PARA Weekly eJOURNAL

- PRICING
- CODING
- REIMBURSEMENT
- COMPLIANCE

NEWS FOR HEALTHCARE DECISION MAKERS

July 3, 2019

IN THIS ISSUE

BREAKING NEWS

Delayed Enforcement Of DOS Exception Policy

Page 8

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

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

***Date Change:* New Edits For Facility Locations** *Page 20*

PARA

FAST LINKS

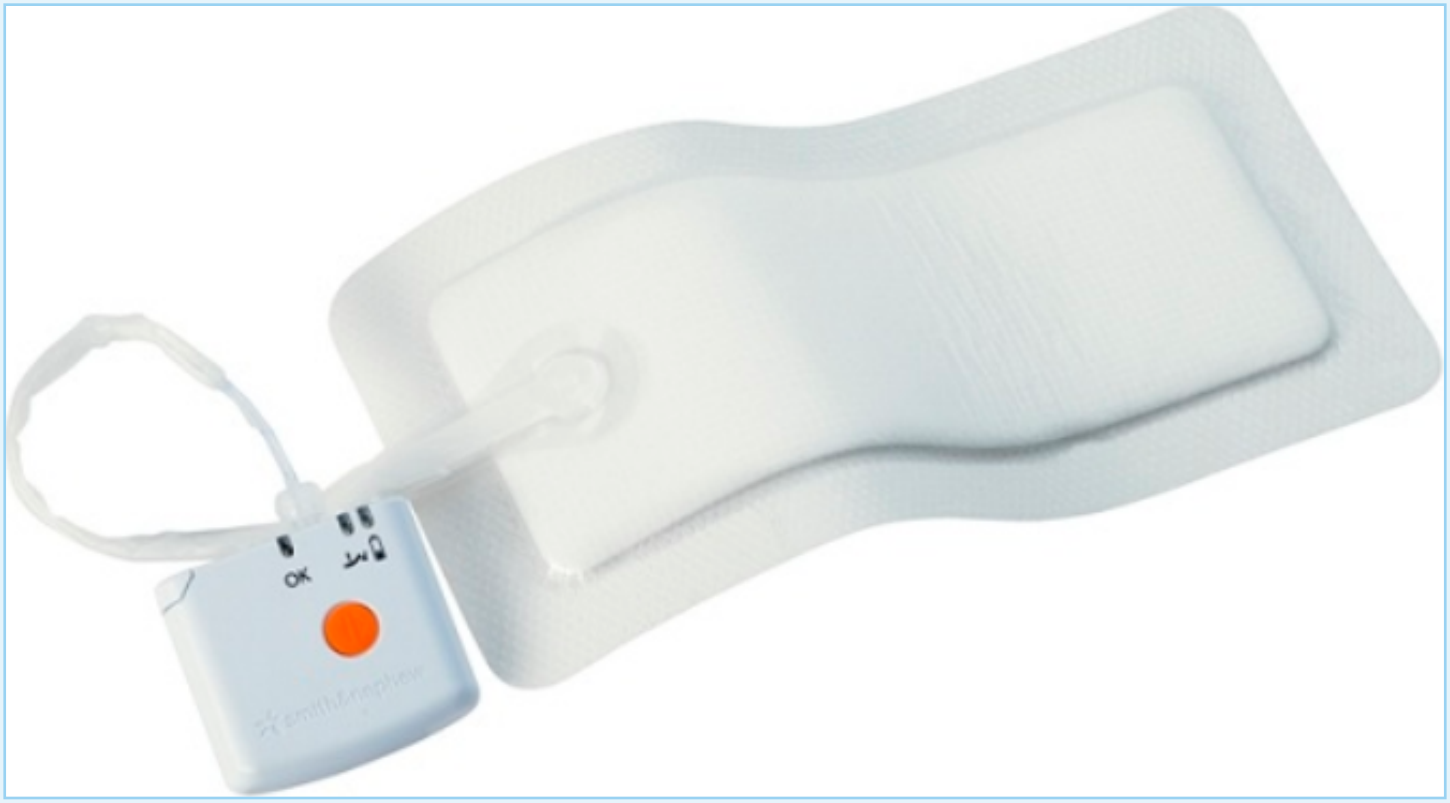
97607 WOUND CARE

Q. Would the following attached orders for wound vac dressing change be considered 97607? The patient brings in their own disposable supplies.

Wound Care Orders
1) Remove old dressings
2) Cleanse left great toe amputation site with saline and pat dry.
3) Place cavilon or other skin barrier around periwound
4) Frame wound with Duoderm to prevent maceration
5) Pack wound with white foam and cover with black foam
6) Replace wound vac at 125mmHg of suction
7) Change MWF

A. **Answer:** No. This service should not be reported as 97607. 97607 is "NEGATIVE PRESSURE WOUND THERAPY, (EG, VACUUM ASSISTED DRAINAGE COLLECTION), UTILIZING DISPOSABLE, NON-DURABLE MEDICAL EQUIPMENT INCLUDING PROVISION OF EXUDATE MANAGEMENT COLLECTION SYSTEM, TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTIONS FOR ONGOING CARE, PER SESSION; TOTAL WOUND(S) SURFACE AREA LESS THAN OR EQUAL TO 50 SQUARE CENTIMETERS".

This kind of dressing change includes the provision of a rather expensive disposable device, such as the Smith and Nephew "PICO" wound dressing (among others):



97607 WOUND CARE

Reimbursement for 97607 includes the cost of this special and expensive dressing. Since the order is for the DME type of NPWT dressing, it would be inappropriate to report 97607. Depending on the documentation of the encounter, the hospital might be able to report 97605 or 97606, depending on the size of the wound, or G0463 (Hospital outpatient clinic visit for the assessment and management of a patient.)

Incidentally, the patient should not be required to bring in their own dressing supplies, the hospital is typically responsible for the cost of supplies. However, since the facility is a Critical Access Hospital, a Medicare beneficiary may save coinsurance expense (20% of the billed charges) by bringing in his/her own supplies.

2019 HCPCS Codes - ALL Quarter: Q2

Codes and/or Descriptions: **97606,97605,G0463** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 3
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule	Initial APC	Payment
97605 - negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters **Q1 - Paid or pkgd w S, T, V**	GB (Physician Facility): $28.44 GB (Physician Non-Facility): $49.65	5051 - Level 1 Skin Procedures	Weight: 2.2198 Payment: $176.45 National Co-pay: $0.00 Minimum Co-pay: $35.29
97606 - negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters **Q1 - Paid or pkgd w S, T, V**	GB (Physician Facility): $30.75 GB (Physician Non-Facility): $58.75	5052 - Level 2 Skin Procedures	Weight: 3.9512 Payment: $314.08 National Co-pay: $0.00 Minimum Co-pay: $62.82
G0463 - hospital outpatient clinic visit for assessment and management of a patient **J2 - Paid under OPPS; Addendum B displays APC assignments when services are separately payable.** **Berenson-Eggers Type of Service:** M1B - OFFICE VISITS - ESTABLISHED		5012 - Clinic Visits and Related Services **Composite(s)**	Weight: 1.4574 Payment: $115.85 National Co-pay: $0.00 Minimum Co-pay: $23.17

VAPOTHERM CHARGES

Q. We are attaching a request for charges from our ER Director regarding oxygen and pulse oximetry monitoring. We have no clue on what HCPCS or CPT® codes need to be used on these charges and neither does she. Can you please let us know?

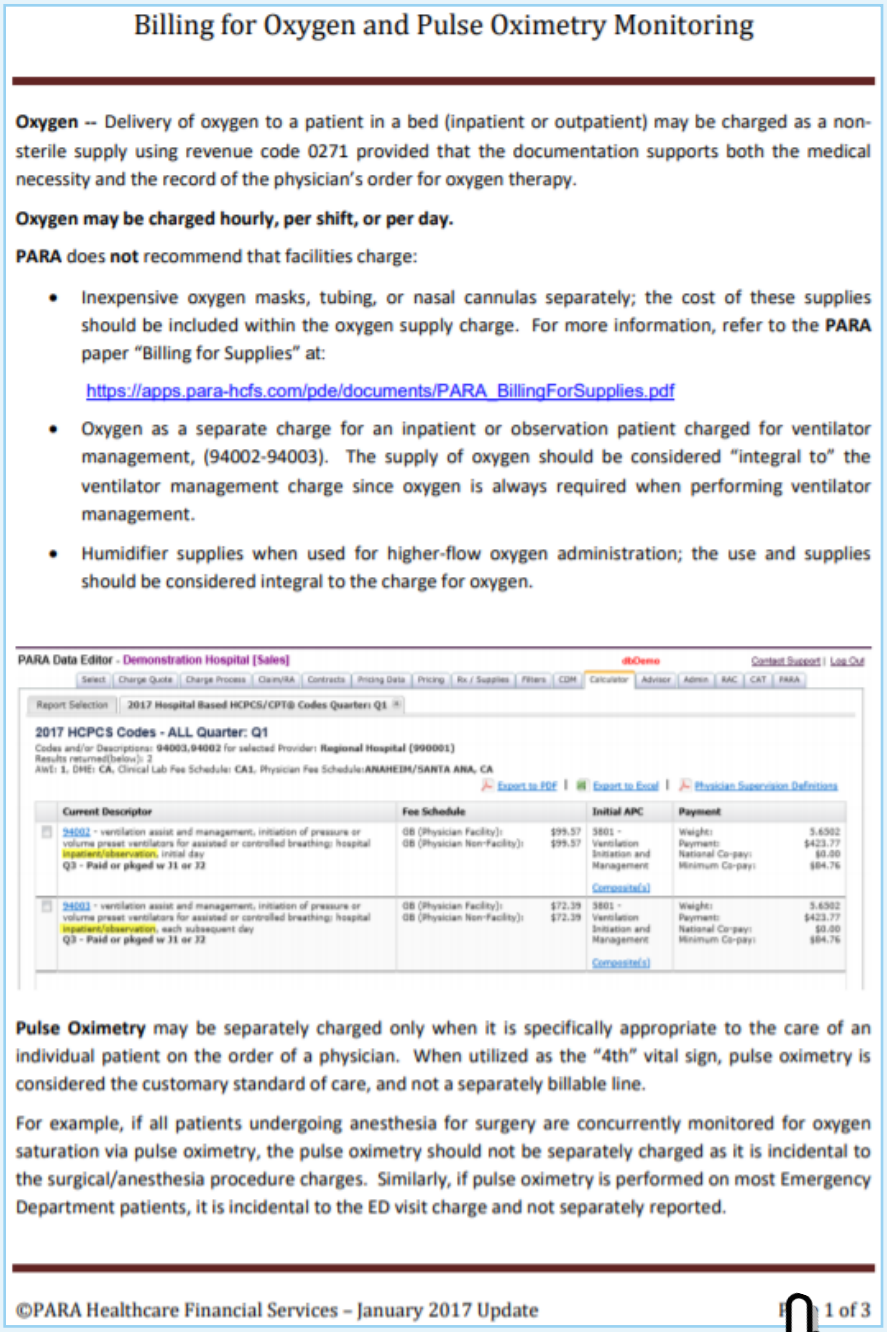
A. **Answer:** The **PARA Data Editor** offers a "Charge Process" feature, which clients can use to submit new charge requests for **PARA** review/correction/approval prior to adding the charge to the chargemaster. Please let us know if you would be interested in utilizing this feature of the **PDE** so that all new charge requests can be vetted by **PARA** staff prior to approval in the CDM.

Vapotherm provides high-velocity nasal flow, humidified oxygen. Our paper on billing for oxygen is attached. We do not recommend reporting the supply expense separately.

High-flow oxygen may be charged at a higher initial hour rate than regular O2; the initial hourly rate represents the higher cost of the disposable supplies (special cannula) and the set-up time required (humidifier.) The hospital may also elect to charge a higher subsequent hourly or daily rate for high-flow oxygen. Charges for oxygen are reported without a HCPCS under revenue code 0270, supplies.

The HCPCS 94002 and 94003 indicated on the charge request form are not appropriate. Those codes are appropriate for patients who require a ventilator, not simply high-flow oxygen.

Furthermore, HCPCS 94002/94003 are appropriate only for patients in observation or inpatient status; typically, patients in the Emergency department are not yet referred to observation or admitted as inpatients.



Billing for Oxygen and Pulse Oximetry Monitoring

Oxygen -- Delivery of oxygen to a patient in a bed (inpatient or outpatient) may be charged as a non-sterile supply using revenue code 0271 provided that the documentation supports both the medical necessity and the record of the physician's order for oxygen therapy.

Oxygen may be charged hourly, per shift, or per day.

PARA does **not** recommend that facilities charge:

- Inexpensive oxygen masks, tubing, or nasal cannulas separately; the cost of these supplies should be included within the oxygen supply charge. For more information, refer to the **PARA** paper "Billing for Supplies" at:

  https://apps.para-hcfs.com/pde/documents/PARA_BillingForSupplies.pdf

- Oxygen as a separate charge for an inpatient or observation patient charged for ventilator management, (94002-94003). The supply of oxygen should be considered "integral to" the ventilator management charge since oxygen is always required when performing ventilator management.

- Humidifier supplies when used for higher-flow oxygen administration; the use and supplies should be considered integral to the charge for oxygen.

