PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

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PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

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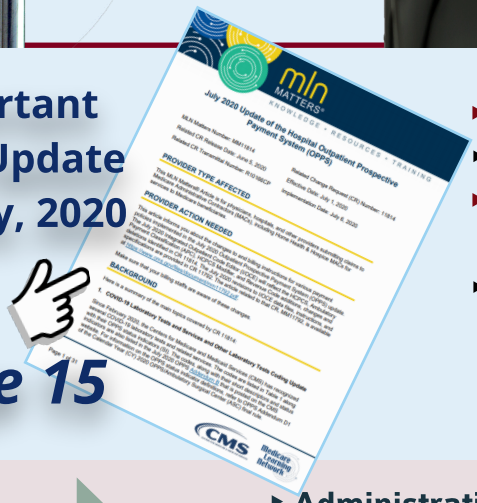
Important OPPS Update For July, 2020



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FAST LINKS

THERASKIN

Q. What are the appropriate coding procedures to include the Theraskin HCPCS that can be billed to Medicare?

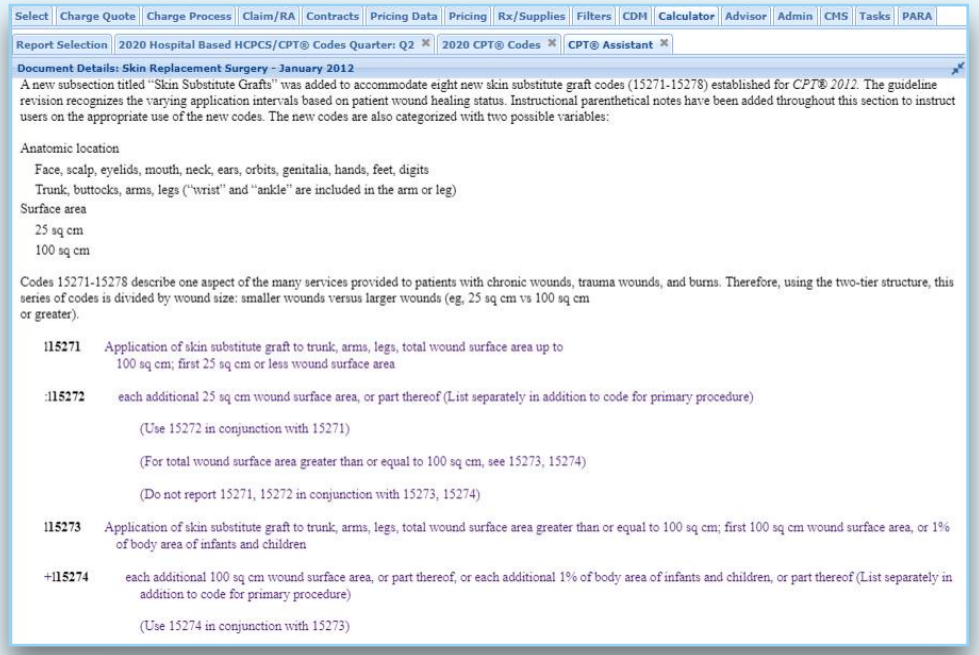
A. **Answer:** Based on the documentation provided, report CPT® code 15275 for application of the 10.85 cm2 graft placed on the foot/heel. Report HCPCS code Q4121 for the Theraskin. CPT® Assistant, October 2013, Page: 15, explains, the new skin Substitute Graft codes 15271-15278 are reported for the topical application of skin substitute grafts involving only the Integumentary System.

CPT® Assistant, January 2012, Pages: 6-10 states, "A new subsection titled "Skin Substitute Grafts" was added to accommodate eight new skin substitute graft codes (1527l-15278) established for CPT® 2012.

The guideline revision recognizes the varying application intervals based on patient wound healing status. Instructional parenthetical notes have been added throughout this section to instruct users on the appropriate use of the new codes.

The new codes are also categorized with two possible variables: site and surface area."

Please refer to the **PARA Data Editor** reference CPT® Assistant October 2013 and January 2012



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Report Selection | 2020 Hospital Based HCPCS/CPT® Codes Quarter: Q2 | 2020 CPT® Codes | CPT® Assistant

Document Details: Skin Replacement Surgery - January 2012

A new subsection titled "Skin Substitute Grafts" was added to accommodate eight new skin substitute graft codes (15271-15278) established for *CPT® 2012.* The guideline revision recognizes the varying application intervals based on patient wound healing status. Instructional parenthetical notes have been added throughout this section to instruct users on the appropriate use of the new codes. The new codes are also categorized with two possible variables:

Anatomic location

Face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, digits

Trunk, buttocks, arms, legs ("wrist" and "ankle" are included in the arm or leg)

Surface area

25 sq cm

100 sq cm

Codes 15271-15278 describe one aspect of the many services provided to patients with chronic wounds, trauma wounds, and burns. Therefore, using the two-tier structure, this series of codes is divided by wound size: smaller wounds versus larger wounds (eg, 25 sq cm vs 100 sq cm or greater).

115271 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

+115272 each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

(Use 15272 in conjunction with 15271)

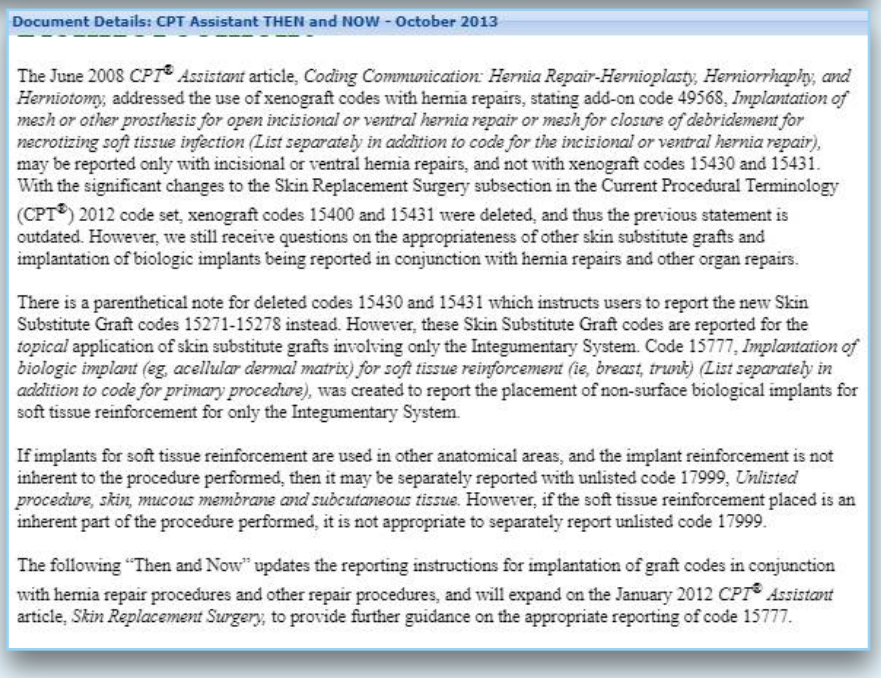
(For total wound surface area greater than or equal to 100 sq cm, see 15273, 15274)

(Do not report 15271, 15272 in conjunction with 15273, 15274)

115273 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

+115274 each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

(Use 15274 in conjunction with 15273)



Document Details: CPT Assistant THEN and NOW - October 2013

The June 2008 *CPT® Assistant* article, *Coding Communication: Hernia Repair-Hernioplasty, Herniorrhaphy, and Herniotomy,* addressed the use of xenograft codes with hernia repairs, stating add-on code 49568, *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair),* may be reported only with incisional or ventral hernia repairs, and not with xenograft codes 15430 and 15431. With the significant changes to the Skin Replacement Surgery subsection in the Current Procedural Terminology (CPT®) 2012 code set, xenograft codes 15400 and 15431 were deleted, and thus the previous statement is outdated. However, we still receive questions on the appropriateness of other skin substitute grafts and implantation of biologic implants being reported in conjunction with hernia repairs and other organ repairs.

There is a parenthetical note for deleted codes 15430 and 15431 which instructs users to report the new Skin Substitute Graft codes 15271-15278 instead. However, these Skin Substitute Graft codes are reported for the *topical* application of skin substitute grafts involving only the Integumentary System. Code 15777, *Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure),* was created to report the placement of non-surface biological implants for soft tissue reinforcement for only the Integumentary System.

If implants for soft tissue reinforcement are used in other anatomical areas, and the implant reinforcement is not inherent to the procedure performed, then it may be separately reported with unlisted code 17999, *Unlisted procedure, skin, mucous membrane and subcutaneous tissue.* However, if the soft tissue reinforcement placed is an inherent part of the procedure performed, it is not appropriate to separately report unlisted code 17999.

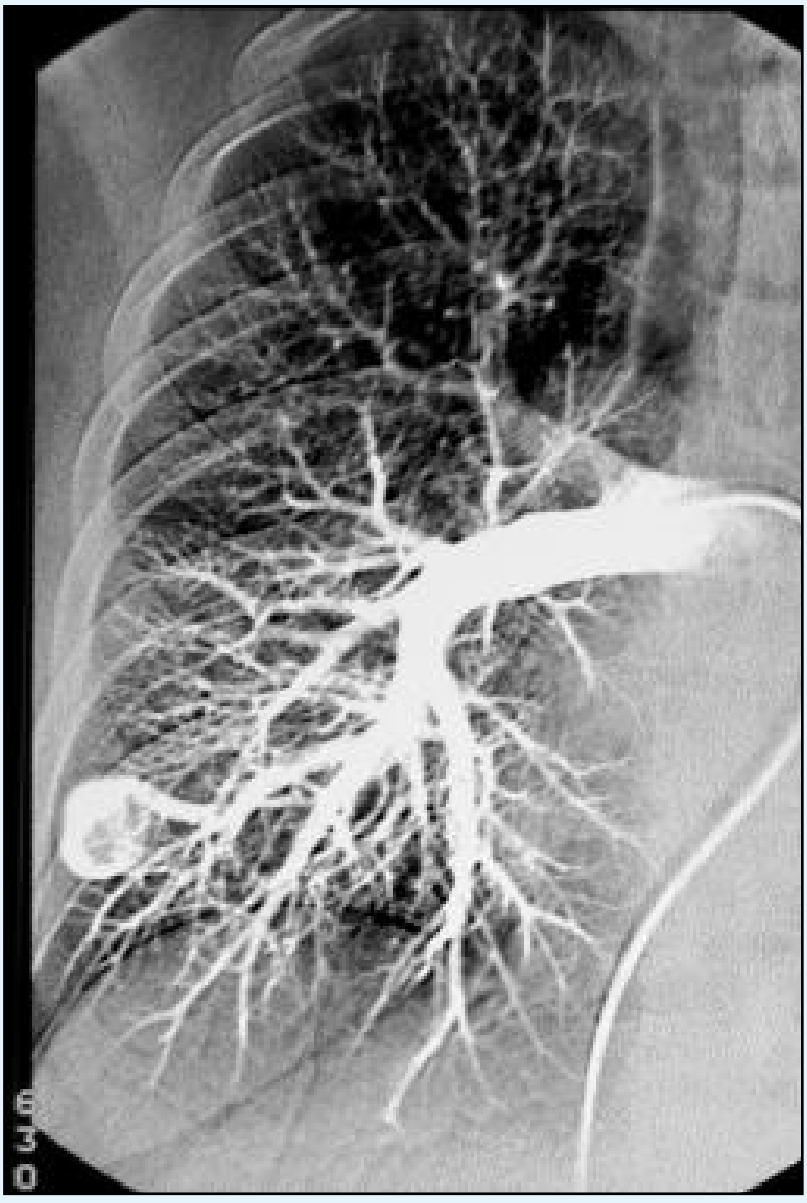
The following "Then and Now" updates the reporting instructions for implantation of graft codes in conjunction with hernia repair procedures and other repair procedures, and will expand on the January 2012 *CPT® Assistant* article, *Skin Replacement Surgery,* to provide further guidance on the appropriate reporting of code 15777.

PULMONARY ANGIO

Q. What is the appropriate code(s) for pulmonary aortogram? We are considering 76937 x 2 modifier XS, 75743 w/XU, 36015, 37211.

A. **Answer:** Report CPT® codes 37211 Thrombolysis arterial infusion and 36015 Selective catheter placement, segmental/subsegmental pulmonary artery. CPT® code 76937 x2 may be reported if there are hard-copy documented images of the two vessels accessed. That documentation was not available.

Report CPT® code 75746-XU for the pulmonary angiography. This was performed from the main pulmonary which is a non-selective catheter placement. There is no subsequent catheter placement in the right or left for this imaging, therefore CPT® code 75743 is not appropriate. The documentation does support an ultrasound of the access for placement of the arterial line, in addition to the ultrasound of the jugular.

