**
	Change Request 11285

Transmittal 2329, dated August 2, 2019, is being rescinded and replaced by Transmittal 2403, dated, November 27, 2019 to remove business requirements 11285.4.1 and 11285.4.2. All other information remains the same.

SUBJECT: Automation of Part B Underpayment Processing of Recovery Audit Contractor (RAC) Adjustments

I. SUMMARY OF CHANGES: This Change Request will allow for the processing of RAC-identified Part B underpayments without manual intervention by the Medicare Administrative Contractor (MAC).

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

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

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

III. FUNDING:
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IV. ATTACHMENTS:

One Time Notification

Contact Our Team

Peter Ripper
President
pripper@para-hcfs.com

Monica Lelevich
Director
Audit Services
mlelevich@para-hcfs.com

Randi Brantner
Director
Financial Analytics
rbrantner@para-hcfs.com

Violet Archuleta-Chiu
Senior Account Executive
varchuleta@para-hcfs.com

Sandra LaPlace
Account Executive
slaplace@para-hcfs.com

Steve Maldonado
Director
Marketing
smaldonado@para-hcfs.com

Nikki Graves
Senior Revenue Cycle Consultant
ngraves@para-hcfs.com

Sonya Sestili
Chargemaster Client Manager
ssestili@para-hcfs.com

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HEALTHCARE FINANCIAL RESOURCES

hfri.net

Mary McDonnell
Director, PDE Training & Development
mmcdonnell@para-hcfs.com

PARA
HealthCare Analytics

Patti Lewis
Director Business Operations
plewis@para-hcfs.com