PARA Data Editor - Demonstration Hospital [Sales]

2017 HCPCS Codes - ALL Quarter: Q1

Current Descriptor	Fee Schedule	Initial APC	Payment
94002 - ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day Q3 - Paid or pkged w J1 or J2	GB (Physician Facility): $99.57 GB (Physician Non-Facility): $99.57	5801 - Ventilation Initiation and Management	Weight: 5.6502 Payment: $423.77 National Co-pay: $0.00 Minimum Co-pay: $84.76
94003 - ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day Q3 - Paid or pkged w J1 or J2	GB (Physician Facility): $72.39 GB (Physician Non-Facility): $72.39	5801 - Ventilation Initiation and Management	Weight: 5.6502 Payment: $423.77 National Co-pay: $0.00 Minimum Co-pay: $84.76

Pulse Oximetry may be separately charged only when it is specifically appropriate to the care of an individual patient on the order of a physician. When utilized as the "4th" vital sign, pulse oximetry is considered the customary standard of care, and not a separately billable line.

For example, if all patients undergoing anesthesia for surgery are concurrently monitored for oxygen saturation via pulse oximetry, the pulse oximetry should not be separately charged as it is incidental to the surgical/anesthesia procedure charges. Similarly, if pulse oximetry is performed on most Emergency Department patients, it is incidental to the ED visit charge and not separately reported.

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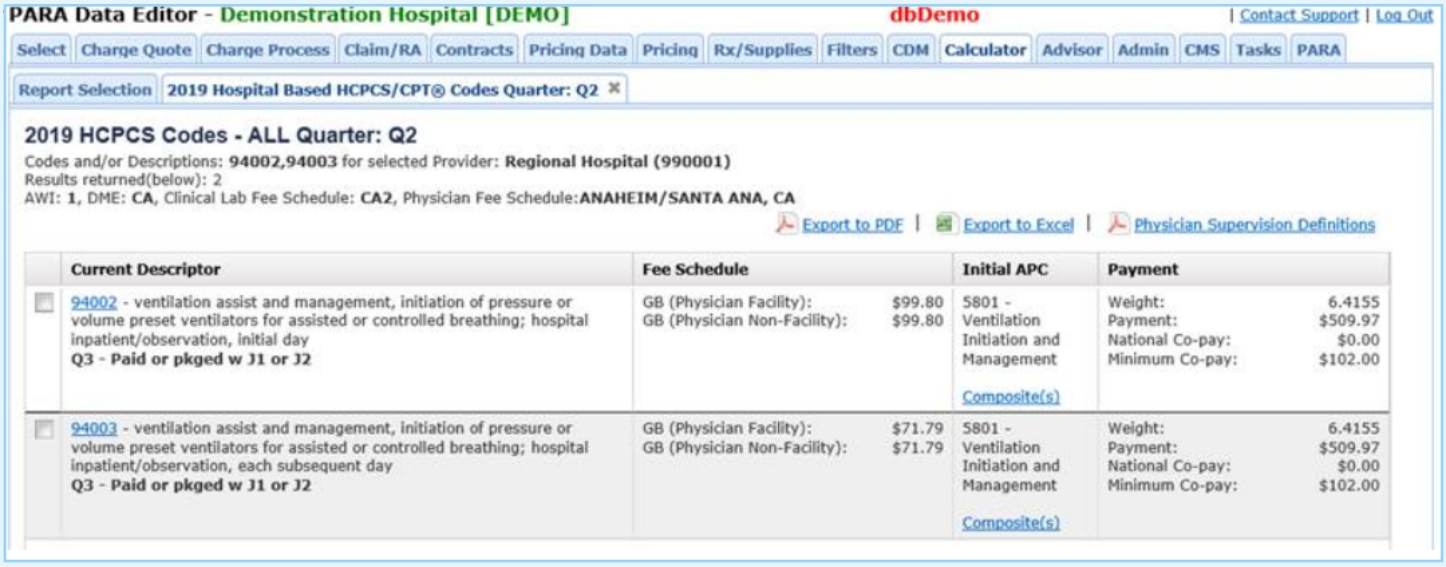
VAPOTHERM CHARGES



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

Report Selection | 2019 Hospital Based HCPCS/CPT® Codes Quarter: Q2

2019 HCPCS Codes - ALL Quarter: Q2

Codes and/or Descriptions: **94002,94003** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 2
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

Export to PDF | Export to Excel | Physician Supervision Definitions

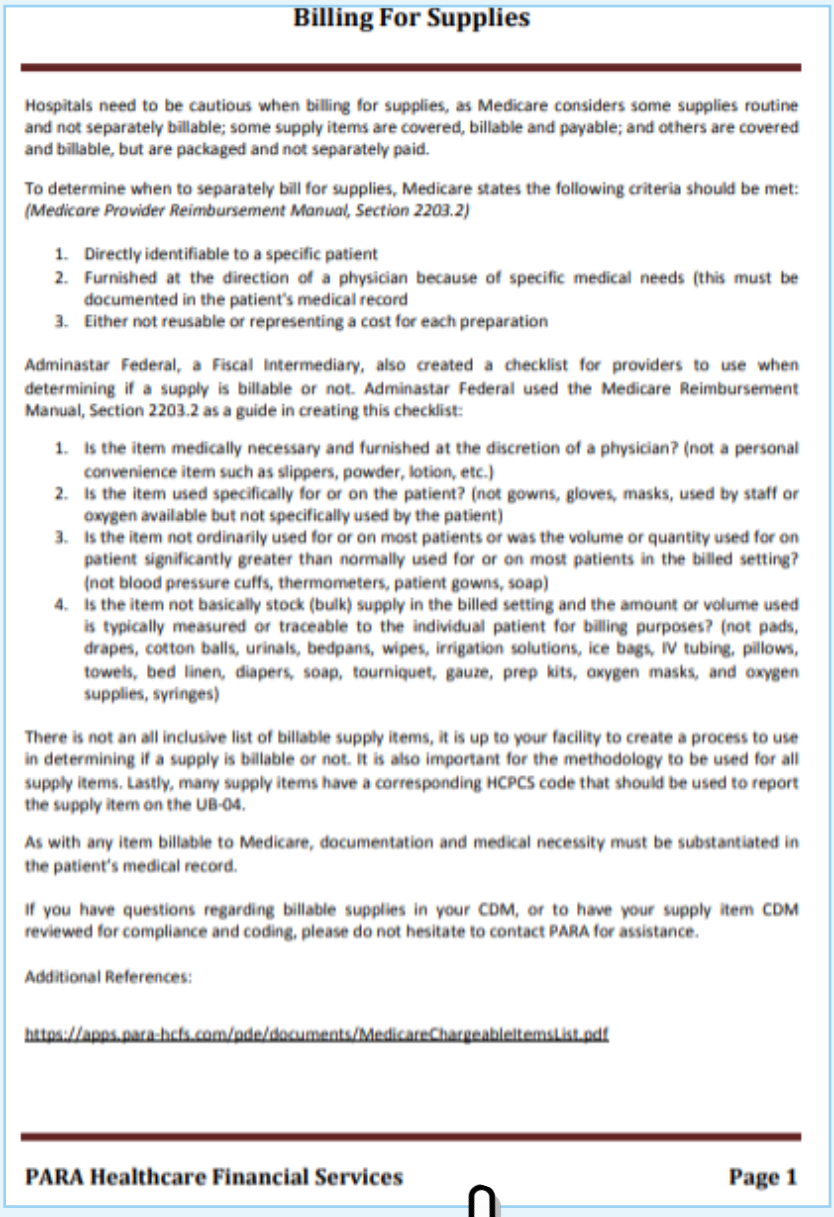
Current Descriptor	Fee Schedule		Initial APC	Payment	
94002 - ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day **Q3 - Paid or pkged w J1 or J2**	GB (Physician Facility): GB (Physician Non-Facility):	$99.80 $99.80	5801 - Ventilation Initiation and Management Composite(s)	Weight: Payment: National Co-pay: Minimum Co-pay:	6.4155 $509.97 $0.00 $102.00
94003 - ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day **Q3 - Paid or pkged w J1 or J2**	GB (Physician Facility): GB (Physician Non-Facility):	$71.79 $71.79	5801 - Ventilation Initiation and Management Composite(s)	Weight: Payment: National Co-pay: Minimum Co-pay:	6.4155 $509.97 $0.00 $102.00

Item/Orderable Description Please provide the exact description that needs to show	Orderable Should this be orderable in PowerChart, or Batch Charge Entry Only?	CDM This is a facility specific designated identifier	Rev Code	CPT/HCPCS **If Applicable**	Technical or Pro Fee	Price	Notes	Effective mm/dd/yyyy Format Example (01/01/2014) = 01012014
Vapotherm initiation charge	yes			94002		$460.70		06112019
Vapotherm subsequent day charge	yes			94003		$460.70		06112019
Oxygen for vapotherm 1 hour	yes							06112019
Oxygen for vapotherm subsequent hour charge	yes							06112019
Medical air first hour	yes							06112019
Medical air subsequent hour	yes							06112019
Vapotherm Circuit-Will ~~work with~~ Lori								
Vapotherm Cannula for adult-~~work with Lori~~								
Vapotherm Cannula for peds-~~work with~~ Lori								

DRESSINGS

Q. Can you please give me feedback on dressings? Our surgery dept doesn't currently charge for many dressings and they have a few new dressings the surgeons want to use and they are $25 apiece. I believe they are Silver-impregnated dressings. I know Medicare doesn't separately reimburse for them but wanted to get your take on non-Medicare.

A. **Answer:** It is appropriate to charge for dressings which are both expensive (we recommend only items that are over $5.00 in cost to the hospital) and ordered specifically to meet the unique medical needs of the patient – as long as the items are not "routine."



Billing For Supplies

Hospitals need to be cautious when billing for supplies, as Medicare considers some supplies routine and not separately billable; some supply items are covered, billable and payable; and others are covered and billable, but are packaged and not separately paid.

To determine when to separately bill for supplies, Medicare states the following criteria should be met: *(Medicare Provider Reimbursement Manual, Section 2203.2)*

1. Directly identifiable to a specific patient
2. Furnished at the direction of a physician because of specific medical needs (this must be documented in the patient's medical record
3. Either not reusable or representing a cost for each preparation

Adminastar Federal, a Fiscal Intermediary, also created a checklist for providers to use when determining if a supply is billable or not. Adminastar Federal used the Medicare Reimbursement Manual, Section 2203.2 as a guide in creating this checklist:

1. Is the item medically necessary and furnished at the discretion of a physician? (not a personal convenience item such as slippers, powder, lotion, etc.)
2. Is the item used specifically for or on the patient? (not gowns, gloves, masks, used by staff or oxygen available but not specifically used by the patient)
3. Is the item not ordinarily used for or on most patients or was the volume or quantity used for on patient significantly greater than normally used for or on most patients in the billed setting? (not blood pressure cuffs, thermometers, patient gowns, soap)
4. Is the item not basically stock (bulk) supply in the billed setting and the amount or volume used is typically measured or traceable to the individual patient for billing purposes? (not pads, drapes, cotton balls, urinals, bedpans, wipes, irrigation solutions, ice bags, IV tubing, pillows, towels, bed linen, diapers, soap, tourniquet, gauze, prep kits, oxygen masks, and oxygen supplies, syringes)

There is not an all inclusive list of billable supply items, it is up to your facility to create a process to use in determining if a supply is billable or not. It is also important for the methodology to be used for all supply items. Lastly, many supply items have a corresponding HCPCS code that should be used to report the supply item on the UB-04.

As with any item billable to Medicare, documentation and medical necessity must be substantiated in the patient's medical record.

If you have questions regarding billable supplies in your CDM, or to have your supply item CDM reviewed for compliance and coding, please do not hesitate to contact PARA for assistance.

Additional References:

https://apps.para-hcfs.com/pde/documents/MedicareChargeableItemsList.pdf

PARA Healthcare Financial Services **Page 1**

Our paper on billing for supplies, including the 4-question test, is attached.

Under Medicare's OPPS reimbursement methodology, no additional reimbursement will be achieved by charging separately for the supply items; however, when Medicare calculates the cost of various procedures using nationwide claims data, the cost of supplies used is included in their calculations.

Therefore it is important for hospitals to charge for expensive supplies when they meet the 4-question test.

Depending on the payment method applicable to non-Medicare payors, dressing supply line item charges may or may not affect reimbursement. If the total billed charges are paid on a percentage basis, supply line items could be scrutinized and challenged if the claim was audited.

However, if the item was specifically ordered by the physician and non-routine (such as a silver-impregnated supply), there is a sound basis for claiming reimbursement.