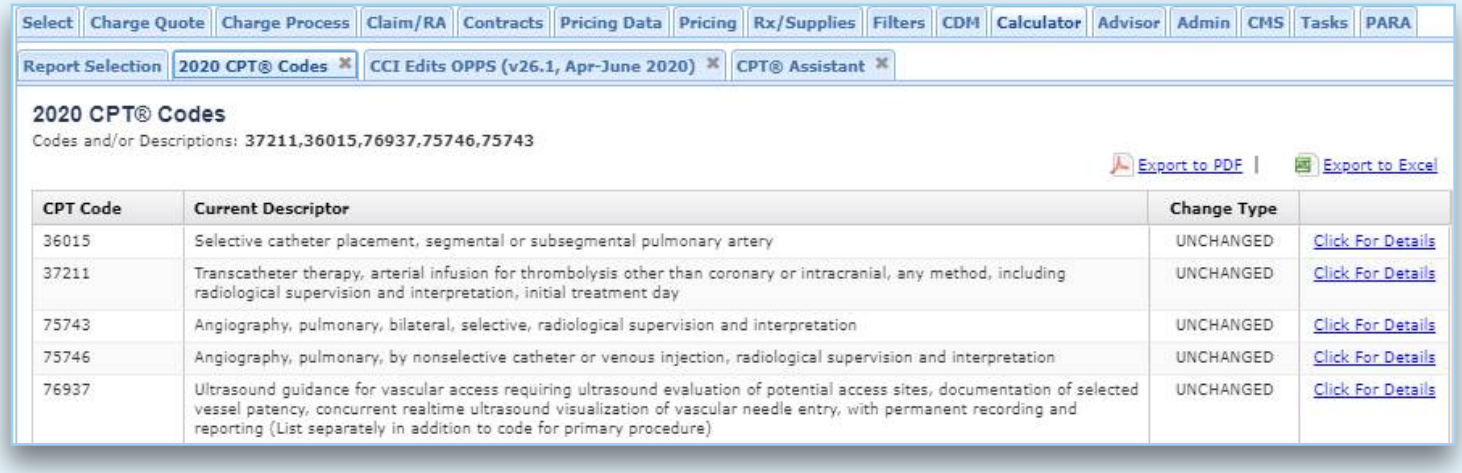


As long as there are documented images these services are reportable. There are no edits that require the NCCI modifiers, therefore modifier XS is not appended to 76937. The arterial line (36620) is not reported due to its "separate procedure" designation. Please refer to the **PARA Data Editor** reference AMA CPT® Assistant, February 2013 Page: 3-6, which discusses Transcatheter cardiovascular procedures.

The reference states, "Codes 37211-37214 do not include ultrasound guidance for vascular access. Radiology add-on code 76937, Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure), may be separately reported, if all the required elements are performed." Please refer to Dr. Z's Interventional Radiology Reference pages 231-240, coding case # 2 which states discusses 76937 and # 4 which discusses 75746.

Please refer to the **PARA Data Editor** code descriptions.

PULMONARY ANGIO



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

Report Selection | 2020 CPT® Codes | CCI Edits OPPS (v26.1, Apr-June 2020) | CPT® Assistant

2020 CPT® Codes

Codes and/or Descriptions: **37211,36015,76937,75746,75743**

Export to PDF | Export to Excel

CPT Code	Current Descriptor	Change Type	
36015	Selective catheter placement, segmental or subsegmental pulmonary artery	UNCHANGED	Click For Details
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	UNCHANGED	Click For Details
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	UNCHANGED	Click For Details
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	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

Dr. Z's Interventional Radiology Reference pages 231-240, coding case # 2

"30-year-old woman presents with bilateral leg swelling with deep vein thrombosis seen on ultrasound. Ultrasound-guided puncture of both popliteal veins (do not report code 76937 without hard copy image documentation) ..."

Dr. Z's Interventional Radiology Reference pages 231-240, coding case #4

Same case as example #3, except after non-selective pulmonary angiography (75746), a catheter is placed in the right lower lobe pulmonary artery (36015), and thrombolysis is started (37211). A second access is obtained, and a second catheter is advanced into the left upper lobe (36015). Thrombolysis is also started at this site (add -50 modifier to 37211). Follow-up angiography is done through each catheter after three hour infusions (bundled)."

DISPOSABLE BRONCHOSOPE

Q. Currently we do not charge for equipment in the OR or for Anesthesia. The OR has asked if we can charge for a disposable specialty bronchoscope. This product is used only for difficult intubation and are only used on one patient (not sterilized and used again) for specialty needs. We currently charge for disposable flex uteroscopes and the disposable bronchoscope is comparable to that per the OR Manager. Is this the correct process?

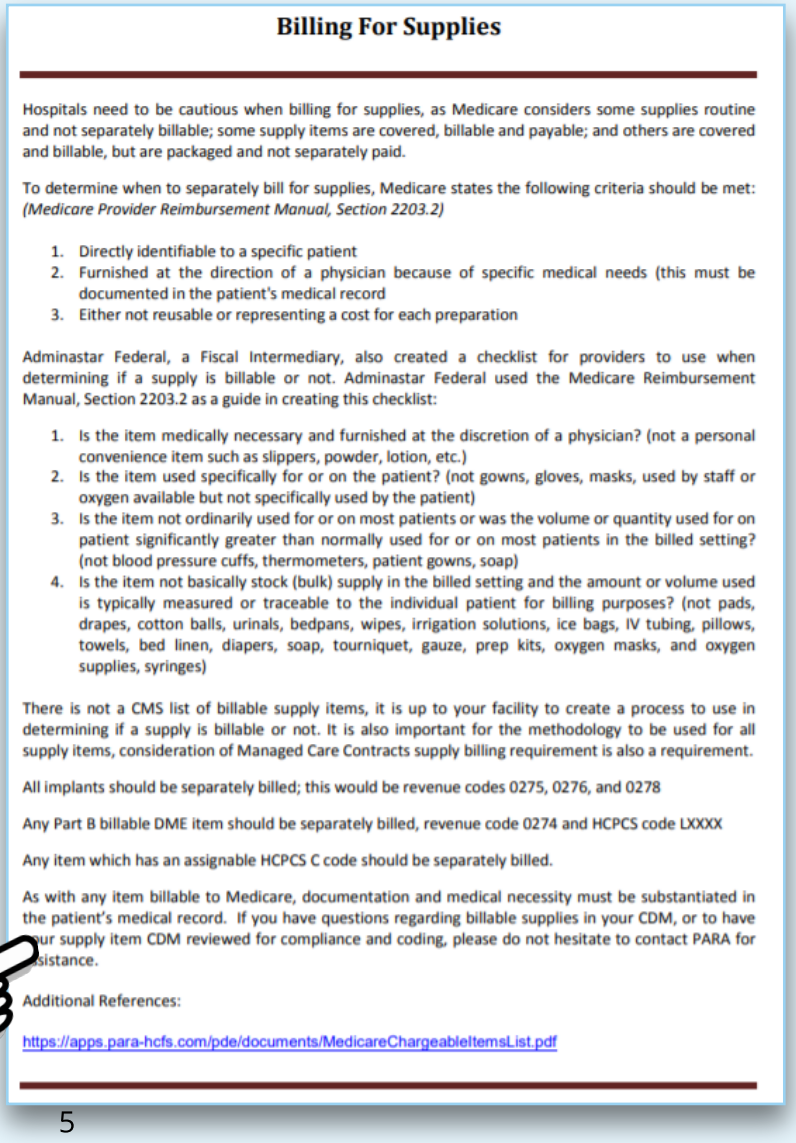
A. **Answer:** Yes, a disposable specialty bronchoscope may be separately charged. Attached is **PARA's** paper on billing for supplies which references the "four question test". A disposable bronchoscope would meet this test. (medically necessary, provided at the direction of the physician, not ordinarily supplied to most patients, and not a "bulk" purchased item.)

That being said, rather than charging individual disposable surgical supplies, some hospitals simply use the cost of disposable supplies as a consideration in assigning the surgical level to the case. This has two benefits:

1. It produces roughly the same amount of gross revenue on the claim without the expenditure of effort in entering the individual charges for each patient, and

2. A surgical level charge is also more difficult for outside claim auditors to challenge and deduct from insurer payments.

Either approach – billing the individual supply or using the cost of supplies in the surgical level assignment, is acceptable.



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 a CMS 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, consideration of Managed Care Contracts supply billing requirement is also a requirement.

All implants should be separately billed; this would be revenue codes 0275, 0276, and 0278

Any Part B billable DME item should be separately billed, revenue code 0274 and HCPCS code LXXXX

Any item which has an assignable HCPCS C code should be separately billed.

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.

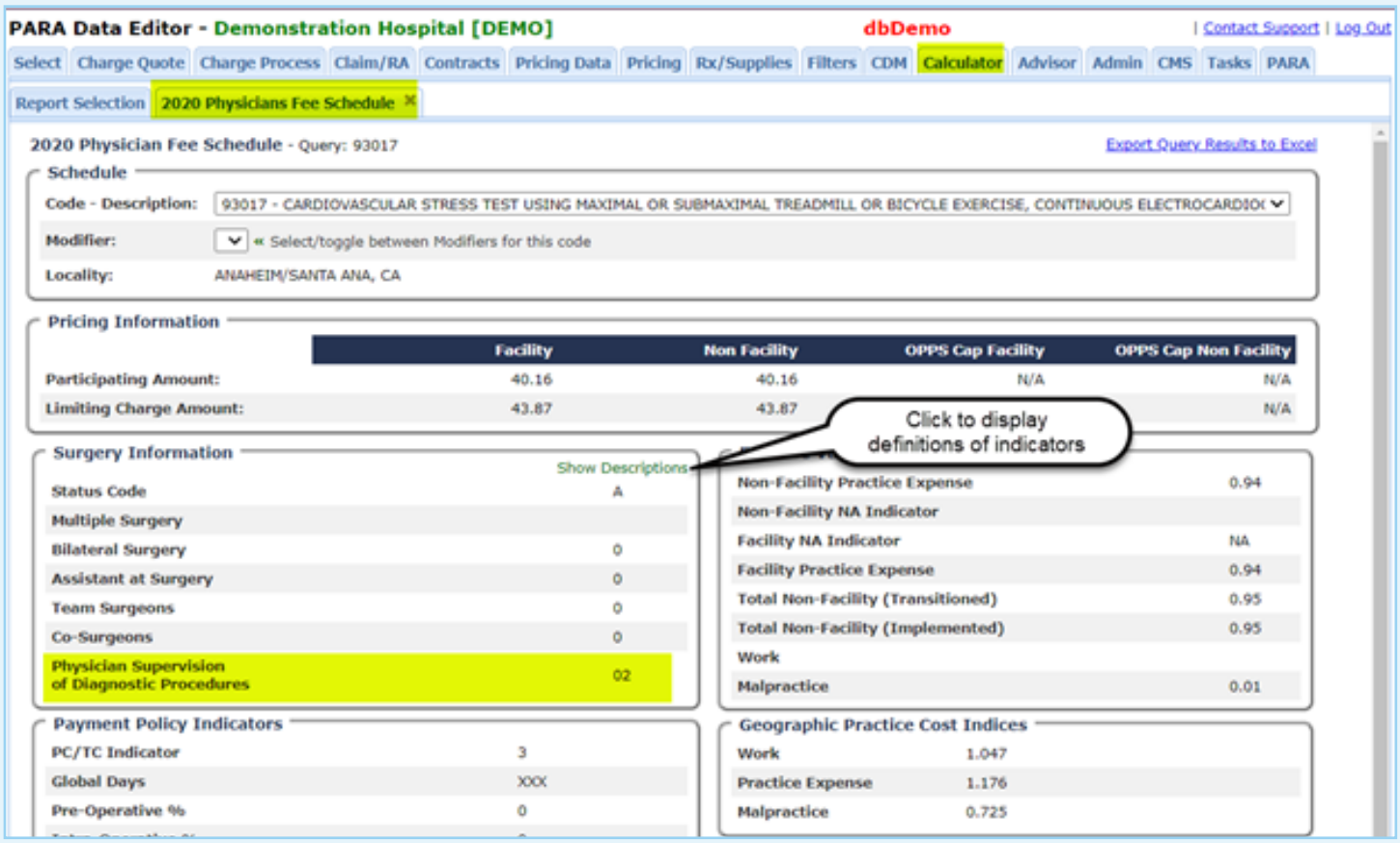
Additional References:

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

CMS CARDIAC STRESS TEST SUPERVISION REQUIREMENTS

Medicare regulations which specify the qualifications required to supervise diagnostic testing, including a cardiac stress test (CPT® 93017), are found in several different regulatory documents.

Within the Medicare Physician Fee Schedule, diagnostic testing HCPCS are assigned a supervision indicator – in the **PARA Data Editor Calculator**, we see that the supervision indicator for CPT® 93017 is set at 2 – "Procedure must be performed under the direct supervision of a physician."



TheMedicare Benefit Policy Manual, Chapter 15, Section 80 discusses the levels of supervision that are required for various procedures.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#

Chapter 15 – Covered Medical and Other Health Services

80 - Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests

(Rev. 251, Issued: 11-30-18, Effective: 01-01- 19, Implementation: 01-02-19)

This section describes the levels of physician supervision required for furnishing the technical component of diagnostic tests for a Medicare beneficiary who is not a hospital inpatient.

Medicare Benefits Policy Manual - continued hospital outpatient diagnostic services, the supervision levels assigned to each CPT or Level II HCPCS code in the Medicare Physician Fee Schedule Relative Value File that is updated quarterly, apply as described below. For more information, see Chapter 6 (Hospital Services Covered Under Part B), §20.4 (Outpatient Diagnostic Services).

CMS CARDIAC STRESS TEST SUPERVISION REQUIREMENTS

Section 410.32(b) of the Code of Federal Regulations (CFR) requires that diagnostic tests covered under §1861(s)(3) of the Act and payable under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a physician (§1861(r) of the Act) to be considered reasonable and necessary and, therefore, covered under Medicare.

The regulation defines these levels of physician supervision for diagnostic tests as follows: General Supervision - means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. 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 when the procedure is performed.