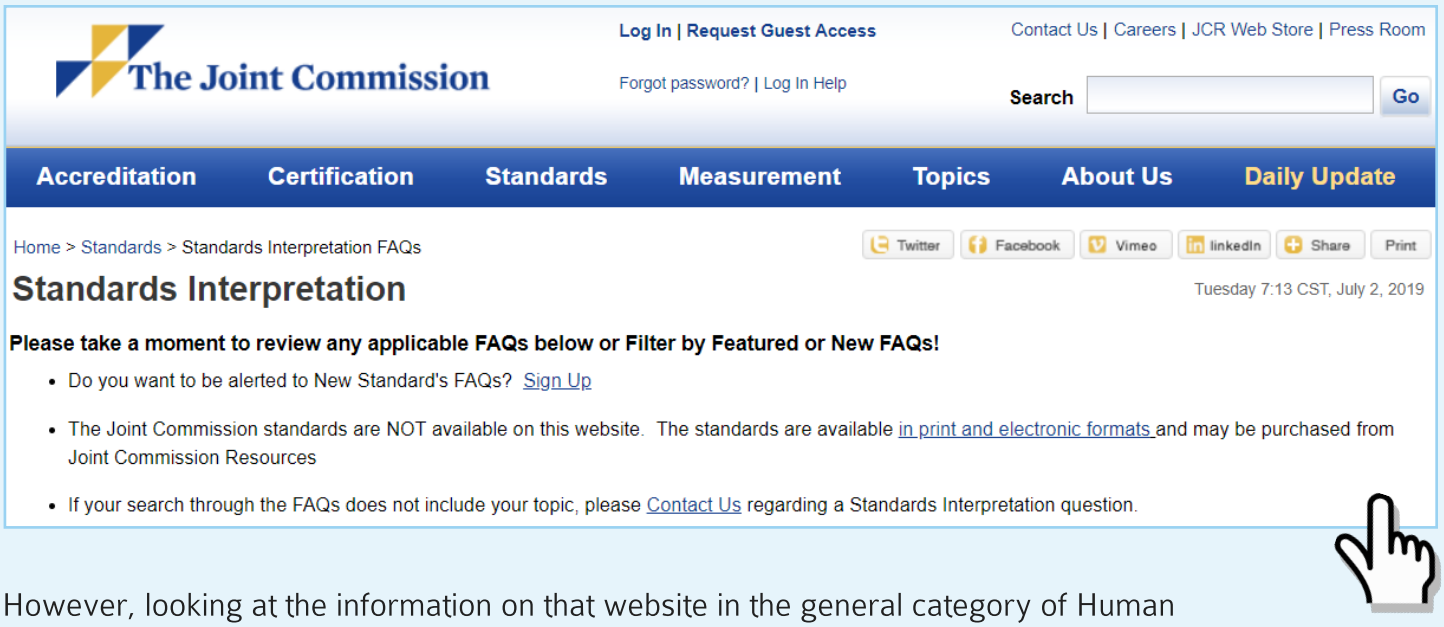
JOINT COMMISSION REQUIREMENTS

Q. Please confirm The Joint Commission requirement for a person to hold the position of Director of Medical Records. Is there any difference if the position is Director of HIM or is it just that the term Medical Records no longer used in the current healthcare environment.

Is there any difference in The Joint Commission requirement for a regular acute care hospital or for a CAH (Critical Access Hospital)?

A. **Answer:** We do not have access to the specific requirements of the Joint Commission. According to the website, their standards are available only for purchase:

https://www.jointcommission.org/standards_information/jcfaq.aspx?ProgramId=5&ChapterId=66&IsFeatured=False&IsNew=False&Keyword=



However, looking at the information on that website in the general category of Human Resources, we would not expect that the Joint Commission would take issue with the wording of the director's title, be it Director of HIM or Medical Records.

The important factors in a well-run hospital is that the employee's responsibilities are well articulated in the job description, and that a qualified individual holds the position, that a new employee in this position would go through a proper orientation, and that the employee is regularly evaluated for competency and performance.

Here is general information from their website under the category "Human Resources":

"Survey activities will focus on the organization's requirements, compliance with evidence-based guidelines, standards of practice and regulatory requirements. The accreditation requirements that address orientation and competency are found in the Human Resource (HR) chapter of the accreditation manual. Each Joint Commission-accredited organization has a copy of the manual containing these requirements."

CMS ADDS ANOTHER 6-MONTH DELAY TO ADLT BILLING RULE

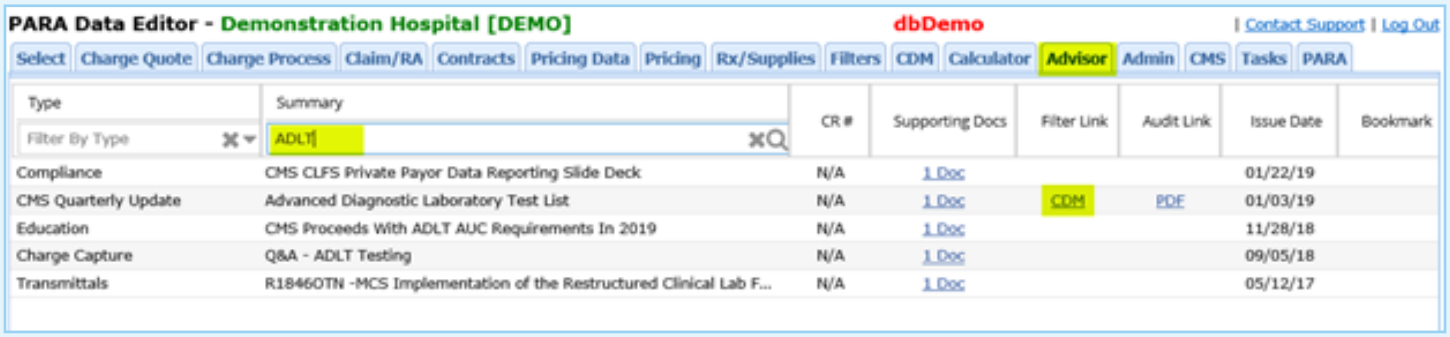
BREAKING NEWS

CMS quietly posted a letter on their DOS Exception website on 6/28/2019 announcing that it has again delayed enforcement of the date of service (DOS) exception policy for Advanced Diagnostic Lab Tests.

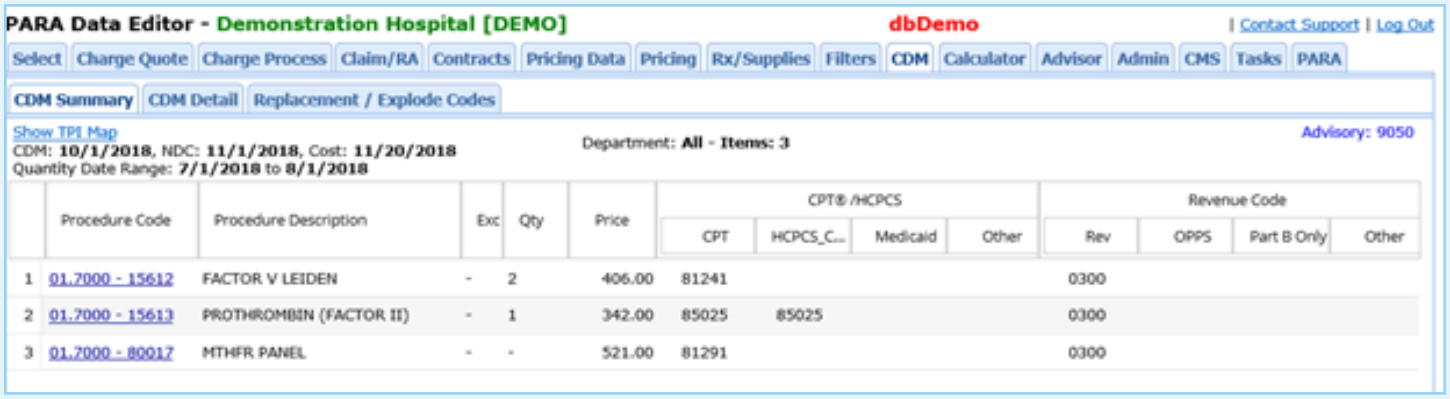
In the 2018 OPPS Final rule, Medicare required outpatient advanced diagnostic laboratory tests (ADLTs) to be billed by the performing lab rather than as send-out lab tests on an outpatient hospital claim.

Since many reference laboratories were unprepared to bill Medicare directly, Medicare first postponed compliance to July 1, 2018, then January 1, 2019, then July 1, 2019, and most recently to January 1, 2020. CMS reiterated in the latest letter that "CMS is committed to the successful implementation of the laboratory DOS exception policy at 42 CFR 414.510(b)(5) and will provide guidance as necessary."

PARA clients can review the list of the ADLT tests in the client chargemaster on the **PARA Data Editor** by finding the ADLT CDM report in the Advisor tab – enter "ADLT" in the summary line and click on the Filter Link labeled CDM:



Clicking the CDM link will deliver the user to the CDM tab with a list of CDM lines which are subject to the CMS ADLT policy.



CMS ADDS ANOTHER 6-MONTH DELAY TO ADLT BILLING RULE

CMS states that performing laboratories need to make every effort to meet the billing requirements as quickly as they can. Performing laboratories that are capable of billing Medicare should do so now. Consequently, clients are advised to work with their performing laboratory vendors to bill Medicare directly for outpatient services now if they are capable, with the deadline for meeting this requirement now postponed to January 1, 2020.

The CMS letter and an updated Questions and Answers document are available at the following link:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Lab-DOS-Policy.html

Subject: 6-Month Extension of Enforcement Discretion Period Announced for Date of Service Exception

CMS Announces Extension of Enforcement Discretion Period for Laboratory Date of Service Exception Policy Under the Medicare Clinical Laboratory Fee Schedule Until January 2, 2020

Today, the Centers for Medicare & Medicaid Services (CMS) announced that it will exercise enforcement discretion for an additional six (6) months, until January 2, 2020, with respect to the laboratory date of service (DOS) exception policy at 42 CFR 414.510(b)(5) under the Medicare Clinical Laboratory Fee Schedule (CLFS). During the enforcement discretion period, hospitals may continue to bill for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests that would otherwise be subject to the laboratory DOS exception. This enforcement discretion applies to providers and suppliers with regard to ADLTs and molecular pathology tests subject to the laboratory DOS exception policy as adopted in the CY 2018 Medicare Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center final rule published on December 14, 2017 (82 FR 59393) and implemented by Change Request 10419, Transmittal 4000.

Medicare first postponed compliance to July 1, 2018, then January 1, 2019, then July 1, 2019, and most recently to January 1, 2020.

CMS ADDS ANOTHER 6-MONTH DELAY TO ADLT BILLING RULE

The complete list of over 300 HCPCS that may be billed by either the hospital or the performing laboratory (not both) until January 2, 2020 is available at the following link:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Lab-DOS-Policy.html

Medicare Clinical Laboratory Fee Schedule
Revised Laboratory Date of Service (DOS) Policy
Laboratory Tests For Which the DOS is the Date the Test is Performed
(Subject to the Conditions Specified in 42 CFR 414.510(b)(5))*

Revisions to Previous List Indicated By Red Font

HCPCS Code	OPPS Payment Status Indicator**	Short Descriptor	Effective Date
81105	A	Hpa-1 genotyping	1/1/2018
81106	A	Hpa-2 genotyping	1/1/2018
81107	A	Hpa-3 genotyping	1/1/2018
81108	A	Hpa-4 genotyping	1/1/2018
81109	A	Hpa-5 genotyping	1/1/2018
81110	A	Hpa-6 genotyping	1/1/2018
81111	A	Hpa-9 genotyping	1/1/2018
81112	A	Hpa-15 genotyping	1/1/2018
81120	A	Idh1 common variants	1/1/2018
81121	A	Idh2 common variants	1/1/2018
81161	A	Dmd dup/delet analysis	1/1/2018
81162	A	Brca1&2 seq & full dup/del	1/1/2018
81170	A	Abl1 gene	1/1/2018
81175	A	Asxl1 full gene sequence	1/1/2018
81176	A	Asxl1 gene target seq alys	1/1/2018
81200	A	Aspa gene	1/1/2018
81201	A	Apc gene full sequence	1/1/2018
81202	A	Apc gene known fam variants	1/1/2018
81203	A	Apc gene dup/delet variants	1/1/2018
81205	A	Bckdhb gene	1/1/2018
81206	A	Bcr/abl1 gene major bp	1/1/2018
81207	A	Bcr/abl1 gene minor bp	1/1/2018
81208	A	Bcr/abl1 gene other bp	1/1/2018
81209	A	Blm gene	1/1/2018

Downloads

Enforcement Discretion (Updated 06/28/2019) [ZIP, 57KB]
Enforcement Discretion (Updated 12/26/2018) [ZIP, 69KB]
Laboratory Test Codes Subject to Date of Service Exception (Updated, 6/24/2019) [ZIP, 198KB]
Enforcement Discretion (Updated 7/3/2018) [ZIP, 275KB]
Frequently Asked Questions (Updated 6/28/2018) [PDF, 204KB]

Related Links

R4000CP [PDF, 306KB]
CMS-1678-FC (PDF)

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

New Lab Reporting Requirements Could Put Your Hospital At Risk

The Center For Medicare and Medicaid (CMS) is now requiring hospital outreach laboratories to report private payer payment rates.

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

Hospitals are required to report private payer payment rates for the same tests that Medicare reimburses on the clinical laboratory fee schedule if they received at least $12,500 in Medicare revenues for claims billed on the 14X TOB for dates of service between January 1, 2019 and June 30, 2019, assuming the majority of the TOB 141 revenues were paid under the Clinical Lab Fee Schedule.

CMS will use the data reported by hospitals to develop its own payment rates under the Clinical Laboratory Fee Schedule (CLFS) in future years.

Medicare clarified reporting requirements in an MLN article published in late February, 2019.

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

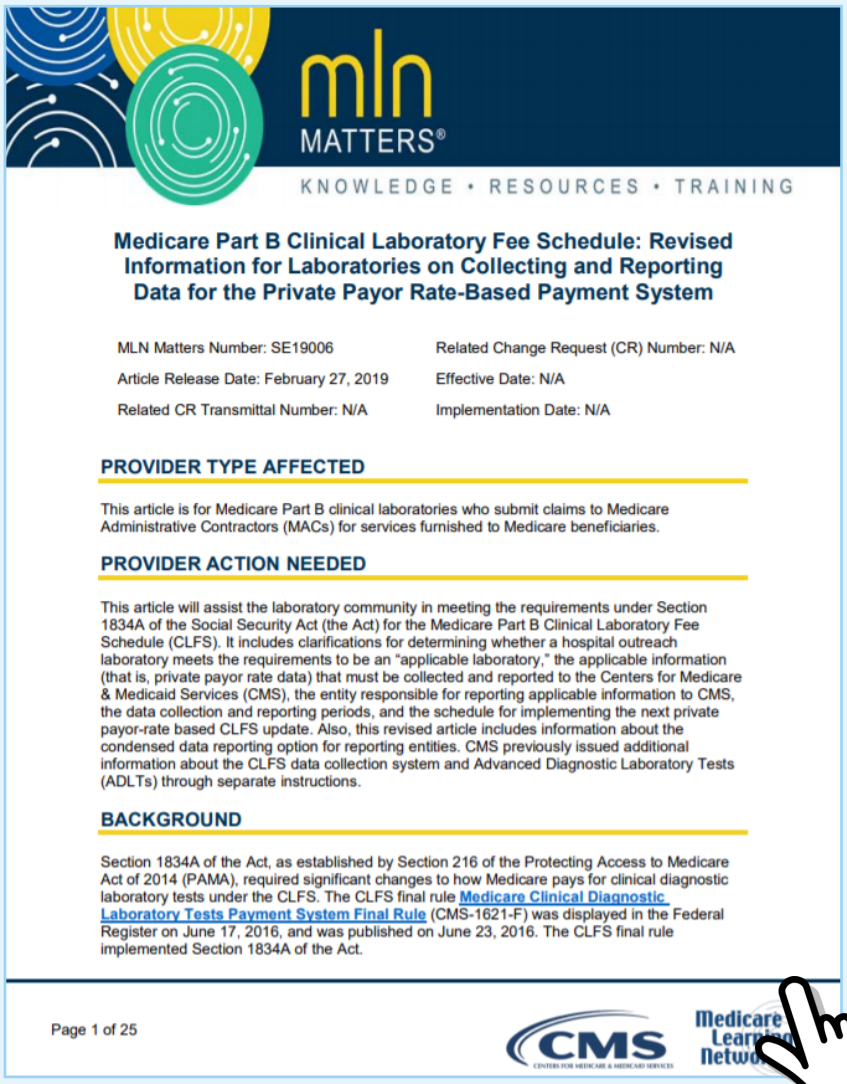
the Problem

Hospitals conducting "outreach" laboratory service should verify whether the 14X bill type was used to report "non-patient services" for lab testing. **PARA** has learned that contrary to its earlier understanding, even if the hospital lab reports under the same NPI as the hospital, the hospital must evaluate whether it meets the other two tests for required reporting.

Hospitals with labs billing on the 14X bill type are required to report payment data if:

- The hospital receives more than $12,500 in Medicare revenue for non-patient clinical lab services reported on bill type 14X in the period January 1 through June 30 2019, and
- the majority of revenues received from Medicare for services billed on the 14X bill type were paid under the Clinical Lab Fee Schedule (this is highly likely for TOB 141 claims.)

For hospitals that are subject to the requirement, private payer data must be collected for the period 1/1/19 through 6/30/19, analyzed, validated, and reported to Medicare in the next reporting period, 1/1/20 through 3/31/20.



mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System

MLN Matters Number: SE19006 | Related Change Request (CR) Number: N/A

Article Release Date: February 27, 2019 | Effective Date: N/A

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

PROVIDER TYPE AFFECTED

This article is for Medicare Part B clinical laboratories who submit claims to Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article will assist the laboratory community in meeting the requirements under Section 1834A of the Social Security Act (the Act) for the Medicare Part B Clinical Laboratory Fee Schedule (CLFS). It includes clarifications for determining whether a hospital outreach laboratory meets the requirements to be an "applicable laboratory," the applicable information (that is, private payor rate data) that must be collected and reported to the Centers for Medicare & Medicaid Services (CMS), the entity responsible for reporting applicable information to CMS, the data collection and reporting periods, and the schedule for implementing the next private payor-rate based CLFS update. Also, this revised article includes information about the condensed data reporting option for reporting entities. CMS previously issued additional information about the CLFS data collection system and Advanced Diagnostic Laboratory Tests (ADLTs) through separate instructions.

BACKGROUND

Section 1834A of the Act, as established by Section 216 of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for clinical diagnostic laboratory tests under the CLFS. The CLFS final rule Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule (CMS-1621-F) was displayed in the Federal Register on June 17, 2016, and was published on June 23, 2016. The CLFS final rule implemented Section 1834A of the Act.

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CMS

Medicare Learning Network

Presumably, this means that the deadline for reporting data from January through June 2019 is after January 1, 2020, but no later than March 31, 2020. Significant penalties apply if reporting is not submitted promptly and accurately.

Since the vast majority of services billable on the 14X bill type are paid under the Clinical Lab Fee Schedule, the central question is whether the hospital received $12,500 in allowable reimbursement from Medicare (not including managed Medicare) during the data collection period January through June 2019.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19006.pdf

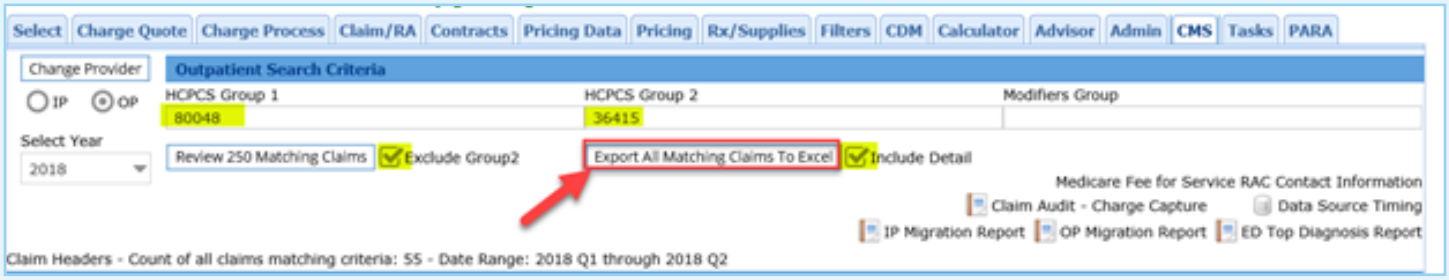
Significant penalties apply if reporting is not submitted promptly and accurately.

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

thePARASolution FOR CLIENTS

To estimate whether a hospital has met the $12,500 threshold, **PARA Data Editor** clients may use the **PARA Data Editor CMS** tab to examine a few of the most common lab tests billed to Medicare for the six-month period January through June 2018. If the threshold was met in that period, it is likely to be met in 2019 as well.

To view revenues received from Medicare in 2018, navigate to the CMS tab on the **PARA Data Editor**. Enter a common lab test, such as 80048 (BMP), 80053 (CMP) or 85025 (CBC with auto diff.) In the second HCPCS field, enter the blood draw code 36415, and click the "Excludes Group 2" box below it, as well as the "Include Detail" box to the right of the Excel export field, as illustrated below:



This will generate an excel report which will yield the claims most likely to be billed on a 141 TOB. The resulting report will identify the bill type:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**Community Hospital [PRIP]**													
2	**2018 Outpatient Claims with one or more of these HCPCS codes: 80048 and excluding one or more of these HCPCS codes: 36415**													
3	**Count of all claims matching criteria: 271 - Date Range: 18 Q1 through 18 Q2**													
5	**PARA ID**	**Prov ID**	**Payment**	**Charges**	**Group**	**Date**	**Bill Type**	**Reason Cd1**	**Reason Cd2**	**Reason Cd3**	**PartB Deduct**	**PartB Coins**	**Provider Payment**	**Diag ICD10 1**
6	74476	340042	10.23	151.11	80048	1/3/2018	141	N184			0.00	0.00	10.23	N184
7	74477	340042	14.98	213.21	80048	1/10/2018	141	N184			0.00	0.00	14.98	N184
8	106079	340042	18.33	222.53	80048	1/16/2018	141	I10			0.00	0.00	18.33	I10
9	504823	340042	65.38	663.45	80048	1/29/2018	131	N184			0.00	0.00	65.38	N184
10	647999	340042	34.53	383.99	80048	1/3/2018	141	E7800			0.00	0.00	34.53	E7800
11	1038496	340042	31.38	383.99	80048	1/3/2018	141	E870			0.00	0.00	31.38	E870
12	1038497	340042	10.23	151.11	80048	1/9/2018	141	E870			0.00	0.00	10.23	N049
13	1038498	340042	10.23	151.11	80048	1/15/2018	141	E870			0.00	0.00	10.23	E870
14	1074894	340042	29.75	447.13	80048	1/19/2018	141	I10			0.00	0.00	29.75	I2510
15	2318756	340042	54.52	515.44	80048	1/17/2018	141	I129			0.00	0.00	54.52	I129
16	2801453	340042	30.56	338.45	80048	1/15/2018	141	N189			0.00	0.00	30.56	E039

If the sum of payments on 14X TOB for several common lab tests gives the impression that the $12,500 threshold was met in 2018, then the hospital should begin planning to report data for the January-June 2019 data collection period.

This process identifies whether or not your hospital meets the qualifying threshold to report and ONLY counts existing Medicare data from bill type 14X during January 1 through June 20, 2019.

Clients will then need to report all private payer tests on all 14X types of bills. But how? This is where **PARA** can help existing clients.

The **PARA Data Editor** offers the ability to analyze electronic remittance files to quickly generate a spreadsheet of the allowable rate paid by CPT® codes on 14X bill types. This data will be configured into the required format for Medicare reporting. However, at this time **PARA** is not able to research payments submitted on paper remittances.

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

the PARA Solution

The process is simple.

*For Existing **PARA** Clients*

Step 1

Initial Eligibility Assessment:

PARA takes existing Medicare bill type 141 data in the **PARA Data Editor** and determines if the client meets the $12,500 billing threshold. **PARA** issues qualified opinion to client.

Step 2

Complete Laboratory Claim Analysis

PARA takes all bill type data labeled as 14X in the **PARA Data Editor** and determines if the total amount to be reported.

Client receives a Data Worksheet and assistance with reporting to CMS.

start Here

Contact your account executive.

Violet Archuleta-Chiu
Senior Account Executive
varchuleta@para-hcfs.com
800-999-3332, ext. 219

Sandra LaPlace
Account Executive
slaplace@para-hcfs.com
800-999-3332, ext. 225

*For new **PARA** Clients*

Step 1

Initial Eligibility Assessment:

PARA takes claim Medicare bill type 141 data uploaded by the new client, and determines if the client meets the $12,500 billing threshold. **PARA** issues qualified opinion to client.

Step 2

Complete Laboratory Claim Analysis

Client uploads 837 electronic claim files for covered period. Client may limit data to 014X bill types or submit all claims within the period.

Client uploads 835 electronic remit files.

Step 3

Complete Laboratory Claim Analysis

PARA takes all bill type data labeled as 14X in the **PARA Data Editor** and determines if the total amount to be reported.

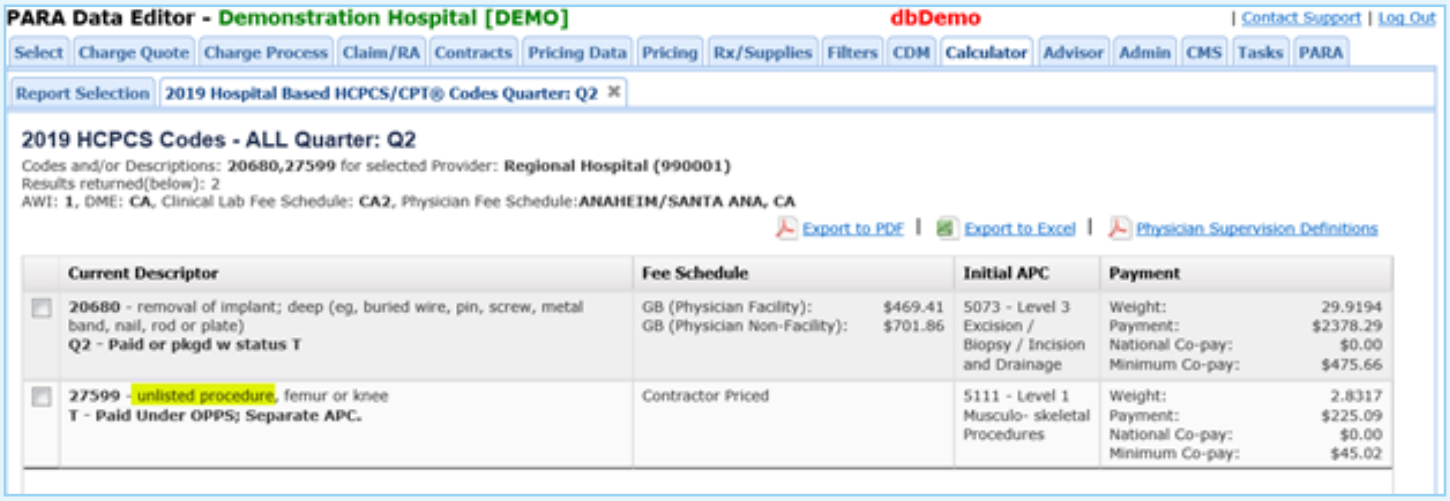
Client receives a Data Worksheet and assistance with reporting to CMS.