Personal Supervision - means a physician must be in attendance in the room during the performance of the procedure.

One of the following numerical levels is assigned to each CPT® or HCPCS code in the Medicare Physician Fee Schedule Database:

0 Procedure is not a diagnostic test or procedure is a diagnostic test which is not subject to the physician supervision policy.

1 Procedure must be performed under the general supervision of a physician.

2 Procedure must be performed under the direct supervision of a physician.

3 Procedure must be performed under the personal supervision of a physician. (For services rendered on or after 01/01/2019 diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by the American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), and is authorized to furnish the procedure under state law, may be performed under direct supervision).

4 Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist or furnished under the general supervision of a clinical psychologist; otherwise must be performed under the general supervision of a physician.

5 Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.

CMS CARDIAC STRESS TEST SUPERVISION REQUIREMENTS

6 Procedure must be performed by a physician or by a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law.

6a Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.

7a Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.

9 Concept does not apply.

21 Procedure must be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.

22 Procedure may be performed by a technician with on-line real-time contact with physician.

66 Procedure must be performed by a physician or by a PT with ABPTS certification and certification in this specific procedure.

77 Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.

Nurse practitioners, clinical nurse specialists, and physician assistants are not defined as physicians under §1861(r) of the Act. Therefore, they may not function as supervisory physicians under the diagnostic tests benefit (§1861(s)(3) of the Act). However, when these practitioners personally perform diagnostic tests as provided under §1861(s)(2)(K) of the Act, §1861(s)(3) does not apply and they may perform diagnostic tests pursuant to State scope of practice laws and under the applicable State requirements for physician supervision or collaboration.

Because the diagnostic tests benefit set forth in §1861(s)(3) of the Act is separate and distinct from the incident to benefit set forth in §1861(s)(2) of the Act, diagnostic tests need not meet the incident to requirements.

Diagnostic tests may be furnished under situations that meet the incident to requirements but this is not required. However, A/B MACs (B) must not scrutinize claims for diagnostic tests utilizing the incident to requirements."

Title 42 of the Code of Federal Regulations provides additional information on the supervision of diagnostic tests:

https://www.law.cornell.edu/cfr/text/42/410.32

§ 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

(a) Ordering diagnostic tests. Except as otherwise provided in this section, all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary (see § 411.15(k)(1) of this chapter).

(1) Mammography exception. A physician who meets the qualification requirements for an interpreting physician under section 354 of the Public Health Service Act as provided in § 410.34(a)(7) may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the beneficiary.

CMS CARDIAC STRESS TEST SUPERVISION REQUIREMENTS

(2)Application to nonphysician practitioners. Nonphysician practitioners (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants) who furnish services that would be physician services if furnished by a physician, and who are operating within the scope of their authority under State law and within the scope of their Medicare statutory benefit, may be treated the same as physicians treating beneficiaries for the purpose of this paragraph.

...

(b) Diagnostic x-ray and other diagnostic tests -

(1) Basic rule. Except as indicated in paragraph (b)(2) of this section, all diagnostic x-ray and other diagnostic tests covered under section 1861(s)(3) of the Act and payable under the physician fee schedule must be furnished under the appropriate level of supervisio nby a physician as defined in section 1861(r) of the Act or, during the Public Health Emergency as defined in § 400.200 of this chapter, for the COVID-19 pandemic, by a nurse practitioner, clinical nurse specialist, physician assistant or a certified nurse-midwife to the extent that they are authorized to do so under applicable state law. Services furnished without the required level of supervision are not reasonable and necessary (see § 411.15(k)(1) of this chapter).

(2) Exceptions. The following diagnostic tests payable under the physician fee schedule are excluded from the basic rule set forth in paragraph (b)(1) of this section:

(i) Diagnostic mammography procedures, which are regulated by the Food and Drug Administration.

(ii) Diagnostic tests personally furnished by a qualified audiologist as defined in section 1861(ll)(3) of the Act.

(iii) Diagnostic psychological and neuropsychological testing services when -

(A) Personally furnished by a clinical psychologist or an independently practicing psychologist as defined in program instructions; or

(B) Furnished under the general supervision of a physician, clinical psychologist, or during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, by a nurse practitioner, clinical nurse specialist, physician assistant or a certified nurse-midwife, to the extent that they are authorized to perform the tests under applicable State law.

(iv) Diagnostic tests (as established through program instructions) personally performed by a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist and permitted to provide the service under State law.

(v) Diagnostic tests performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable State laws.

(vi) Pathology and laboratory procedures listed in the 80000 series of the Current Procedural Terminology published by the American Medical Association.(vii) Diagnostic tests performed by a certified nurse-midwife authorized to perform the tests under applicable State laws.

(viii) During the COVID-19 Public Health Emergency as defined in § 400.200 of this chapter, diagnostic tests performed by a physician assistant authorized to perform the tests under applicable State law.

CMS CARDIAC STRESS TEST SUPERVISION REQUIREMENTS

(3) Levels of supervision. Except where otherwise indicated, all diagnostic x-ray and other diagnostic tests subject to this provision and payable under the physician fee schedule must be furnished under at least a general level of supervision as defined in paragraph (b)(3)(i) of this section. In addition, some of these tests also require either direct or personal supervision as defined in paragraph (b)(3)(ii) or (iii) of this section, respectively. When direct or personal supervision is required, supervision at the specified level is required throughout the performance of the test.

(i) General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

(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 when the procedure is performed. During a PHE, as defined in § 400.200 of this chapter, the presence of the physician includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.

(iii) Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

The hospital in which the testing is performed also has obligations.The Medicare Benefits Policy Manual assigns considerable responsibility to the hospital for ensuring that only qualified practitioners perform services:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf

"Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws, and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations.

For services not furnished directly by a physician or non-physician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate."

Generally, Medicare looks to state licensing regulations to verify that the service delivered by a healthcare professional is consistent with state scope of practice laws corresponding to licensure or certification. For your reference, the Medicare hospital CoPs are found in the Code of Federal Regulations at 42 CFR Part 482 – a link and excerpts are provided:

https://ecfr.io/Title-42/pt42.5.482#se42.5.482_154

§482.54 Condition of participation: Outpatient services.

If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.

(a) Standard: Organization. Outpatient services must be appropriately organized and integrated with inpatient services.

(b) Standard: Personnel. The hospital must—

(1) Assign one or more individuals to be responsible for outpatient services.

CMS CARDIAC STRESS TEST SUPERVISION REQUIREMENTS

(2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services.

(c) Standard: Orders for outpatient services. Outpatient services must be ordered by a practitioner who meets the following conditions:

(1) Is responsible for the care of the patient.

(2) Is licensed in the State where he or she provides care to the patient.

(3) Is acting within his or her scope of practice under State law.

(4) Is authorized in accordance with State law and policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services. This applies to the following:

(i) All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services.

(ii) All practitioners not appointed to the medical staff, but who satisfy the above criteria for authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients.

[51 FR 22042, June 17, 1986, as amended at 77 FR 29075, May 16, 2012; 79 FR 27154, May 12, 2014]

Also listed within the conditions of participation is this interesting section on Respiratory Therapy:

§482.57 Condition of participation: Respiratory care services.

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care service.

(a) Standard: Organization and Staffing. The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.

1)There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge experience, and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis.

2)There must be adequate numbers of respiratory therapists, respiratory therapy technicians, and other personnel who meet the qualifications specified by the medical staff, consistent with State law.

(b) Standard: Delivery of Services. Services must be delivered in accordance with medical staff directives.

(1) Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing.

(2) If blood gases or other laboratory tests are performed in the respiratory care unit, the unit must meet the applicable requirements for laboratory services specified in §482.27.

(3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.

CMS CARDIAC STRESS TEST SUPERVISION REQUIREMENTS

(4)All respiratory care services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.

[51 FR 22042, June 17, 1986; 51 FR 27848, Aug. 4, 1986, as amended at 57 FR 7136, Feb. 28, 1992; 75 FR 50418, Aug. 16, 2010]

Some Medicare Administrative Contractors provide specific guidance Local Coverage Determinations and Local Coverage Articles (LCDs and LCAs.)An example from an LCD document is provided here.

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=38396&ver=4&articleId=56952&CntrctrSelected=372*1&SearchType=Advanced&CoverageSelection=Local&ArticleType=Ed%7cKey%7cSAD%7cFAQ&PolicyType=Both&s=---&Cntrctr=372&ICD=&kq=true&bc=IAAAACAAOAAA&

Local Coverage Determination (LCD):

Cardiology Non-emergent Outpatient Stress Testing (L38396)

Provider Qualifications

The CMS IOM, Publication 100-08, Medicare Program Integrity Manual, Chapter 13, Section 13.5.4, outlines that reasonable and necessary services are ordered and furnished by qualified personnel. Services will be considered medically reasonable and necessary only if performed by appropriately trained providers. A qualified physician for this service/procedure is defined as follows:

A) Physician is properly enrolled in Medicare.

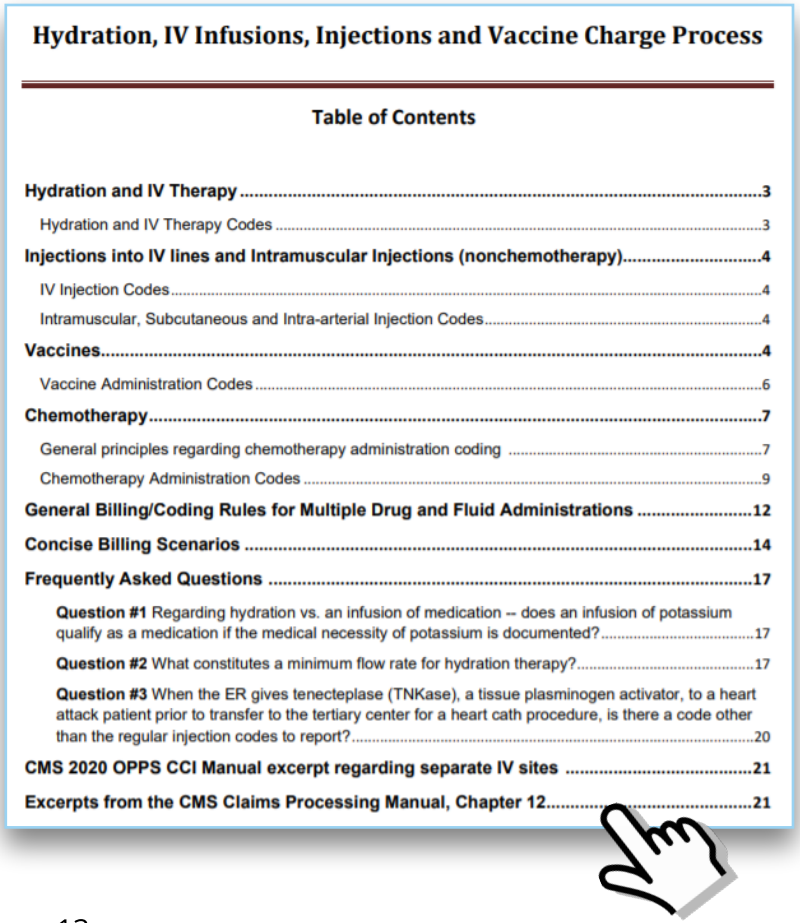
B) Training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty in the United States or must reflect equivalent education, training, and expertise endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States.Exercise testing must be supervised by a physician appropriately trained in exercise testing, capable of recognizing symptoms and signs of cardiac disease and be capable of interpreting the exercise test findings.Exercise testing in selected patients can be conducted by a healthcare professional that has training in a related health area, has appropriate training in the supervision of exercise stress tests, and is capable of performing cardio-pulmonary resuscitation. The appropriately trained healthcare professional should work directly under the supervision of a physician, who must be in the immediate vicinity and available for emergencies.38In addition, all cardiovascular imaging studies must be performed under the general supervision of a physician. Please refer to CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80 for the description and requirements for general and direct supervision.

HYDRATION, IV INFUSION, INJECTIONS & VACCINE CHARGE PROCESS

Coding for drug therapy in an outpatient/ambulatory setting can be confusing. Appropriate code selection depends on the type of medication administered, the method of administration, the time required to administer the medication, the access site, and the sequence (concurrent or sequential) of administration.

This paper provides coding information, code tables, general billing guidance, references and billing scenarios to assist providers in reporting these services correctly.

For the complete article and detailed guidance, click here.