REPORTING "UNLISTED" HCPCS ON HOSPITAL CLAIMS

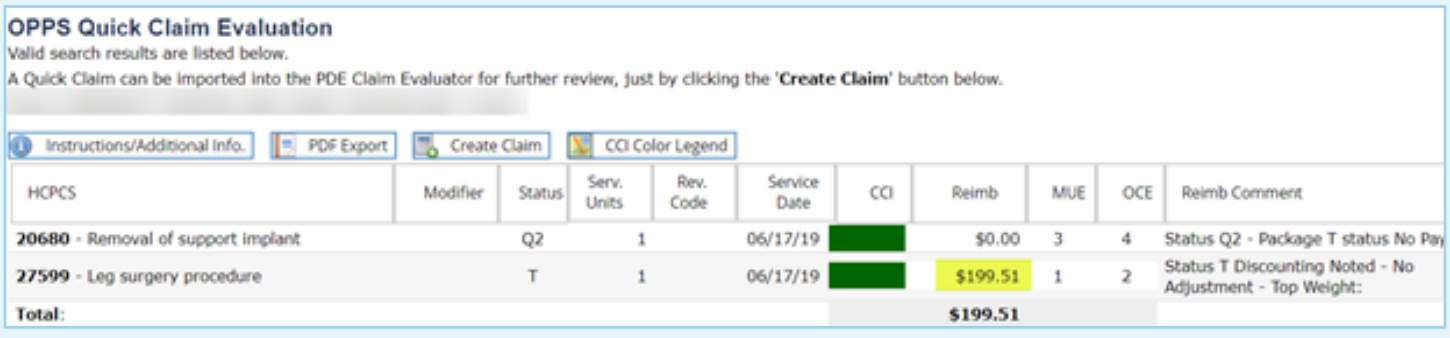
Hospitals should exercise caution when reporting "unlisted" codes to payers, particularly those which are hard-coded in the chargemaster. Because unspecified codes do not precisely describe the procedure or the service performed, unlisted codes entered by HIM coders should be monitored closely.

For example, unlisted pulmonary service or procedure HCPCS 94799 should not be used to report incentive spirometry. Incentive spirometry does not have a HCPCS code and is not separately reportable. It should be considered a component of the visit charge, recovery room charge, or inpatient room rate. Some hospitals mark up the supply charge for the spirometer to account for the labor expense in providing incentive spirometry coaching to patients by respiratory therapists.

Reporting an unlisted code instead of the specific code may negatively affect reimbursement. For instance, HCPCS 20680 (Removal of implant; deep (eg buried wire, pin, screw, metal band, nail, rod or plate)) has a Medicare OPPS reimbursement of $2,378.29. Using a less specific unlisted procedure, femur or knee HCPCS code of 27599 results in Medicare OPPS reimbursement of only $225.09.



If both HCPCS 20680 and the less-specific code of 27599 were on the same claim, because the 20680 has a status indicator of Q2, it would be packaged with the 27599 and reimbursed only $199.51.



When in doubt, coders should always query the physician on the procedure if the documentation is unclear, rather than simply assign an unlisted code. When it is necessary to report an unlisted code, most payers will require additional documentation to adjudicate payment, such as the operative report, lab orders or results, and invoices for implants.

REPORTING "UNLISTED" HCPCS ON HOSPITAL CLAIMS

Noridian, the Medicare Administrative Contractor for California and several northwestern states, provides illuminating guidance on the use of unlisted codes on their website at the link below:

https://med.noridianmedicare.com/web/jeb/topics/claim-submission/submission-errors-solutions/unlisted-procedure-and-noc-codes

Unlisted Procedure and Not Otherwise Classified Codes

When billing a service or procedure, select the CPT or HCPCS code that accurately identifies the service or procedure performed. If no such code exists, report the service or procedure using the appropriate "unlisted procedure code or Not Otherwise Classified (NOC) code" (which often end in 99). Noridian will **not** correctly code unlisted codes when a valid code is available.

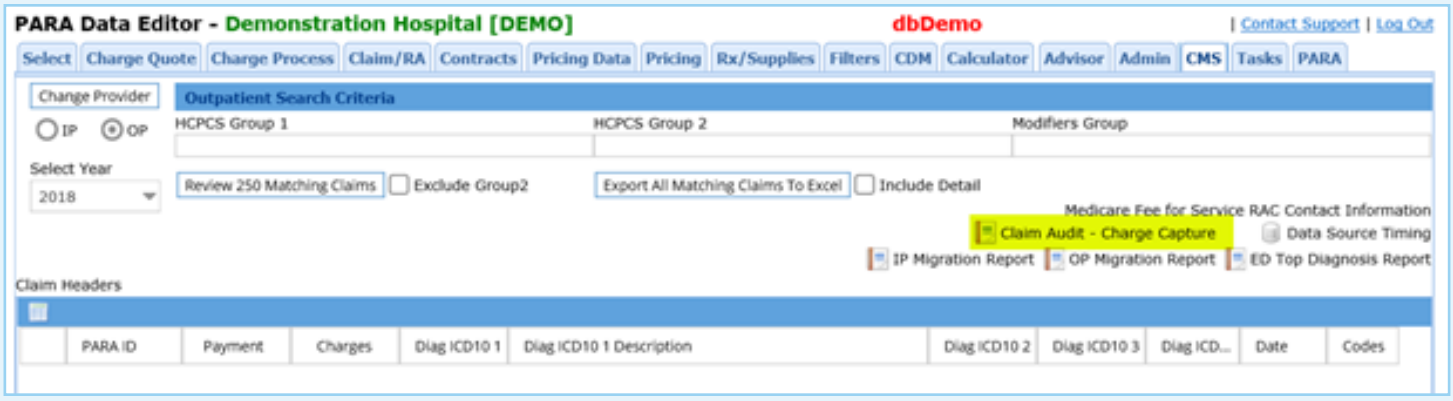
It is the responsibility of the provider to ensure all information required to process unlisted procedure codes or NOC codes is included on the CMS-1500 form or the electronic media claim (EMC) when the claim is submitted. If required information is missing, the code will be deemed unprocessable.

An unlisted procedure code or NOC must have a **concise description of the services** rendered in Item 19 on the CMS-1500 claim form or electronic equivalent. The electronic equivalent for Item 19 on EMC submissions will hold up to 80 characters for the concise statement and should be enough space to describe the unlisted procedure code. If the description does not fit in Item 19, providers who submit paper claims should include an attachment to describe the services. PWK segment is provided. See PWK article titled "Submitting Paperwork (PWK) Electronically."

Do not submit a written request or contact the Noridian Provider Call Center to inquire if the description is appropriate for payment. We cannot determine if the comment is sufficient for payment without viewing the entire claim.

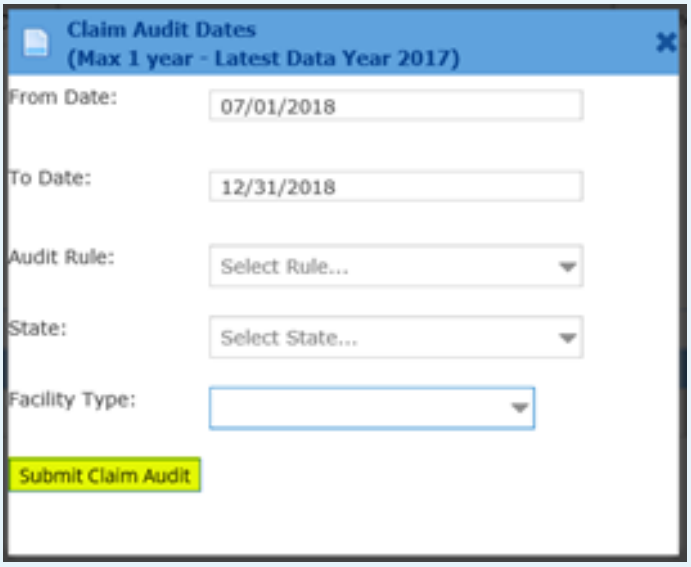
PARA clients may examine unlisted codes which were submitted to Medicare in a recent prior period by running a report on the CMS tab of the **PARA Data Editor**. Alternately, the same report can be acquired on 837 claims data submitted to the **PARA Data Editor**.

PARA's "Claim Audit Report" generates an excel download which itemizes claims with unlisted codes reported by the client to Medicare in a prior period. To run the report, click on the hyperlink to open the report parameters window:

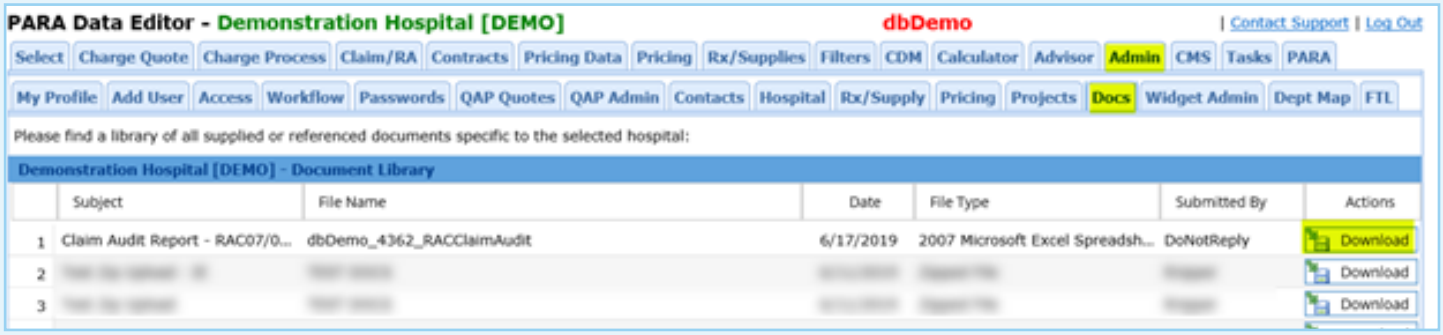


REPORTING "UNLISTED" HCPCS ON HOSPITAL CLAIMS

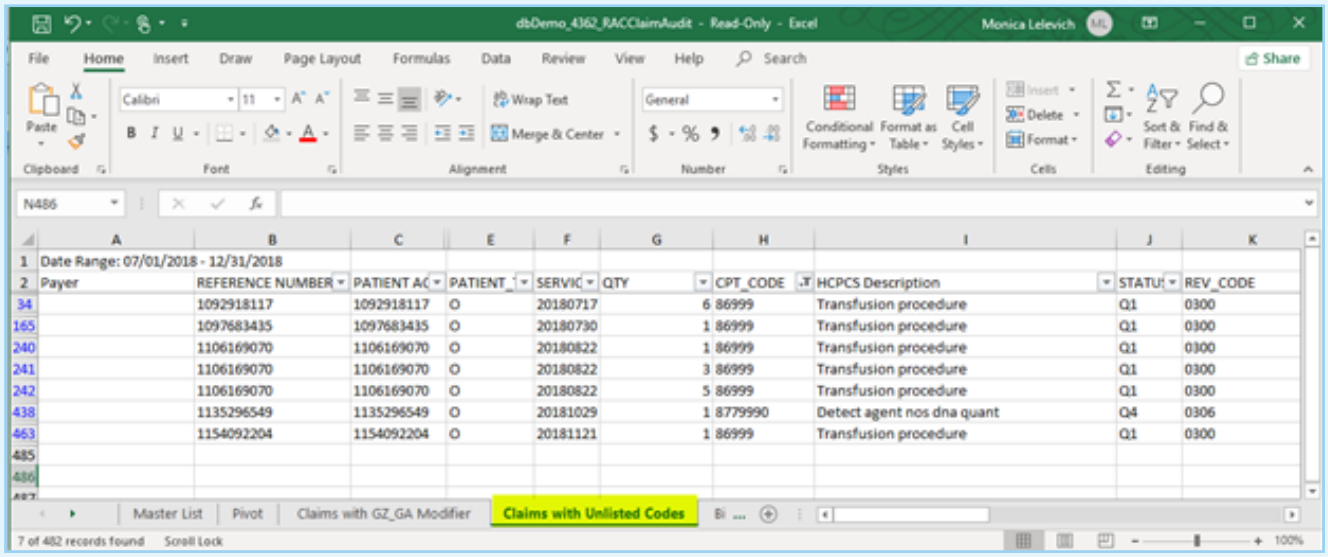
In the report parameters pop-up, enter the dates from the available data (view the dropdown under "Select Year" to see which quarterly data files are available on the CMS tab). It is optional to enter the audit rule, state, and facility type:



The excel will generate within 5 to 10 minutes; it is found on the Admin tab/Docs subtab:



Refer to the tab labeled "Claims with Unlisted Codes" to view the results



HETS QUERY FOR MEDICARE DIABETES PREVENTION PROGRAM

CMS has announced changes to the HIPAA Eligibility Transaction System (HETS) that will allow query returns for Medicare Diabetes Prevention Program (MDPP) usage information.