Hydration, IV Infusions, Injections and Vaccine Charge Process

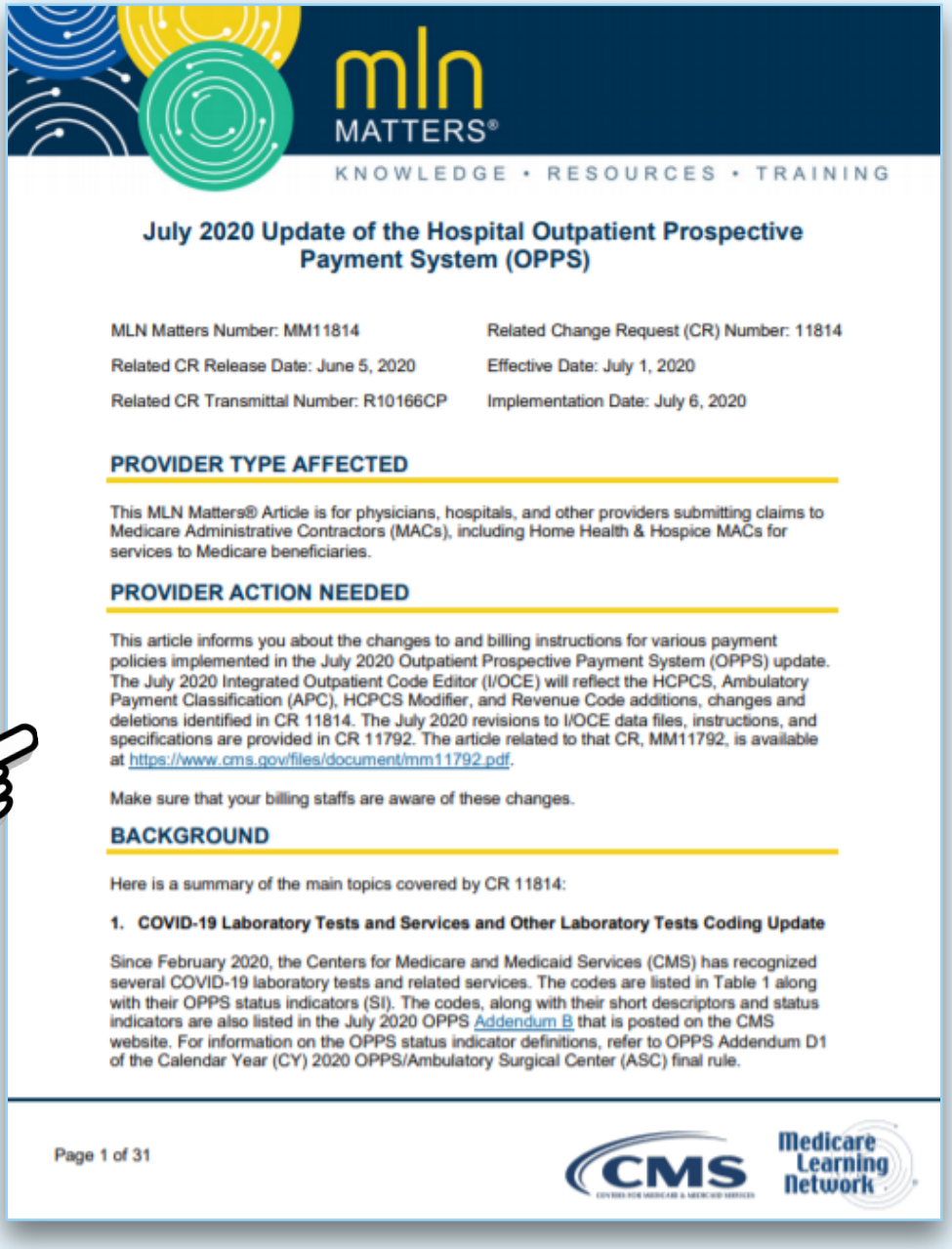
Table of Contents

UPDATE ON OPPS FOR JULY, 2020

Several changes are on the horizon for the Outpatient Prospective Payment System (OPPS). The attached MLN Matters Article detailed changes to and billing instructions for various payment policies implemented, effective July 2020.

This is important information for billing and coding staffs.

For the complete article and detailed guidance, click here.



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

MLN Matters Number: MM11814 | Related Change Request (CR) Number: 11814

Related CR Release Date: June 5, 2020 | Effective Date: July 1, 2020

Related CR Transmittal Number: R10166CP | Implementation Date: July 6, 2020

PROVIDER TYPE AFFECTED

This MLN Matters® Article is for physicians, hospitals, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs for services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you about the changes to and billing instructions for various payment policies implemented in the July 2020 Outpatient Prospective Payment System (OPPS) update. The July 2020 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes and deletions identified in CR 11814. The July 2020 revisions to I/OCE data files, instructions, and specifications are provided in CR 11792. The article related to that CR, MM11792, is available at https://www.cms.gov/files/document/mm11792.pdf.

Make sure that your billing staffs are aware of these changes.

BACKGROUND

Here is a summary of the main topics covered by CR 11814:

1. **COVID-19 Laboratory Tests and Services and Other Laboratory Tests Coding Update**

Since February 2020, the Centers for Medicare and Medicaid Services (CMS) has recognized several COVID-19 laboratory tests and related services. The codes are listed in Table 1 along with their OPPS status indicators (SI). The codes, along with their short descriptors and status indicators are also listed in the July 2020 OPPS Addendum B that is posted on the CMS website. For information on the OPPS status indicator definitions, refer to OPPS Addendum D1 of the Calendar Year (CY) 2020 OPPS/Ambulatory Surgical Center (ASC) final rule.

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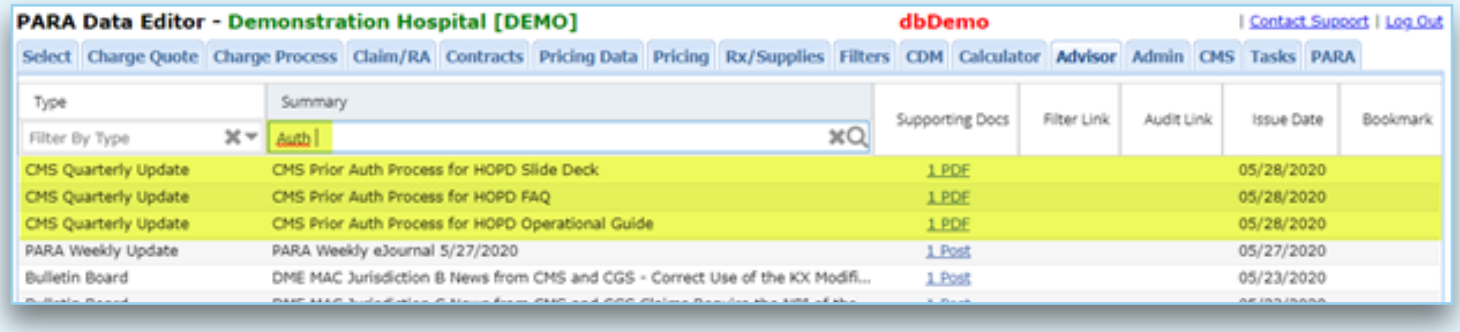
CMS Medicare Learning Network

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

In the 2020 Hospital Outpatient Prospective Payment (OPPS) Final Rule, Medicare finalized its plan to require hospitals to obtain prior authorization to perform certain outpatient procedures 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.

CMS made no exception for Critical Access Hospitals in its communications to date. The regulations appear to apply to both OPPS and CAH facilities.

On May 28, 2020 CMS presented a webinar on the Prior Authorization Process for Certain Hospital Outpatient Department (OPD) services.The slide deck, FAQ, and the Prior Authorization (PA) Program for Certain Hospital Outpatient Department Services Operational Guide can be downloaded from the Advisor tab of the **PARA Data Editor**. Enter the word "Auth" in the summary field as shown:



Medicare has not changed its coverage or documentation requirements for the list of services that now require prior authorization.Implementation of the prior authorization process should improve transparency on beneficiary coverage for both the provider and the patient. Providers need to continue providing the beneficiary with Advance Beneficiary Notices (ABN) for services which do not meet medical necessity in advance.

There are five groups of hospital OPD services included in the prior authorization process. A full list of services with HCPCS codes begins on page 4.

- **Blepharoplasty**
- **Botulinum Toxin Injections**
- **Panniculectomy**
- **Rhinoplasty**
- **Vein Ablation**

Providers and hospitals may start submitting Prior Authorization Requests (PARs) to the regional MAC **beginning June 17, 2020 for services rendered on or after July 1, 2020.** The requests need to include medical record documentation that supports medical necessity for the service as well as a completed PAR Form available through the provider's Medicare Administrative Contractor (MAC) website.

The MACs will accept initial or resubmitted requests via mail, fax, MAC portal, or (beginning July 6, 2020) using electronic submission documentation (esMD).CMS encourages requestors to submit by fax or electronic means to avoid delays in mailing. The MAC will provide determination letters via the same method the authorization was requested and send response no more than 10 business days from receipt. 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.

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

Decision letters sent from the MACs will include a 14-byte Unique Tracking Number (UTN) that providers will need to include on the beneficiary claims, positions 1 through 18 on electronic claims.A MAC can render a decision:

- **Provisional affirmation:** Services requested meet Medicare coverage requirement
- **Partial affirmation:** One or more services (but not all services requested) meet the requirement
- **Non-affirmation:** Services requested do not meet requirements

If a MAC returns either a partial or a non-affirmation decision, the decision will include detailed reasons for the finding.The provider should review and consider if additional record documentation could address the finding. A provider may submit a subsequent review request with additional documentation.The MAC will return its reconsideration decision within 10 business days.

The final rule was published in the Federal Register on 11/12/19 in section XIX (Prior Authorization Process and Requirements for Certain Hospital Outpatient Department (OPD) Services):

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

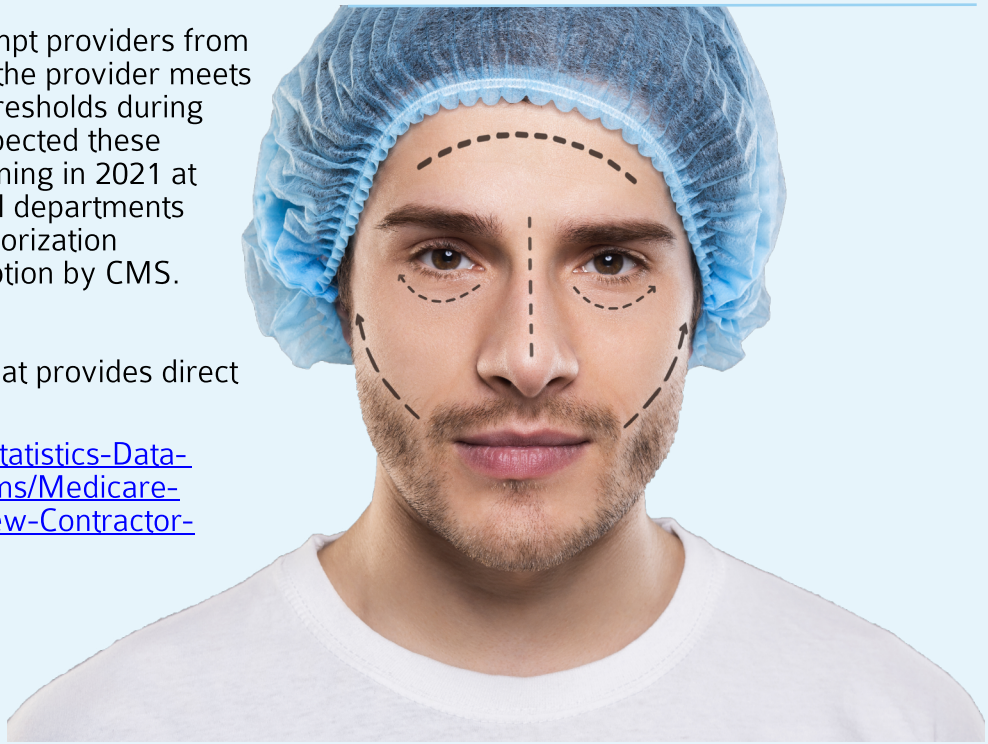
NATIONAL ARCHIVES

FEDERAL REGISTER

The Daily Journal of the United States Government

> "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. ..."

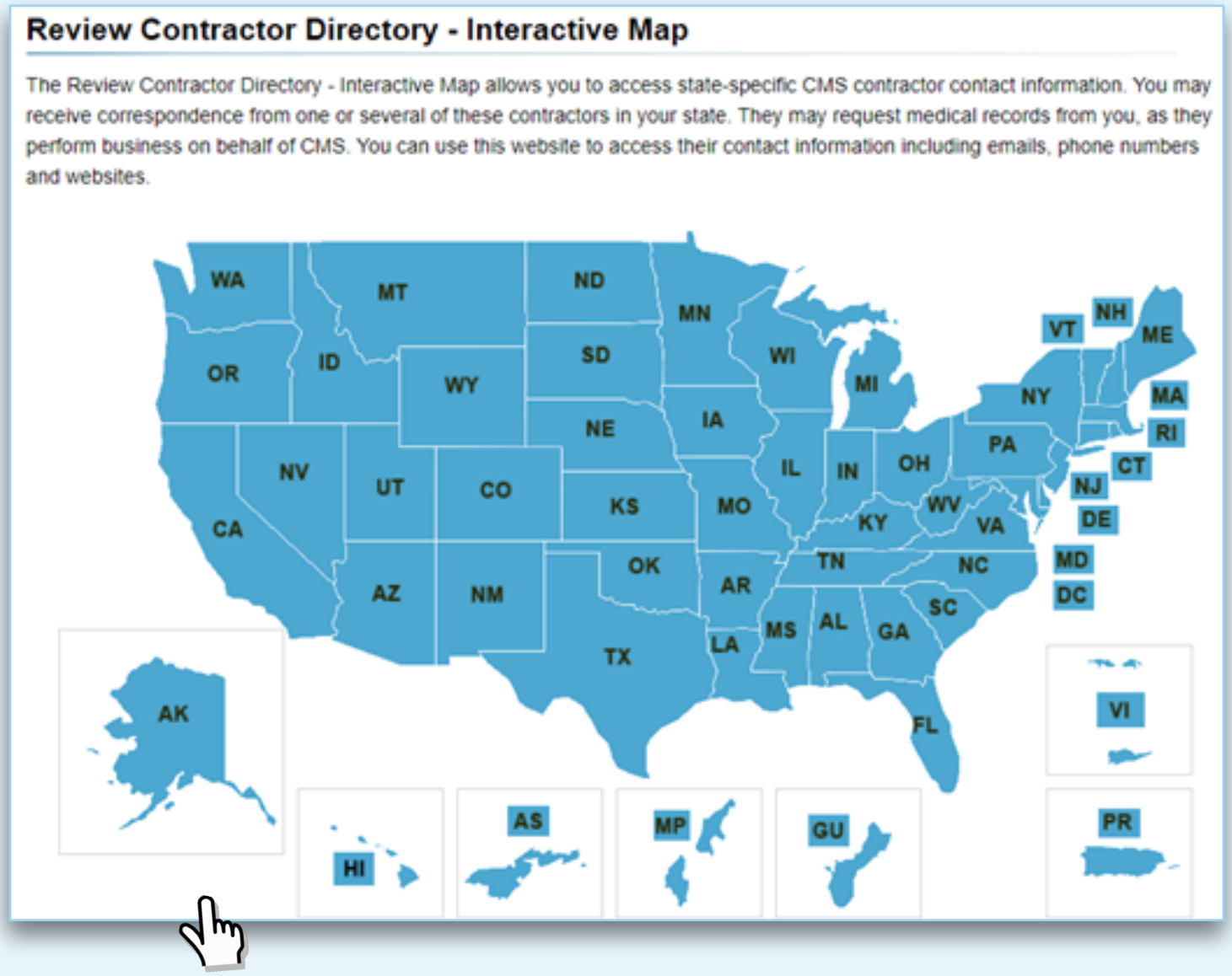
The final rule allows CMS to exempt providers from the prior authorization process if the provider meets ninety (90) percent provisional thresholds during semiannual assessments. It is expected these exemptions will be granted beginning in 2021 at the earliest. All outpatient hospital departments should comply with the prior authorization process until notified of an exemption by CMS.