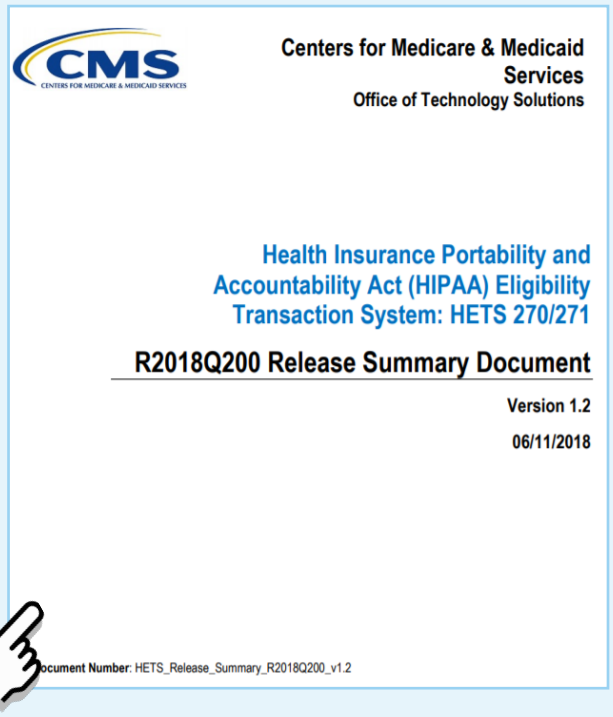
The HETS Medicare beneficiary eligibility response (Form 271) includes HCPCS codes for MDPP services if the National Provider Identifier (NPI) on the eligibility inquiry (270) belongs to a Medicare enrolled MDPP supplier or if it includes the Service Type Code "CQ"

https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/R2018Q200HETS270271ReleaseSummary.pdf

Providers will be able to use this information to determine the next available MDPP service for Medicare beneficiaries. If the Medicare beneficiary is ineligible for MDPP, HETS will not return MDPP usage information.

The 271-return query should display the following HCPCS codes:

- No prior MDPP usage: G9873
- MDPP usage: G9873, G9874, G9875, G9876, G9877, G9878, G9879, G9880, G9881, G9882, G9883, G9884, G9885, G9890, and G9891, including the reporting NPI and the date of service
- G9890 and G9891 can be returned multiple times. All other MDPP HCPCS codes are once-in-a-lifetime services and will only return once


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services
Office of Technology Solutions

Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System: HETS 270/271

R2018Q200 Release Summary Document

Version 1.2

06/11/2018

ocument Number: HETS_Release_Summary_R2018Q200_v1.2

Table 1 - Example of Limited MDPP Supplier Eligibility Response

Type	Response
Beneficiary Demographics	NM1*IL*1*LNAME*FNAME*M***MI*123456789A~
	N3*ADDRESSLINE1*ADDRESSLINE2~
	N4*CITY*ST*ZIPCODE~
	DMG*D8*19400401*F~
	DTP*307*RD8*20180101-20181104~
Unlawful Occurrence	EB*6**30~
	DTP*307*RD8*20180101-20180108~
Part B Entitlement	EB*1**30*MB~
	DTP*291*D8*20050401~
MDPP Coverage	EB*1**CQ*MB~
	DTP*292*RD8*20180101-20180603~
MDPP Financial Information	EB*C**CQ*MB**23*0~
	DTP*292*RD8*20180101-20180603~
	EB*A**CQ*MB**27**0~
	DTP*292*RD8*20180101-20180603~

HETS QUERY FOR MEDICARE DIABETES PREVENTION PROGRAM

Providers should note:

- MDPP eligibility data does not impact non-MDPP services
- Providers must be enrolled as an MDPP supplier to be able to provide MDPP services to Medicare beneficiaries and to be able to bill Medicare for these services
- Not an enrolled MDPP supplier?

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html

Medicare Provider-Supplier Enrollment

- DMEPOS Enrollment
- Enrollment Applications
- Internet-based PECOS
- Medicare Application Fee
- Ordering & Referring Information
- National Site Visit Contractor
- Opt Out Affidavits
- Preclusion List
- Provider Enrollment Moratorium
- Provider Enrollment Events
- Provider Enrollment Regulation
- Revalidations
- Taxonomy

Enrollment Applications

Medicare Provider/Supplier Enrollment Applications

The Medicare enrollment application (CMS-855 or Internet-based Provider Enrollment, Chain and Ownership System (PECOS)) is an Office of Management and Budget approved form and is available in PDF fillable format. This format allows a user to complete an application using Adobe Acrobat and save this information on their personal computer or download the application. To access the applications, please refer to the CMS Forms List link below.

- CMS-855A Medicare Enrollment Application for Institutional Providers
- CMS-855B Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers
- CMS-855I Medicare Enrollment Application for Physicians and Non-Physician Practitioners
- CMS-855R Medicare Enrollment Application for Reassignment of Medicare Benefits
- CMS-855O Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Non-physician Practitioners
- CMS-855S Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers
- CMS-855POH Medicare Enrollment Application for Physician Owned Hospitals
- CMS-20134 Medicare Enrollment Application for Medicare Diabetes Prevention Program (MDPP) Suppliers

https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-12-05-Diabetes.html

MLN Homepage

Return to List

Details for title: 2017-12-05

Date 2017-12-05

Event Medicare Diabetes Prevention Program Model Expansion Call

Topic Medicare Diabetes Prevention Program

When: Tuesday, December 5, 2017, from 1:30 to 3 pm ET

Registration: Visit the MLN Event Registration website.

Event Materials:

- Presentation [PDF, 279KB]
- Audio Recording [ZIP, 19MB]
- Transcript [PDF, 490KB]
- Clarification [PDF, 192KB]

Description:

The CY 2018 Medicare Physician Fee Schedule final rule includes the expansion of the Medicare Diabetes Prevention Program (MDPP) Model starting in 2018. During this call, CMS experts provide a high-level overview of the finalized policies. A question and answer session follows the presentation.

NEW EDITS TO BE ACTIVATED FOR FACILITY LOCATION

Facilities billing various hospital locations to Medicare may experience some RTP claim rejections (FISS edits 34977 and 34978) sometime after July 1, 2019 if the address reported on the claim does not exactly match the location address provided on the enrollment form (855A) for that location.

The new edits will particularly affect facilities which report modifiers "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) or modifier "PN" (Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) on an institutional claim.

On Friday, June 28, 2019, Medicare announced a delay of the validation edits. They will be activated after the October, 2019 quarterly release.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se19007.pdf

Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

MLN Matters Number: SE19007

Related Change Request (CR) Number: 9613; 9907

Date: March 26, 2019

Effective Date: N/A

Related CR Transmittal Numbers: R1704OTN and R1783OTN

Implementation Date: N/A

During the week of July 23, 2018, through July 30, 2018, CMS performed a national trial activation of the FISS Edits 34977 and 34978 in production environments. Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO) were activated. The testing was transparent to providers as most claims impacted by the test were suspended for one billing cycle and then editing was turned off so the claim could continue processing as normal.

This national test brought to light that many providers are not sending the correct exact service facility location on the claim that produces an exact match with the Medicare enrolled location as based on the information entered into the PECOS for their off-campus provider departments.

Most discrepancies had to do with spelling variations. For example, in PECOS the word entered was "Road" as part of their address, but the provider entered "Rd" or "Rd." as part of their address on the claim submission.

Once the edits have been permanently turned on, claims will Return-to-Provider (RTP) if they do not exactly match. Providers with access to the Medicare FISS system by DDE can make corrections to their service facility address for a claim submitted in the DDE MAP 171F screen.

Medicare cautions that providers who need to add a new or correct an existing practice location address will still need to submit a new 855A enrollment application in PECOS.

MEDI-CAL HEPATITIS B VACCINE UPDATE

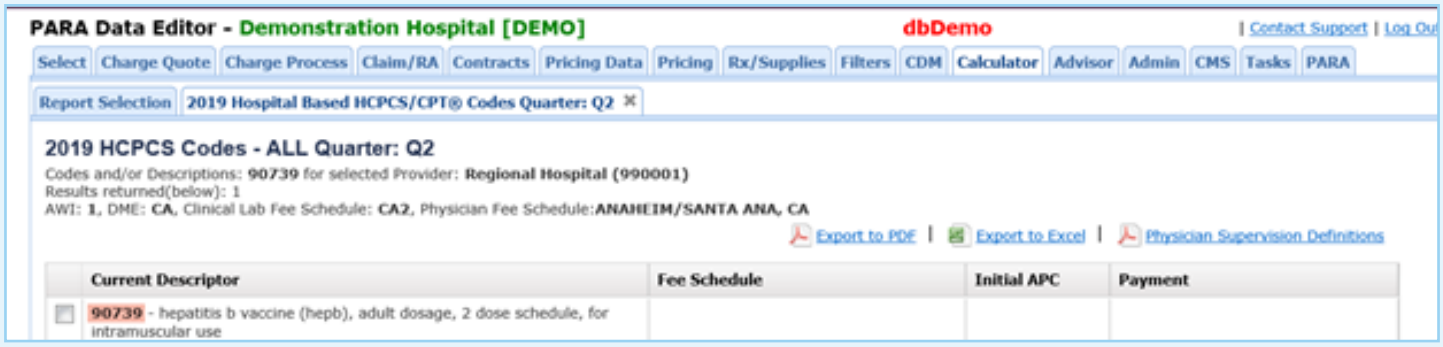
California Update

Effective retroactively for dates of service on or after March 1, 2018 Medi-Cal will now reimburse providers for CPT® Code 90739, Hepatitis B Vaccine, administered to recipients age 18 years or older.

Previous Medi-Cal bulletins instructed providers not to bill for this service until the claims processing system was updated and policies for the vaccine were created. The claims processing system and policies have been implemented.

Providers may bill retroactively for dates of service on or after March 1, 2018 with timely filing restrictions waved for six months, beginning June 6, 2019.

Medi-Cal will initiate an Erroneous Payment Correction to reprocess denied claims.



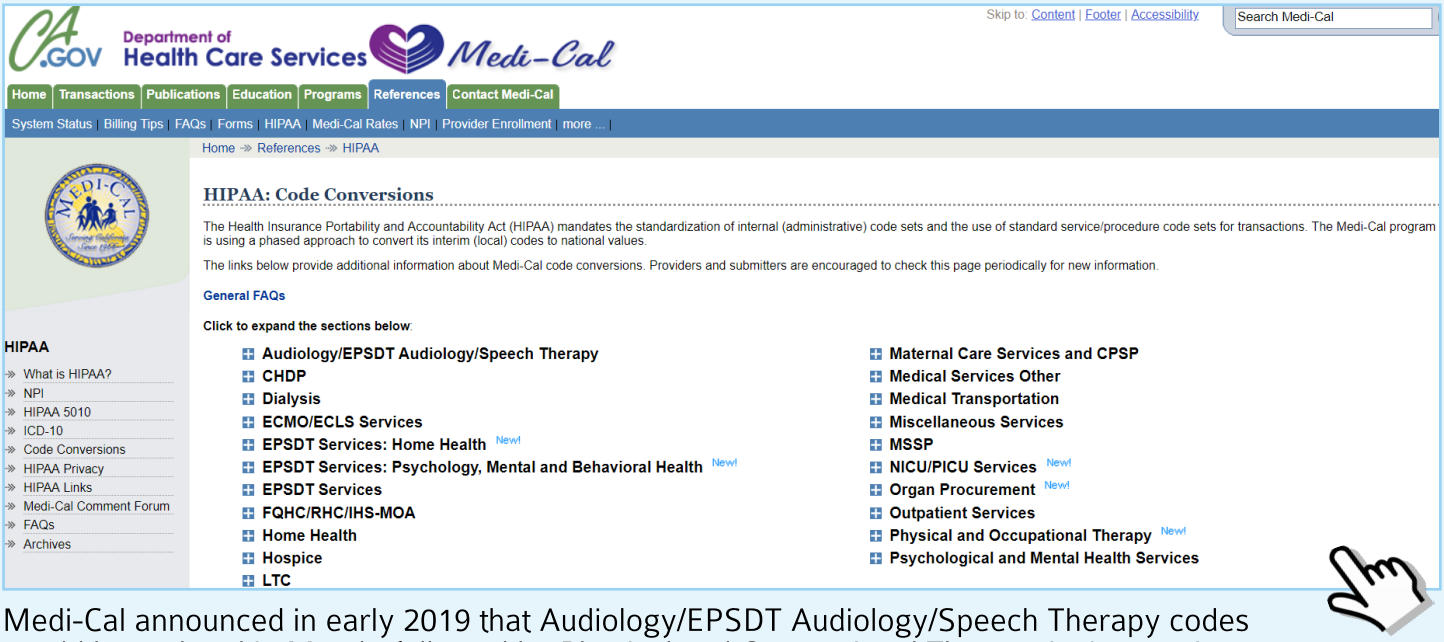
http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_27677Rev2.asp

DELAY FOR THERAPY SERVICE CONVERSIONS

California Update

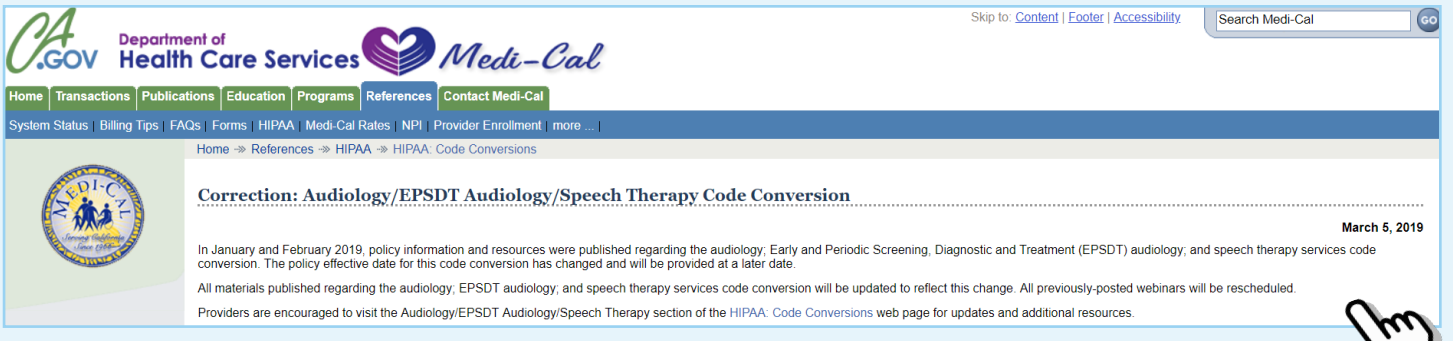
Historically, California has used local codes or HCPCS Level III codes for reimbursement of services and supplies. CPT® Category I codes and HCPCS Level II codes are more specific in nature and are considered HIPAA-Compliant National Codes. California Medi-Cal will be converting from HCPCS Level III codes to HIPAA-Compliant National Codes in order to meet the requirements set forth in the Health Insurance Accountability and Portability Act to meet the mandated billing requirements throughout 2019.

http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaacorrelations_home.asp



Medi-Cal announced in early 2019 that Audiology/EPSDT Audiology/Speech Therapy codes would be updated in March, followed by Physical and Occupational Therapy in August. It was recently announced that both categories would see delays in HCPCS code conversions with no conversion date having been announced at this time.

http://files.medi-cal.ca.gov/pubsdoco/hipaa/articles/codeconversionsnews_27557_01.asp

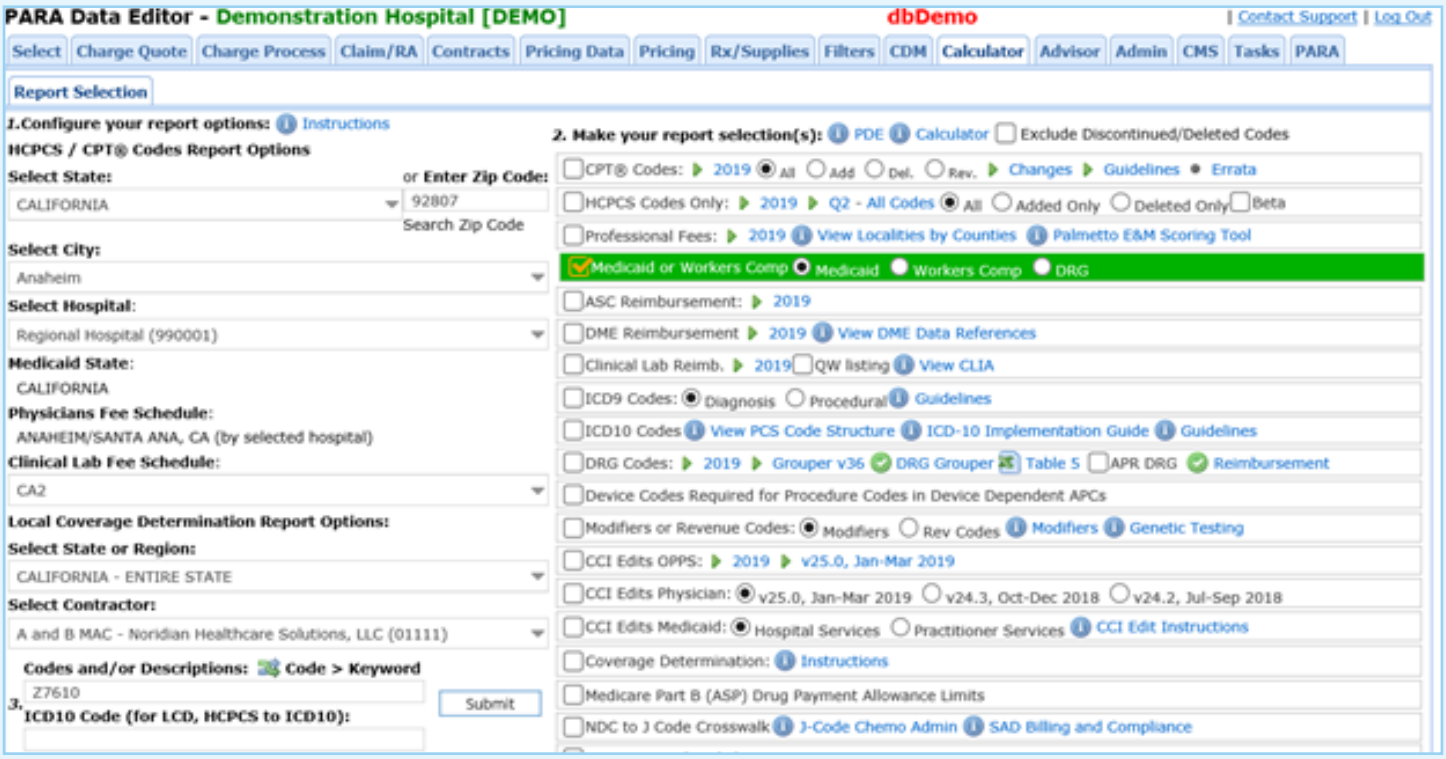


DELAY FOR THERAPY SERVICE CONVERSIONS

California Update

http://files.medi-cal.ca.gov/pubsdoco/hipaa/articles/codeconversionsnews_22100_05.asp

PARA clients can review the Calculator tab in the **PARA Data Editor** to pull up Medi-Cal specific code and fee schedule information. It is important to note that though the HIPAA Compliant CPT® codes are currently located within the Medi-Cal Fee Schedule and showing as reimbursable, these codes are not effective until Medi-Cal and DHCS provide a conversion effective date.



MLN CONNECTS

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

mlnconnects
Official CMS news from the Medicare Learning Network

Thursday, June 27, 2019

News

· Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28

· MIPS Data Validation and Audit for Performance Years 2017 and 2018

Claims, Pricers & Codes

· FY 2020 ICD-10-CM Diagnosis Code Updates

Events

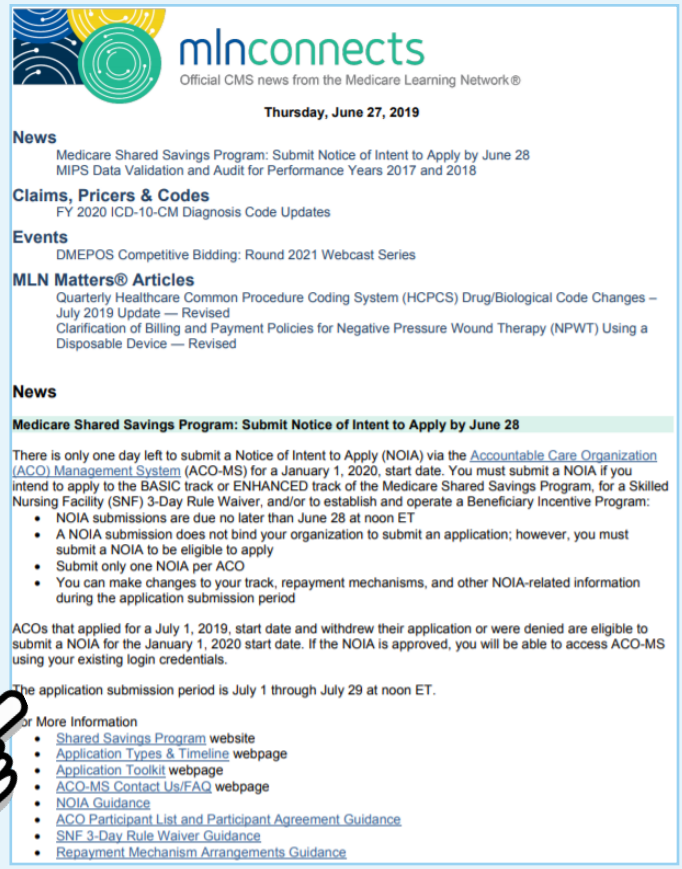
· DMEPOS Competitive Bidding: Round 2021 Webcast Series

MLN Matters® Articles

· Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – July 2019 Update — Revised

· Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device — Revised

View this edition as a PDF [PDF, 254KB]



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Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device — Revised

News

Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28

There is only one day left to submit a Notice of Intent to Apply (NOIA) via the Accountable Care Organization (ACO) Management System (ACO-MS) for a January 1, 2020, start date. You must submit a NOIA if you intend to apply to the BASIC track or ENHANCED track of the Medicare Shared Savings Program, for a Skilled Nursing Facility (SNF) 3-Day Rule Waiver, and/or to establish and operate a Beneficiary Incentive Program:

- NOIA submissions are due no later than June 28 at noon ET
- A NOIA submission does not bind your organization to submit an application; however, you must submit a NOIA to be eligible to apply
- Submit only one NOIA per ACO
- You can make changes to your track, repayment mechanisms, and other NOIA-related information during the application submission period

ACOs that applied for a July 1, 2019, start date and withdrew their application or were denied are eligible to submit a NOIA for the January 1, 2020 start date. If the NOIA is approved, you will be able to access ACO-MS using your existing login credentials.

The application submission period is July 1 through July 29 at noon ET.

r More Information
- Shared Savings Program website
- Application Types & Timeline webpage
- Application Toolkit webpage
- ACO-MS Contact Us/FAQ webpage
- NOIA Guidance
- ACO Participant List and Participant Agreement Guidance
- SNF 3-Day Rule Waiver Guidance
- Repayment Mechanism Arrangements Guidance

WEEKLY IT UPDATE

PARA HealthCare Analytics has provided a list of enhancements and updates that our Information Technology (IT) team has made to the **PARA Data Editor** this past week.

The following tables includes which version of the **PDE** was updated, the location within the **PDE**, and a description of the enhancement.

This Week's Updates

Week Ending	Platform	Tab	Enhancement	User Action
June 28, 2019	PARA Data Editor	Calculator	May 2019 CPT Assistant added to Calculator	Users can query CPT Assistant documents and view 10+ years of PDF versions.
June 28, 2019	PARA Data Editor	Calculator	2019 National payment rate added to HCPCS Query for G0071	Fee schedule amount is published in a Medicare FAQ.

Previous Updates

Week Ending	Platform	Tab	Enhancement	User Action
June, 21st 2019	Multi-Browser/IE	Calculator	HCPCS query for July 1st rates will be availabe on that day. Updated OPPS Addendum B, HCPCS and CPT codes will be available.	Users can query July 2019 reimbursement rates using the HCPCS query.
June, 21st 2019	Multi-Browser/IE	Calculator	July 2019 ASC Fee Schedule has been loaded into the PDE Calculator.	Users can view current ASC fee schedule information using the ASC reimbursement query on the PDE Calculator.
June, 21st 2019	Multi-Browser/IE	Calculator	July 2019 Medicaid NCCI Edits have been loaded into the PDE Calculator.	Users can view this information using the CCI Edits Medicaid query on the PDE Calculator.
June, 21st 2019	Multi-Browser/IE	Calculator	July 2019 Physician Fee Schedule and RVU data from CMS has been loaded into the PDE Calculator.	Users can view current Physician fee schedule and RVU information using the Professional Fees query on the PDE Calculator.
June, 21st 2019	Multi-Browser/IE	Calculator	July 2019 Medically Unlikely Edits from CMS have been loaded into the PDE Calculator.	Users can view MUE values on the detail pop-up within the HCPCS query. MUE values are also displayed on Quick Claim results.
June, 21st 2019	Multi-Browser/IE	Calculator	NDC-HCPCS Crosswalk has been updated for July 2019.	Users can query NDC codes in the PDE Calculator to find any associated J codes and vice versa.
June, 21st 2019	Multi-Browser/IE	Calculator	July 2019 ASP Pricing File from CMS has been loaded into the PDE Calculator.	Users can query drug codes to find payment allowance limits.
June, 21st 2019	Multi-Browser/IE	Calculator	July 2019 Medicare Outpatient and Physician CCI Edits have been loaded into the PDE Calculator.	Users can view this information using the CCI Edits OPPS and Physician queries on the PDE Calculator.

RURAL HOSPITAL PROGRAM GRANTS AVAILABLE

Rural hospitals and clinics face their own set of unique and burdensome challenges when it comes to program development, cash management and maintaining volume. That's why it's great when they can get some assistance from external funding sources.

At **PARA**, we've found an excellent source of funding opportunities for rural healthcare facilities. Here are some examples.

340B Drug Pricing Program

- **The program provides prescription drugs at a reduced cost to eligible entities. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers.**
- **Registration periods are open 4 times throughout the year, and are processed in quarterly cycles.**
- **Funding cycles are as follows: July 1 - July 15 for an October 1 start date; October 1 - October 15 for a January 1 start date**

Tribal Opioid Response Grants

Short Title: TOR

Initial Announcement

Funding Opportunity Announcement (FOA) Information

FOA Number: TI-19-012

Posted on Grants.gov: Friday, June 7, 2019

Application Due Date: Tuesday, August 6, 2019

Catalog of Federal Domestic Assistance (CFDA) Number: 93.788

Tribal Opioid Response Grants

Provides up to $50,000 to develop a strategic plan to address opioid addiction in tribal nations.

Application Deadline: August 6, 2019

Service Area Competition Funding For Health Center Programs

Multi-year funding of up to $1.3 million dollars to provide comprehensive primary healthcare services to an underserved area or population. Areas with a March 1, 2020 project period start date are eligible to apply.