CMS Offers an interactive map that provides direct links to the MACs.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES



The final list of procedures for which prior authorization is available on the CMS website at https://www.cms.gov/files/document/cpi-opps-pa-list-services.pdf

The CMS final list is appended to this paper on the following pages.

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

FINAL RULE: CMS-1717-FC: PRIOR AUTHORIZATION PROCESS and REQUIREMENTS for CERTAIN HOSPITAL OUTPATIENT DEPARTMENT (OPD) SERVICES

TABLE 65: FINAL LIST of OUTPATIENT SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Federal Register */ Vol. 84, No. 218 / Tuesday, November 12, 2019*

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
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)

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

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
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

MICRO-INVASIVE GLAUCOMA SURGERY COVERAGE AND CODING

Micro-invasive glaucoma surgery (MIGS) is becoming a commonplace surgical procedure performed in conjunction with cataract surgery for patients who have both cataracts and a diagnosis of glaucoma.If the hospital has a fixed charge master price for cataract surgery, it can miss the additional coding and charges appropriate to claim reimbursement for the MIGS procedure as well.

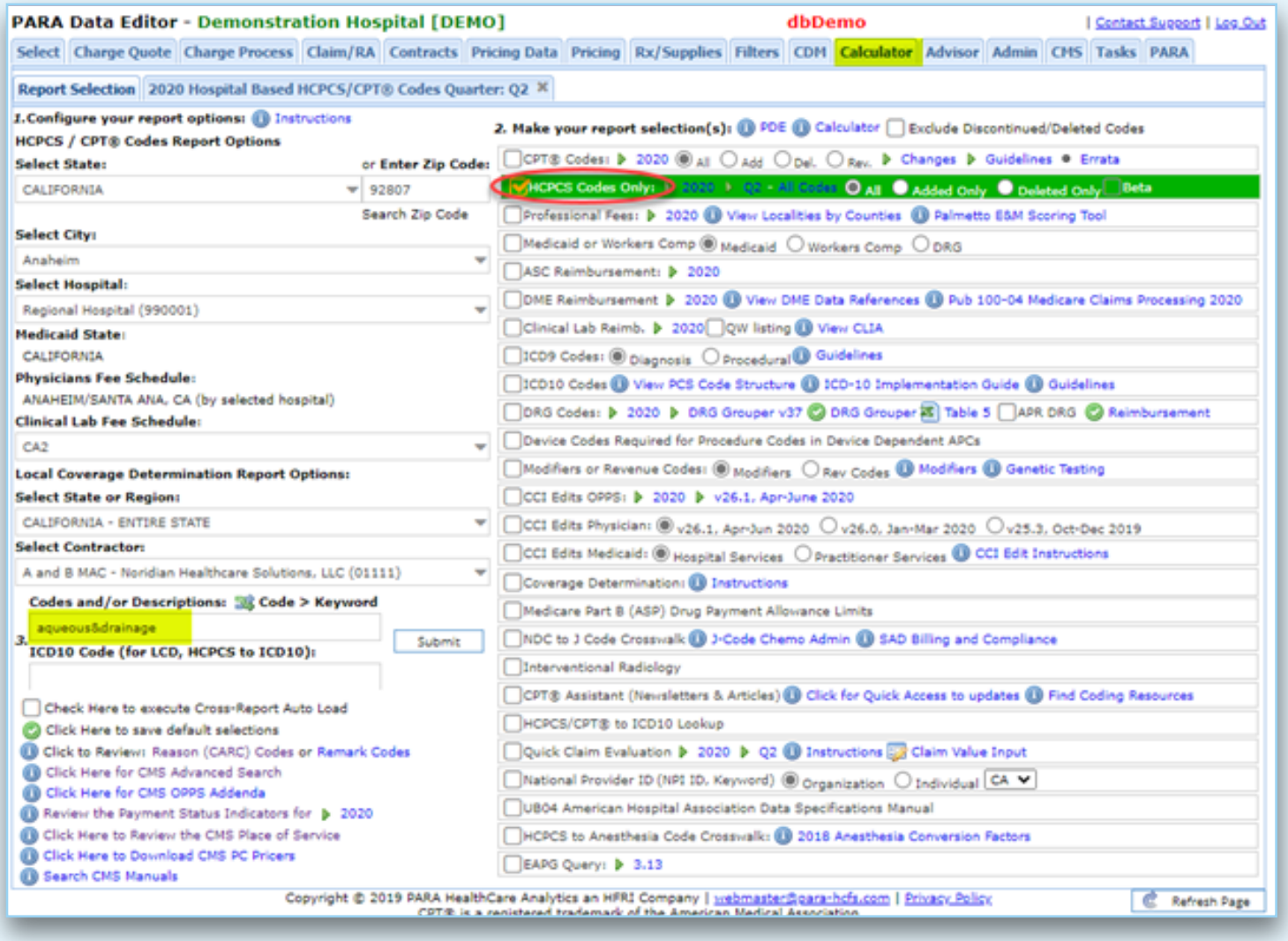
The MIGS procedure implants an aqueous drainage device into the eye which serves to control high intraocular pressure-–a symptom of, and a contributing factor to, glaucoma.

The aqueous drainage device is reported with HCPCS C1793; the insertion procedure is commonly reported with CPT® 0191T, although there are a number of other codes that may be appropriate depending on the specific surgical approach:

- **0191T:** INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE TRABECULAR MESHWORK; INITIAL INSERTION
- **C1783:** OCULAR IMPLANT, AQUEOUS DRAINAGE ASSIST DEVICE

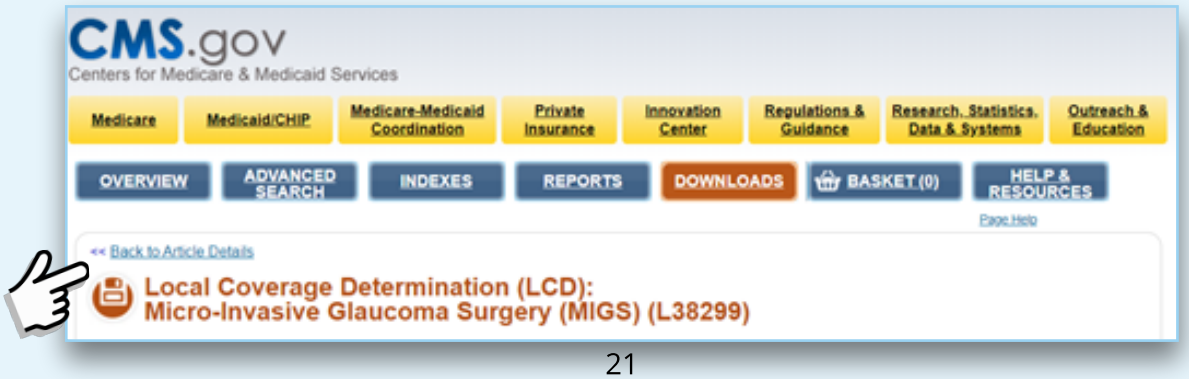
PARA Data Editor users can review a list of the various MIGS procedure codes by navigating to the Calculator tab, selecting the HCPCS report on the right, and entering the two-word search phrase "aqueous & drainage":

MICRO-INVASIVE GLAUCOMA SURGERY COVERAGE AND CODING



Many Medicare Administrative Contractors have published Local Coverage Determinations which limits coverage for MIGS only when it is performed together with cataract surgery.This requirement is also common among commercial insurance carriers, since an elevated intraocular pressure can also be treated pharmacologically by eye drops.For example, Noridian has implemented LCD L38299:

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=38299&ver=5&articleId=57863&CntrctrSelected=360*1&SearchType=Advanced&CoverageSelection=Local&ArticleType=Ed%7cKey%7cSAD%7cFAQ&PolicyType=Both&s===---&Cntrctr=360&ICD=&kq=true&bc=IAAAACAAOAAA&



MICRO-INVASIVE GLAUCOMA SURGERY COVERAGE AND CODING

Under OPPS, when the MIGS procedure is reported together with cataract surgery, the MIGS procedure alone carries the reimbursement—the cataract procedure is "packaged. However, in 2020, reimbursement for the MIGS procedure is about $1,800 higher than cataract surgery alone:

Current Descriptor	Fee Schedule	Initial APC	Payment
0191T - insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion **J1 - Paid under OPPS; other services on the claim become packaged.**		5492 - Level 2 Intraocular Procedures	Weight: 47.2606 Payment: $3,818.33 National Co-pay: $0.00 Minimum Co-pay: $763.67
66984 - extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation **J1 - Paid under OPPS; other services on the claim become packaged.**	GB (Physician Facility): $612.87 GB (Physician Non-Facility): $612.87	5491 - Level 1 Intraocular Procedures	Weight: 25.0252 Payment: $2,021.86 National Co-pay: $0.00 Minimum Co-pay: $404.38
C1783 - ocular implant, aqueous drainage assist device **N - Payment is packaged into payment for other services.** **Berenson-Eggers Type of Service:** D1A - MEDICAL/SURGICAL SUPPLIES			

Here is an example of a Medicare OPPS claim that clearly missed capturing the MIGS procedure code. While the implant was reported, only the cataract surgery code was billed under revenue code 0360.Consequently, the hospital was paid at lower Medicare reimbursement than it was entitled to receive:

Claim Details

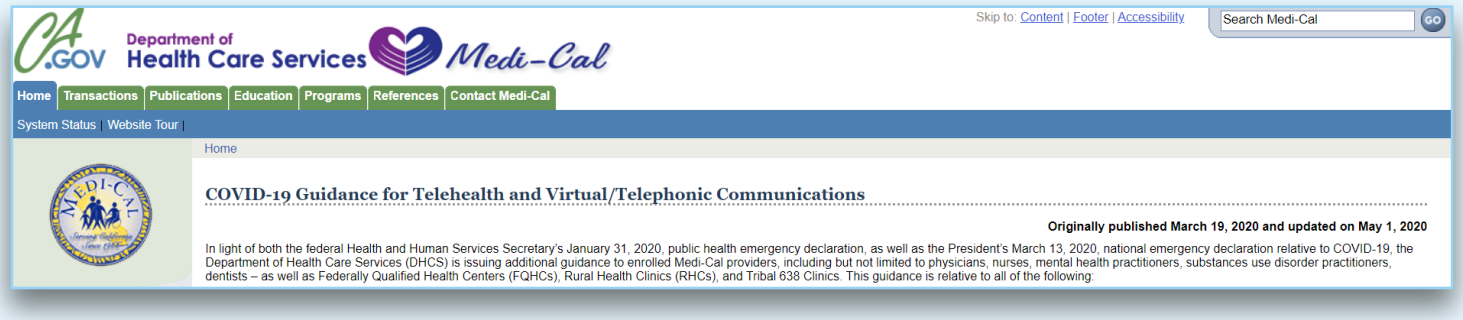
	PARA ID	Rev Code	HCPCS	HCPCS Desc	Mod 1	Mod 2	Units	Payment	Charges
1	55648562	0276	C1780	LENS, INTRAOCULAR (NEW TECHNOLOGY)			1		$698.74
2	55648562	0278	C1783	OCULAR IMPLANT, AQUEOUS DRAINAGE ASSIST DEVICE			1		$7,154.50
3	55648562	0360	66982	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS P...	RT		1	$1,613.07	$3,946.00

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

In response to the public health declaration made on March 13, 2020, The California Department of Healthcare Services (DHCS) and Medi-Cal released a bulletin on May 15, 2020 issuing guidance to providers, including but not limited to physicians, nurses, mental health practitioners, substance use disorder practitioners, dentists, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Tribal 638 Clinics.

The guidance is pertinent to all participating providers to assist with providing medically necessary health care services for patients impacted by COVID-19.

http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_02.asp



The provisions for telehealth and COVID-19 include:

- Reiterating the flexibility allowed for delivery of covered Medi-Cal services via telehealth
- Ensuring beneficiaries have access to durable medical equipment (DME) and medical supplies
- Ensuring beneficiaries are not held financially responsible for any payment, including balance billing, for Medi-Cal covered services by providers, including testing and treatment for COVID-19
- Reviewing DHCS issued guidance on pharmacy services, Non-Emergency Medical Transportation and Non-Medical Transportation, as well as any other relevant guidance on DHCS website

Telehealth and Virtual Communication Options

Traditional Telehealth: Medi-Cal providers may utilize existing telehealth policies as an alternative modality for delivering covered health care services when medically appropriate. Highlights from the Medi-Cal provider manual on Telehealth include:

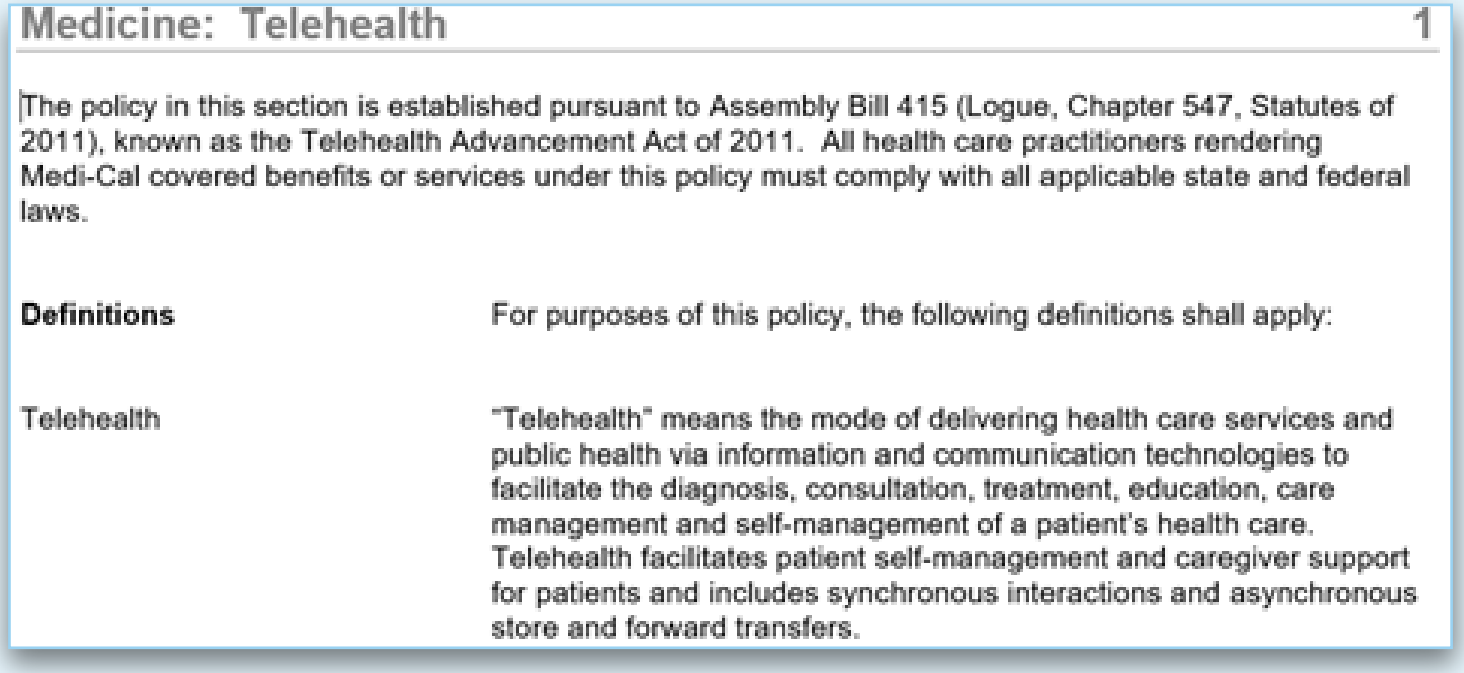
"Medi-Cal covered benefits and/or services, identified by Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any Treatment Authorization Request (TAR)/Service Authorization Request (SAR) requirements, may be provided via telehealth, as outlined in the "Medicine: Telehealth" Section of the Provider Manual, if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT® or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual; and

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information."

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/part2/mednetele_m01o03.doc



Medicine: Telehealth 1

The policy in this section is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. All health care practitioners rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws.

Definitions	For purposes of this policy, the following definitions shall apply:
Telehealth	"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

For Medi-Cal Managed Care plan members, providers **should follow health plan procedures** for billing and/or submitting referrals for telehealth services.

COVID-19 update for Traditional Telehealth:

- Reporting POS 02 remains as appropriate for reporting
    - Synchronous, interactive audio and telecommunications systems: Modifier 95
    - Asynchronous store and forward telecommunications systems: Modifier GQ

Providers will utilize reported telehealth modifiers to identify that the covered Medi-Cal services were rendered via telehealth and were related to a COVID-19 diagnosis.

COVID-19 update for Synchronous Telehealth:

Medi-Cal benefits which include medical, mental health and substance use disorders, that are services rendered via a synchronous telehealth modality, must meet all of the criteria below:

- The treating practitioner at the distant site believes the Medi-Cal services being rendered are clinically appropriate based on evidence-based medicine and/or best practices to be delivered via telehealth, subject to oral or written consent by the Medi-Cal participant

- Examples of scenarios that would NOT be appropriate for delivery via telehealth:
    - Benefits or services that are performed in an operating room or while the patient is under anesthesia
    - Benefits or services that require direct visualization or instrumentation of bodily structures
    - Benefits or services that involve sampling of tissue or insertion/removal of medical devices

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

- Benefits or services that otherwise would require the in-person presence of the patient for any reason

- The benefits or services delivered via telehealth meet the procedural definition and components of the assigned CPT®/HCPCS as defined by the AMA

- The benefits or services delivered meets all the established laws regarding confidentiality of health care information and the patient's rights to his/her medical information

COVID-19 Medi-Cal Dental Benefits/services via Telehealth update:

- Medi-Cal participating dentists and Allied dental professionals (under the supervision of a dentist) can render limited services via synchronous/live transmission teledentistry, as long as the services being rendered are within their degree scope of practice

- When reporting D9995 for services via teledentistry, Medi-Cal policy is as follows:

  - CDT code D9995 is reimbursed at 0.24 cents per minute, up to a maximum of 90 minutes or $21.60 maximum reimbursement

  - D9995 may only be used once (1) per date of service per beneficiary, per provider

For Medi-Cal dental benefits, D9996 identified under dental services were rendered as tele-dentistry. CDT D9996 is NOT reimbursed, instead, the billing dental provider would be reimbursed based upon the applicable CDT procedure code and paid according to the SMA schedule.

The following table identifies the valid Medi-Cal Tele-dentistry codes that can be reported via asynchronous store and forward:

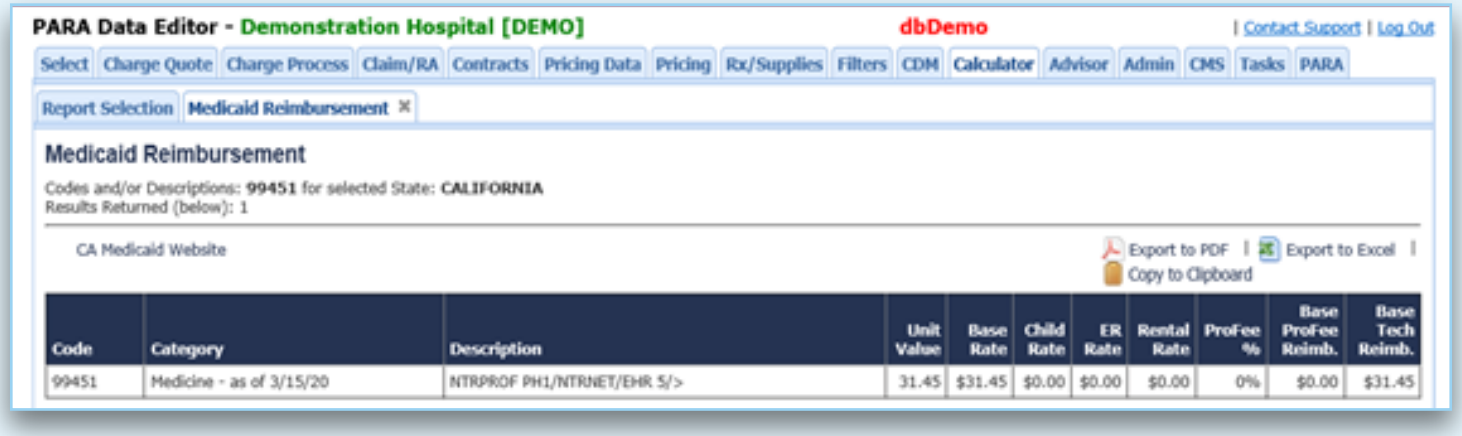
COVID-19 Medi-Cal Teledentistry	
Code	Description
D0120	Periodic oral evaluation – established patient
D0150	Comprehensive oral evaluation – new or established patient
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical first radiographic image
D0230	Intraoral – periapical each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0274	Bitewings – four radiographic images
D0330	Panoramic radiographic image
D0350	Oral/Facial photographic images

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

COVID-19 Asynchronous Store and Forward, inclusive of E-Consults via Telehealth update:

Medi-Cal benefits are including but not limited to tele-ophthalmology, tele-dermatology, tele-dentistry and tele-radiology. These services may all be delivered via asynchronous store and forward, including E-Consults, when all of the criteria outlined below are met by providers:

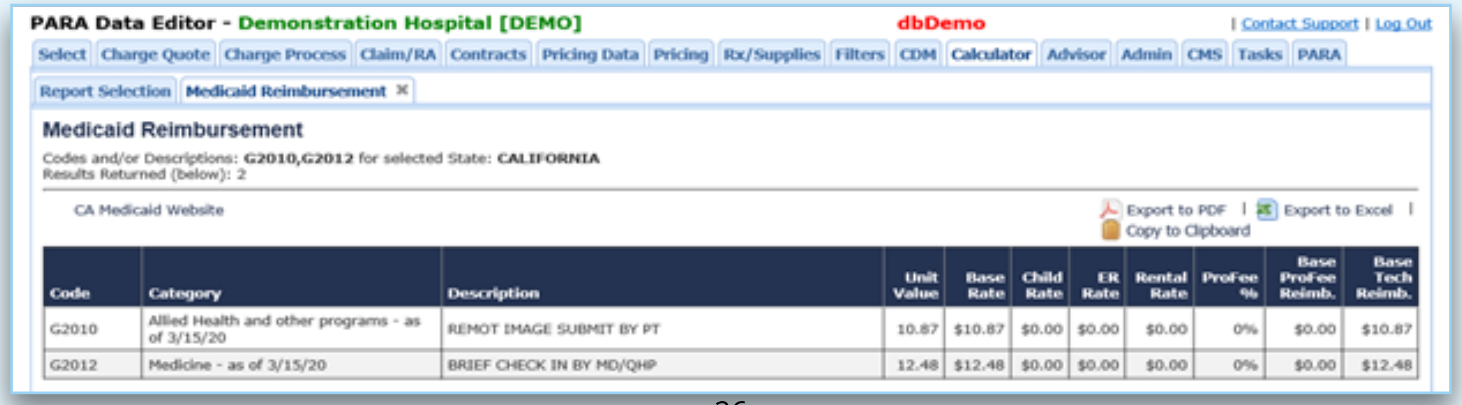
- Health care practitioner must ensure that the documentation, images, sent via store and forward be specific to the patient's condition and adequate for meeting the procedural definition and components of the assigned CPT®/HCPCS code that is submitted on the claim
- E-Consults must report the modifier GQ to designate the health care practitioner is the distant site consultant. This modifier is reported in conjunction with the assigned CPT®/HCPCS 99451
- CPT® code 99451 describes an inter-professional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified healthcare professional; 5 minutes or more in medical consultative time



COVID-19 Medi-Cal Other Virtual/Telephone Communication update:

For enrolled Medi-Cal providers, the policy below applies to services that are rendered in conjunction with a COVID-19 diagnosis.

Virtual Communication:This technology includes a brief communication with another practitioner or with a patient, and in the case of COVID-19, a patient who is not, cannot, or should not be physically present (face-to-face). In this case scenario, Medi-Cal participating providers may be reimbursed using the HCPCS codes indicated below, (G2010 and G2012):



COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

For Medi-Cal Managed Care plan members, providers are instructed to bill and/or submit a referral as indicated per health plan procedures.

Of note, the bulletin says virtual communication codes are billable by physicians and "nurses"; since Medi-Cal enrolls only advanced practice nurses, such as CRNAs, ARNPs, and nurse midwives, **PARA** presumes that the mention of nurses would be limited to those who have the advanced qualifications to become enrolled providers.