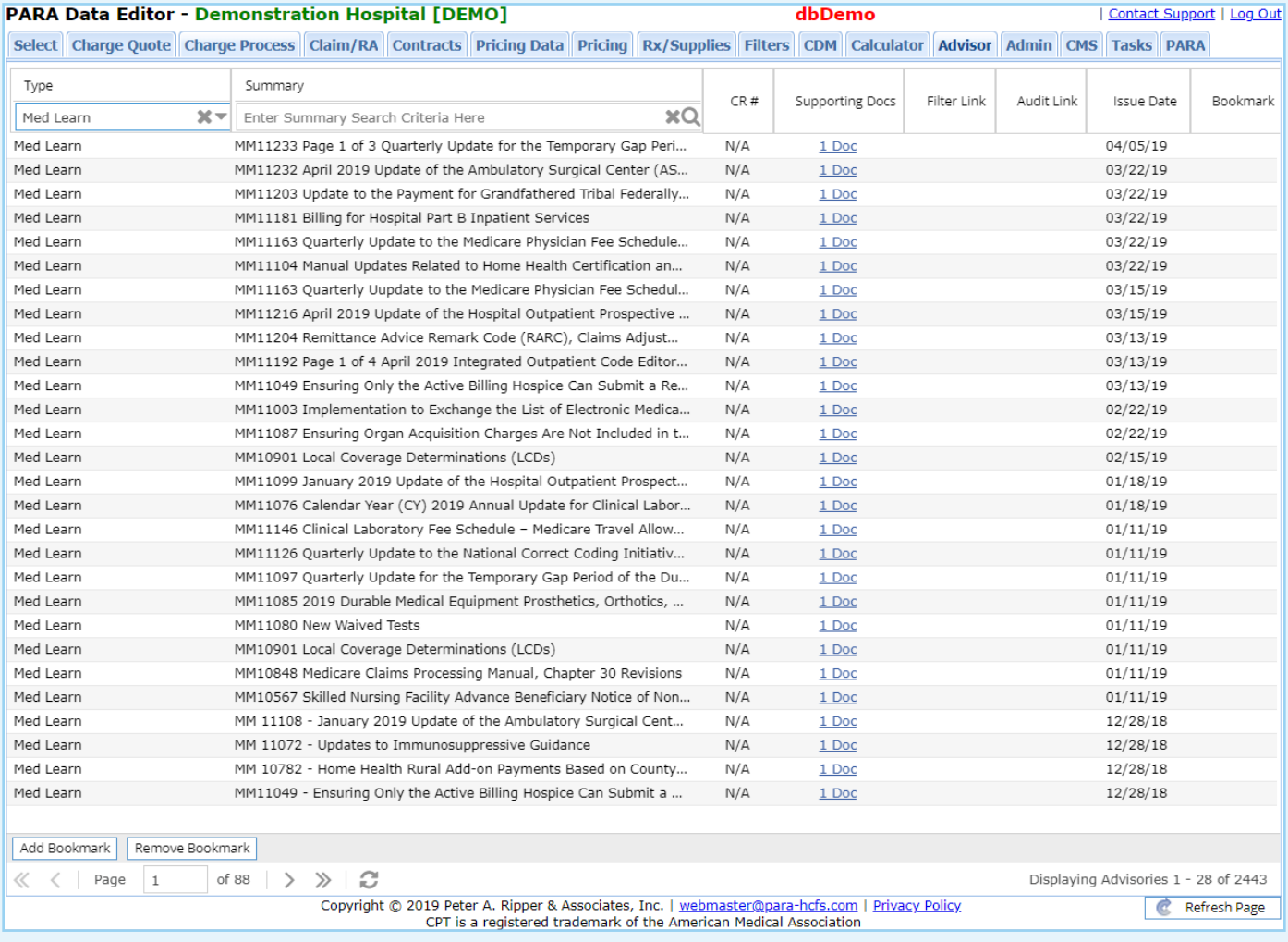
Application Deadline: August 26, 2019

Announcement Information	
Announcement Number	HRSA-20-017
Announcement Code	SAC
CFDA Number	93.224
Provisional	No
ctivity Code	H80
Competitive	Yes
Fiscal Year	2020

There were TWO 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.**

FIND ALL THESE MED LEARNS IN THE **ADVISOR** TAB OF THE **PDE** 2



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Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date	Bookmark
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 Med Learn MM11347

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KNOWLEDGE • RESOURCES • TRAINING

Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2020

MLN Matters Number: MM11347 | Related Change Request (CR) Number: 11347

Related CR Release Date: June 28, 2019 | Effective Date: October 1, 2019

Related CR Transmittal Number: R4325CP | Implementation Date: October 7, 2019

PROVIDER TYPE AFFECTED

This MLN Matters Article is for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries paid under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS).

PROVIDER ACTION NEEDED

CR 11347 provides information on the Fiscal Year (FY) 2020 updates to the SNF PPS payment rates, as required by statute. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1888(e) of the Social Security Act (as amended by: 1) the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP), the Balanced Budget Refinement Act of 1999 (the BBRA), 2) the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and 3) the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA)), requires annual updates to the SNF PPS rates, relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes, in the Federal Register, the SNF payment rates for the upcoming Fiscal Year (FY) (in this case, October 1, 2019 through September 30, 2020). This information is available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html.

The current update methodology is similar to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds a 0.5 percentage point threshold. The payment rates will be

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KNOWLEDGE • RESOURCES • TRAINING

July Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM11334 Revised
Related Change Request (CR) Number: 11334
Related CR Release Date: June 28, 2019
Effective Date: July 1, 2019
Related CR Transmittal Number: R4328CP
Implementation Date: July 1, 2019

Note: We revised this article on July 2, 2019, to reflect the revised CR11334 issued on June 28. CMS revised the CR to include a correction to the fee schedule amounts for HCPCS codes E1353 and E1355. The article includes this correction information on page 4. Also, we revised the CR release date, transmittal number, and the web address of CR11334. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

CR11334 informs DME MACs about the changes to the DMEPOS fee schedule which Medicare updates on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Sections 1834(a), (h), and (i) of the Social Security Act (the Act) requires payment on a fee schedule basis for DMEPOS and surgical dressings by. Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician's office. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts under section 1834(a)(1)(F) of the Act as well as codes that are not subject to the fee schedule Competitive Bidding Program (CBP) adjustments.

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There were 7 new or revised
Transmittals released this week.

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

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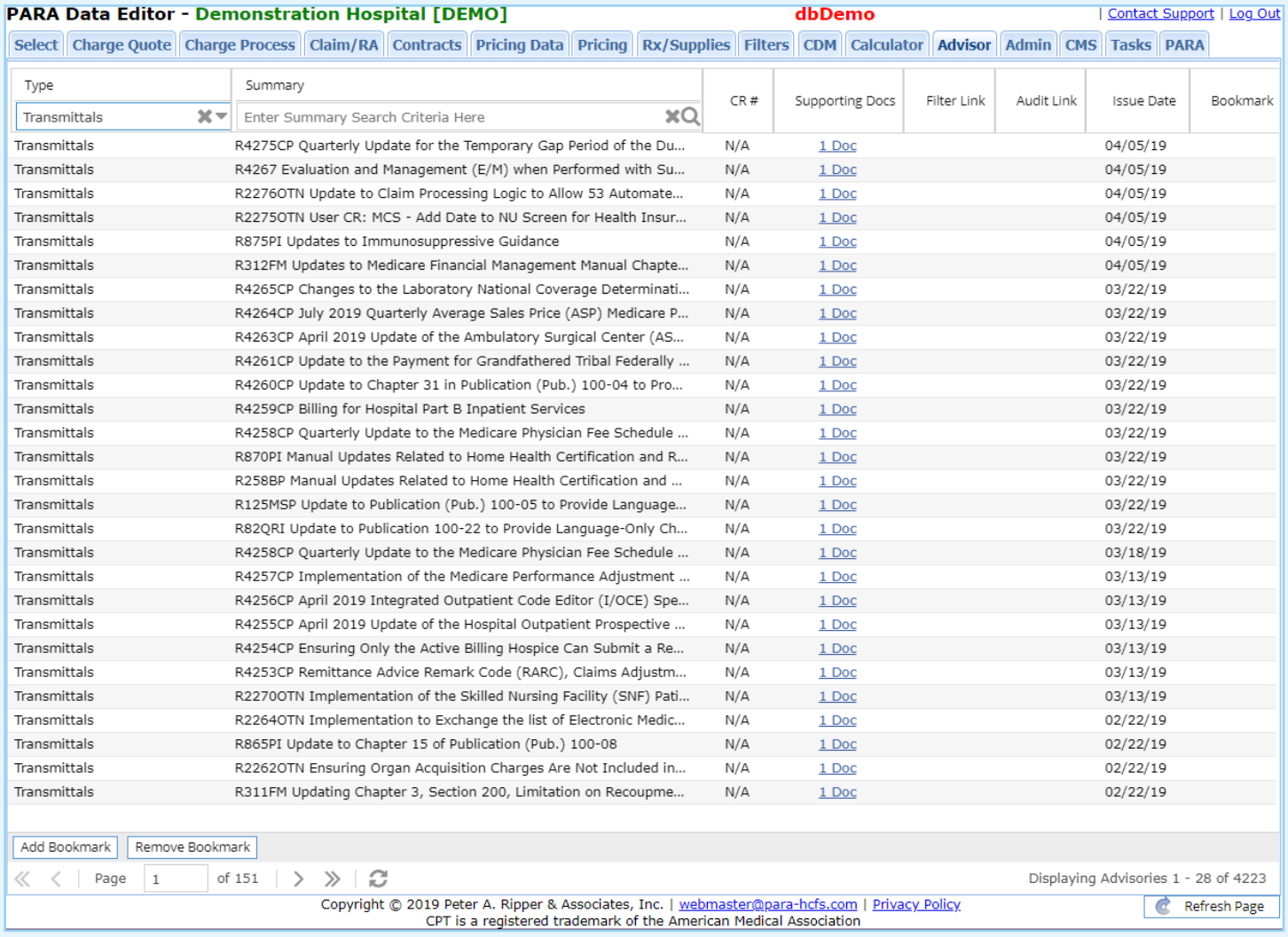

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Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date	Bookmark
Transmittals	Enter Summary Search Criteria Here						
Transmittals	R4275CP Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			04/05/19	
Transmittals	R4267 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 R4235CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4325	**Date: June 28, 2019**
	Change Request 11347

SUBJECT: Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2020

I. SUMMARY OF CHANGES: This attachment provides information on the updates to the payment rates used under the PPS for SNFs, for FY 2020, as required by statute. The update can be found in Chapter 6, Section 30.7 of the Claims Processing Manual.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

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

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

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

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

IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R227DEMO

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 227	**Date: June 28, 2019**
	Change Request 11340

SUBJECT: Next Generation ACO Model - Demo Code Placement

I. SUMMARY OF CHANGES: This Change Request (CR) provides instruction to Medicare payment contractors to revise the Next Generation Accountable Care Organization (ACO) Model's implementation CR 9151 to allow for two demo codes on a claim. Specifically, it requires that the NGACO demo code 74 take precedence over the BPCI Advanced's demo code 86.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

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IV. ATTACHMENTS:

Demonstrations

The link to this Transmittal R2317OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2317	**Date: June 28, 2019**
	Change Request 11308

SUBJECT: Possible Use of Session Initiation Protocol (SIP) at Medicare Administrative Contractors (MACs)

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the MACs interested in transitioning from the traditional telephony technology to SIP to deliver telephone calls over internet protocol networks to submit a proposal.

EFFECTIVE DATE: July 30, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 30, 2019

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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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R4326CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4326	**Date: June 28 ,2019**
	Change Request 11280

Transmittal 4296, dated May 3, 2019, is being rescinded and replaced by Transmittal 4326, dated, June 28, 2019 to update the policy section with additional information regarding Advanced Diagnostic Laboratory Tests (ADLTs). All other information remains the same.

SUBJECT: Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

I. SUMMARY OF CHANGES: This Recurring Update Notification (RUN) provides instructions for the quarterly update to the clinical laboratory fee schedule. This RUN applies to chapter 16, section 20.

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019

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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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R4327CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4327	**Date: June 28, 2019**
	Change Request 11298

Transmittal 4314, dated May 24, 2019, is being rescinded and replaced by Transmittal 4327 dated, June 28, 2019 to update the attachments related to the change request. All other information remains the same.

SUBJECT: July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2

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

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019

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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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R4328CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4328	**Date: June 28, 2019**
	Change Request 11334

Transmittal 4321, dated June 14, 2019, is being rescinded and replaced by Transmittal 4328, dated, June 28, 2019 to include a correction to the fee schedule amounts for HCPCS codes E1353 and E1355. All other information remains the same.

SUBJECT: July Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

I. SUMMARY OF CHANGES: The DMEPOS fee schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The quarterly update process for the DMEPOS fee schedule is located at publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019

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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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R2316OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2316	**Date: June 25, 2019**
	Change Request 11070

Transmittal 2228, dated January 25, 2019, is being rescinded and replaced by Transmittal 2316, dated, June 25, 2019 to revise the implementation date and the date in business requirement 11070.1.9. All other information remains the same.

SUBJECT: Fiscal Intermediary Shared System (FISS) Enhancement of PC Print Billing Software

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is for FISS to enhance the PC Print billing software utilized by the providers.

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019 - Business Requirement (BR) 1, BR 1.1, BR 1.2, BR 1.3, and BR 1.4; October 7, 2019 - BR 1, BR 1.5, BR 1.6, BR 1.7, BR 1.8, and BR 1.10; January 6, 2020 - BR 1, BR 1.11 and 1.12; April 6, 2020 - BR 1, BR 1.9, BR 1.13, BR 1.14, BR 1.15, BR 1.16 and BR 1.17

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

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

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

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

IV. ATTACHMENTS:

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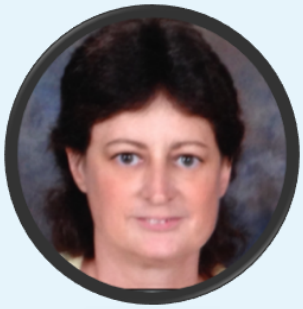

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