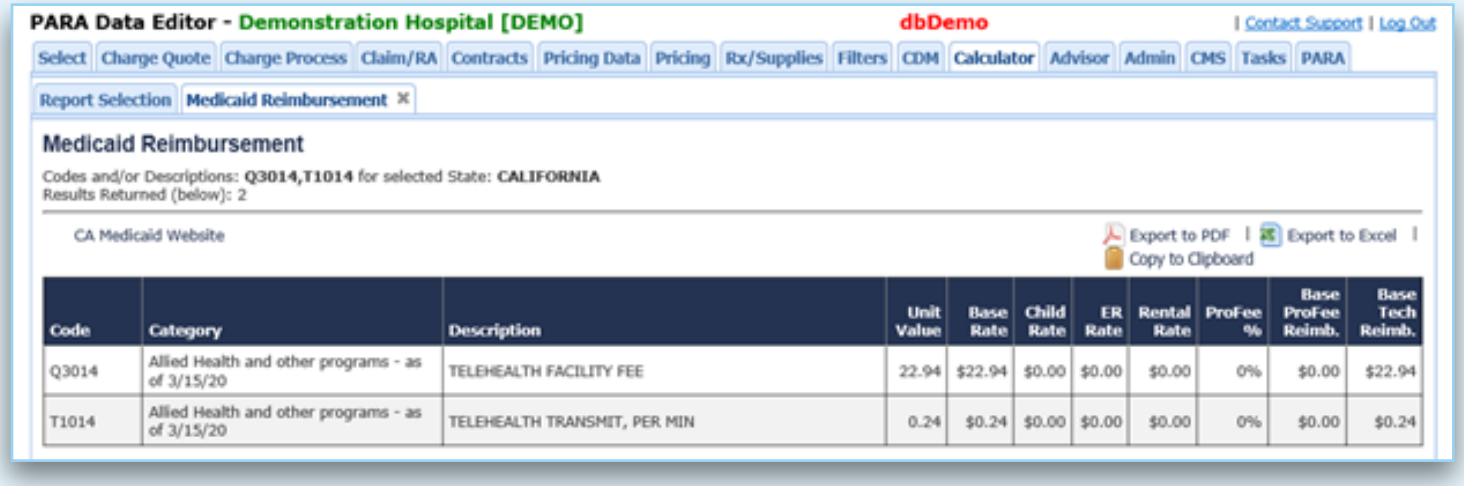
However, these services are **NOT billable** by:

- Federally Qualified Health Center (FQHC)
- Rural Health Clinics (RHC)
- Indian Health Services (IHS)
- Memorandum of Agreement (MOA) 638 Clinics

DHCS will issue future guidance to Medi-Cal providers, as needed, upon any approval with their Federal Partners via an 1135 Waiver Request for FQHCs, RHCs, IHS, and MOA.

COVID-19 Originating Site and Transmission Fee updates:

The originating site facility fee is reimbursed only to the originating site when billed with HCPCS Q3014. Transmission costs incurred from providing telehealth services via audio/video communication is reimbursed when billed with HCPCS T1014: telehealth transmission, per minute. Professional services are billed separately.



Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
Q3014	Allied Health and other programs - as of 3/15/20	TELEHEALTH FACILITY FEE	22.94	$22.94	$0.00	$0.00	$0.00	0%	$0.00	$22.94
T1014	Allied Health and other programs - as of 3/15/20	TELEHEALTH TRANSMIT, PER MIN	0.24	$0.24	$0.00	$0.00	$0.00	0%	$0.00	$0.24

Medi-Cal has applied the following restrictions when reporting Q3014 and T1014 at the claim level:

- Q3014: Billable by originating site; once per day; same patient, same provider
- T1014: Originating site and distant site; maximum of 90 minutes per day (1 unit =1 minute), same patient, same provider
- Originating site fee and transmission costs are NOT available for telephonic services
- Providers, if billing store and forward, including e-consults at the originating site may bill originating site fee with HCPCS code Q3014, but may not bill for the transmission fee.Further, providers originating site and transmission fee restrictions are NOT applicable to FQHCs, RHCs, or Tribal 638 clinics.

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

New: Billing Instructions for Presumptive Eligibility (PE) for COVID-19 Program:

On April 08, 2020, The California Department of Health Care Services (DHCS) implemented Presumptive Eligibility (PE) benefits for the coronavirus disease (COVID-19).

Medi-Cal benefits are available for individuals with no health insurance or who currently have private insurance that does not have benefits to cover diagnostic testing, testing-related service and treatment services, which includes all medically necessary care as a result of COVID-19.

Eligibility for COVID-19 will use the established Aid Code of V2 to determine the limited benefits for these individuals. Aid Code V2 is a limited-scope code that will allow access to COVID-19 diagnostic testing, testing-related service and treatment services, which include all medically necessary care for COVID-19 including laboratory services and the associated office, clinic or emergency room visits, without regard to immigration status, income or resources.

Providers should note: Aid Code V2 will be assigned a date specific eligibility. A Qualified Provider (QP) will enroll the individual on the date of application and their PE eligibility will end on the last calendar day of the month in which the 60th day falls from the date of their PE application.

Providers must include the ICD-10 diagnosis code U07.1 on all claims for COVID-19 claim reimbursement. Claims submitted without this diagnosis will be denied.

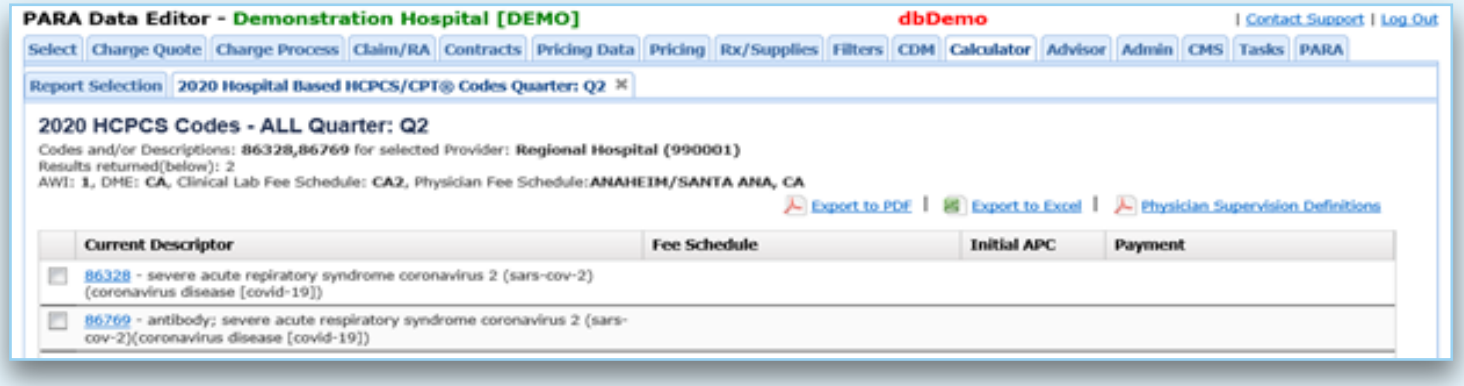
Update On Laboratory Diagnostic Testing:

Effective for dates of service on or after April 10, 2020, the AMA has released the following specific codes which will be utilized to report and track COVID-19 antibody testing.

In doing so, the AMA has revised code 86318(immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method) and established 86328 (immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and 86769 (antibody, severe acute respiratory syndrome coronavirus, to provide increased specificity to report serologic laboratory testing.

Frequency requirements for codes 86328 and 86769 apply as follows:

- 86328 and 86769 have an assigned frequency limit of two per day
- 68328 and 86769 may NOT be billed with each other on the same date of service



COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

DHCS has implemented three new HCPCS codes (U0001, U0002, 87635) which will be retro-active for dates of service on or after February 04, 2020.

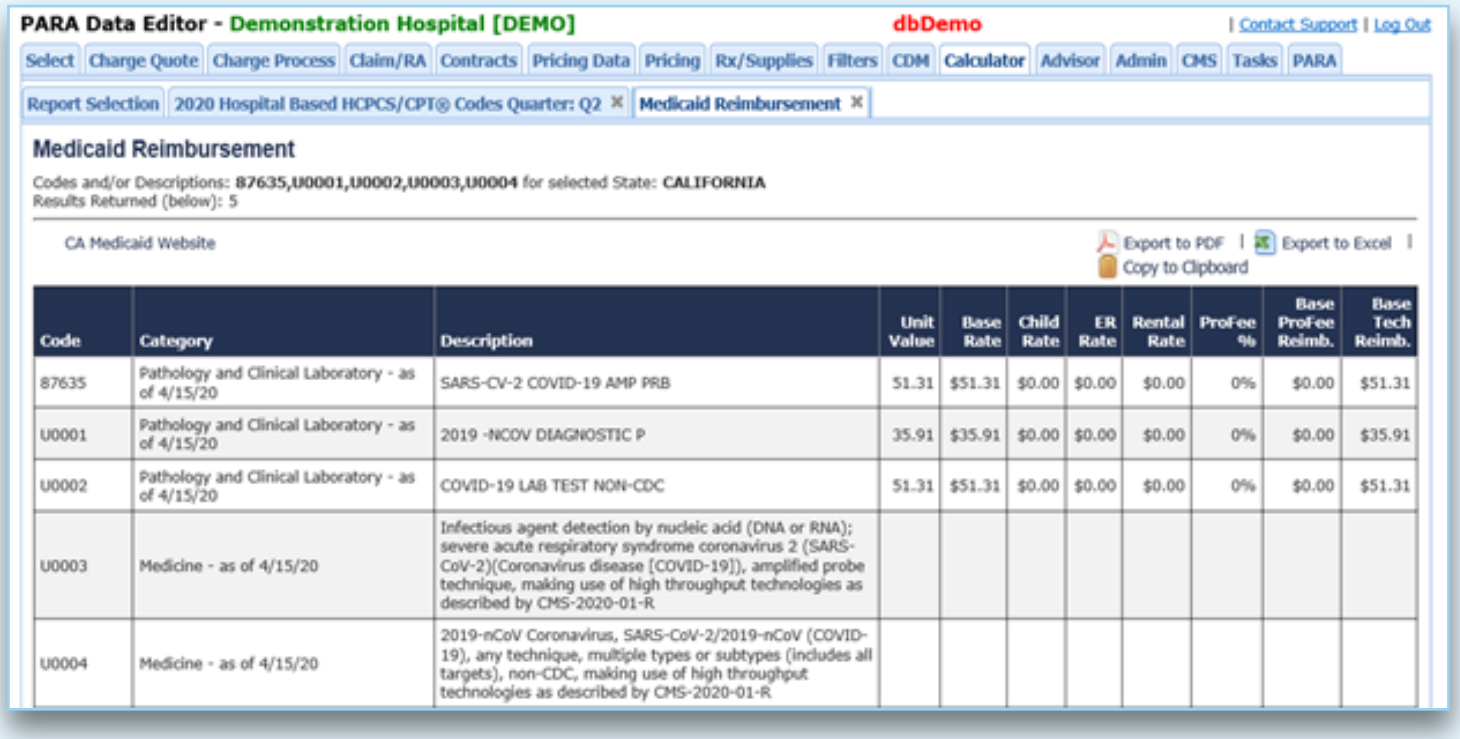
Reimbursement established:

Effective for dates of service on or after March 13, 2020, the Centers for Medicare and Medicaid Services (CMS) established Current Procedural Terminology (CPT®) code 87635 (SARS-COV-2 COVID-19 AMP PRB) for COVID-19 diagnostic testing services. When billing, providers may be reimbursed up to $51.31 for these services.

May update:

New HCPCS for COVID-19 Diagnosis:Effective for dates service on or after March 18, 2020, Medi-Cal will reimburse for HCPCS U0003 and U0004. Medi-Cal has the following restrictions linked to the utilization of these codes at the claim level:

- U0003 and U0004 have a frequency limit of two (2) of each test per day, per patient, on the same DOS
- U0003 and U0004 are eligible as a Presumptive Eligible Benefit
- U0003 and U0004 are billable with modifiers 33, 59, 90 and 99
- U0003 and U0004 are not reimbursed when billed with each other, 87635, U0001 and U0002



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 | 2020 Hospital Based HCPCS/CPT® Codes Quarter: Q2 | Medicaid Reimbursement

Medicaid Reimbursement

Codes and/or Descriptions: **87635,U0001,U0002,U0003,U0004** for selected State: **CALIFORNIA**
Results Returned (below): 5

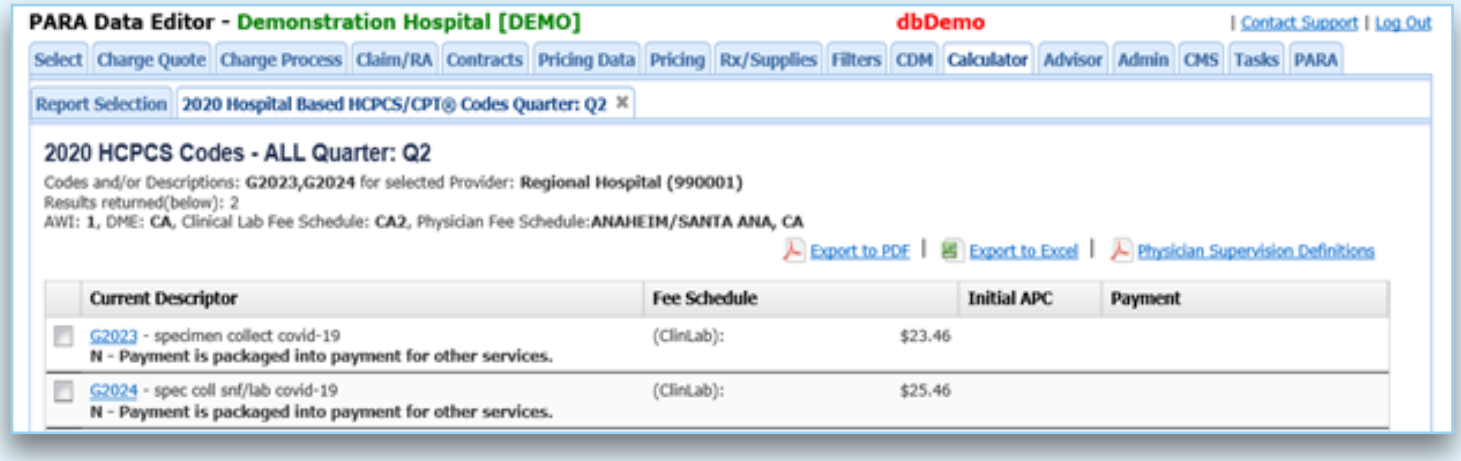
CA Medicaid Website | Export to PDF | Export to Excel | Copy to Clipboard

Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
87635	Pathology and Clinical Laboratory - as of 4/15/20	SARS-CV-2 COVID-19 AMP PRB	51.31	$51.31	$0.00	$0.00	$0.00	0%	$0.00	$51.31
U0001	Pathology and Clinical Laboratory - as of 4/15/20	2019 -NCOV DIAGNOSTIC P	35.91	$35.91	$0.00	$0.00	$0.00	0%	$0.00	$35.91
U0002	Pathology and Clinical Laboratory - as of 4/15/20	COVID-19 LAB TEST NON-CDC	51.31	$51.31	$0.00	$0.00	$0.00	0%	$0.00	$51.31
U0003	Medicine - as of 4/15/20	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R								
U0004	Medicine - as of 4/15/20	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R								

May 2020 Update:

Specimen Collection for COVID-19:Effective for dates of service on or after March 01, 2020, HCPCS G2023 and G2024 are now Medi-Cal benefits. These codes are billable by clinical diagnostic laboratories

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE



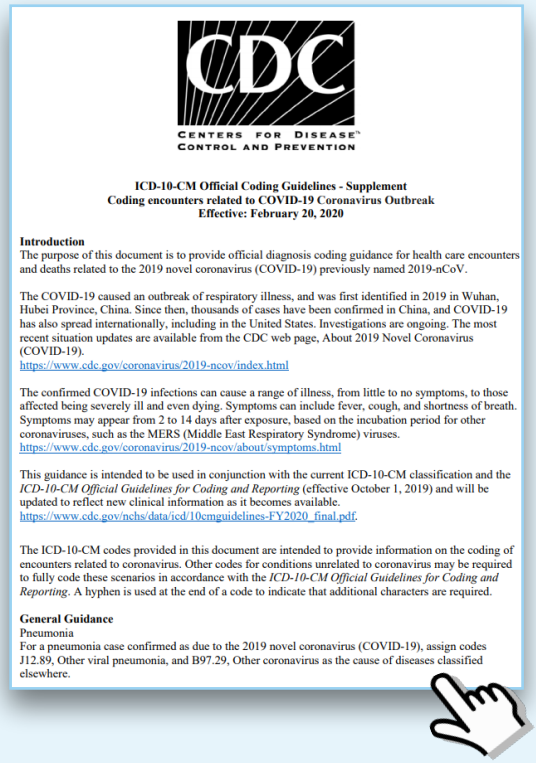
Diagnosis Coding:

Currently, the Medi-Cal billing system is programmed to edit for any ICD-10 diagnosis codes identified by the Centers for Disease Control and Prevention (CDC) and the World Health Organization. DHCS is encouraging Medi-Cal participating providers to review the links below for assistance in diagnosis coding for COVID-19.

COVID-19 Diagnosis update:

Medi-Cal is allowing U07.1 for claims related to COVID-19 services effective on or after April 01, 2020.

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf



CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-10-CM Official Coding Guidelines - Supplement
Coding encounters related to COVID-19 Coronavirus Outbreak
Effective: February 20, 2020

Introduction
The purpose of this document is to provide official diagnosis coding guidance for health care encounters and deaths related to the 2019 novel coronavirus (COVID-19) previously named 2019-nCoV.

The COVID-19 caused an outbreak of respiratory illness, and was first identified in 2019 in Wuhan, Hubei Province, China. Since then, thousands of cases have been confirmed in China, and COVID-19 has also spread internationally, including in the United States. Investigations are ongoing. The most recent situation updates are available from the CDC web page, About 2019 Novel Coronavirus (COVID-19).
https://www.cdc.gov/coronavirus/2019-ncov/index.html

The confirmed COVID-19 infections can cause a range of illness, from little to no symptoms, to those affected being severely ill and even dying. Symptoms can include fever, cough, and shortness of breath. Symptoms may appear from 2 to 14 days after exposure, based on the incubation period for other coronaviruses, such as the MERS (Middle East Respiratory Syndrome) viruses.
https://www.cdc.gov/coronavirus/2019-ncov/about/symptoms.html

This guidance is intended to be used in conjunction with the current ICD-10-CM classification and the *ICD-10-CM Official Guidelines for Coding and Reporting* (effective October 1, 2019) and will be updated to reflect new clinical information as it becomes available.
https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf.

The ICD-10-CM codes provided in this document are intended to provide information on the coding of encounters related to coronavirus. Other codes for conditions unrelated to coronavirus may be required to fully code these scenarios in accordance with the *ICD-10-CM Official Guidelines for Coding and Reporting*. A hyphen is used at the end of a code to indicate that additional characters are required.

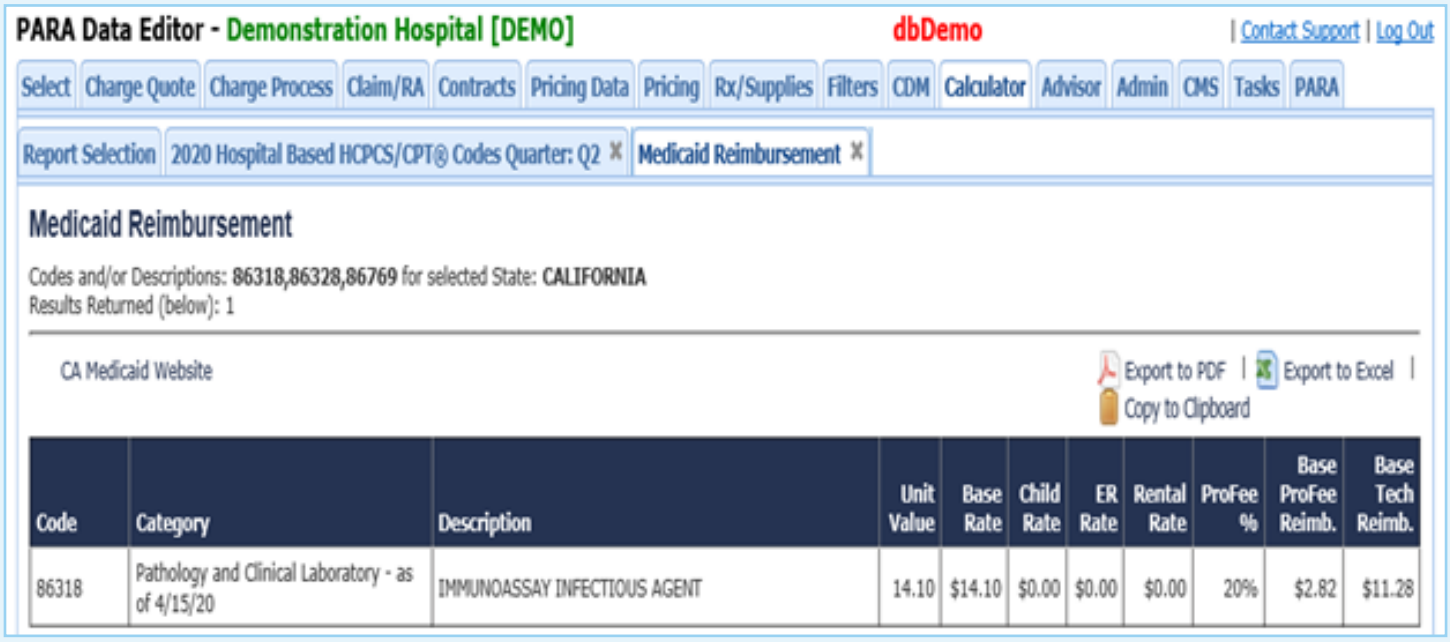
General Guidance
Pneumonia
For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes J12.89, Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

New: CPT® Codes for COVID-19 Antibody Testing: Effective for dates of service on or after April 10, 2020, the AMA has released CPT codes 86318, 86328 and 86769 to allow for increased specificity to report serologic laboratory testing.

Codes 86328 and 86769 both have restrictive frequency limits of two per day and may NOT be billed with each other on the SAME date of service.

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

The update manual pages for this change will be released in a future Medi-Cal Update

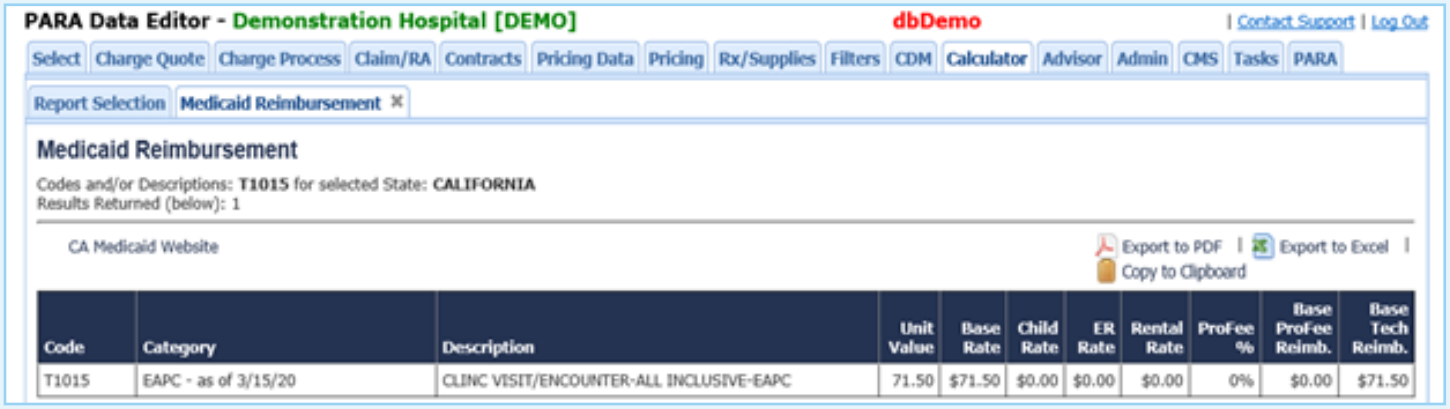


Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
86318	Pathology and Clinical Laboratory - as of 4/15/20	IMMUNOASSAY INFECTIOUS AGENT	14.10	$14.10	$0.00	$0.00	$0.00	20%	$2.82	$11.28

COVID-19 Traditional Telehealth (Synchronous or Asynchronous) Policy updates for FQHCs, RHCs, and Tribal 638 Clinics:

For FQHCs, RHCs and Tribal 638 Clinics, participating providers may provide Medi-Cal covered benefits/services via synchronous telehealth to ESTABLISHED PATIENTS. Medi-Cal defines an established patient as those patients that have been seen at the FQHC, RHC or Tribal 638 Clinic within the last three years.

Medi-Cal covered benefits or services that have been rendered via synchronous telehealth, FQHCs, RHC and Tribal 638 Clinics should report the telehealth services using T1015. Services reported under T1015 are reimbursed at the All-inclusive Rate (AIR).



Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
T1015	EAPC - as of 3/15/20	CLINC VISIT/ENCOUNTER-ALL INCLUSIVE-EAPC	71.50	$71.50	$0.00	$0.00	$0.00	0%	$0.00	$71.50

For COVID-19, FQHC, RHC and Tribal 638 Clinics, Medi-Cal covered benefits outside of the four walls, may be provided via synchronous telehealth for certain populations pursuant to applicable federal law, including migrant/seasonal workers, homeless individuals, and homebound individuals.FQHCs, RHCs and Tribal 638 Clinics, cannot bill for e-Consults or telephone visits.

NEW 2020 MEDICARE COVERAGE FOR ESKETAMINE FOR TRD

In 2020, Medicare will reimburse two new HCPCS codes reported by physicians or hospital outpatient clinics for supervising the patient use of esketamine nasal spray for treatment-resistant depression (TRD.)

The 2020 HCPCS are:

New HCPCS	Long Description	OPPS Status Ind.	OPPS Facility Reimb.	MPFS Pro Fee Reimb (non-fac)
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation.	S	$650.50	$590.02
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation.	S	$950.50	$885.02

Since the cost of the esketamine nasal spray is the main consideration in the payment levels, the physician or qualified non-physician practitioner cannot claim reimbursement for G0282 or G0283 in the facility setting, where the health care professional supervising the self administration and observation does not also provide the esketamine product.

Rather, the professional fee for the visit (including the extended observation by the billing professional, if personally performed) should be reported using the existing E/M codes that describe the visit and the prolonged service of the professional.

In the freestanding clinic setting, billing providers may report G2082 and G2083, when the conditions of coverage are met.

The excerpt from the 2020 Medicare Physician Fee Schedule Final Rule discussing the treatment and the new codes is provided on the following pages.

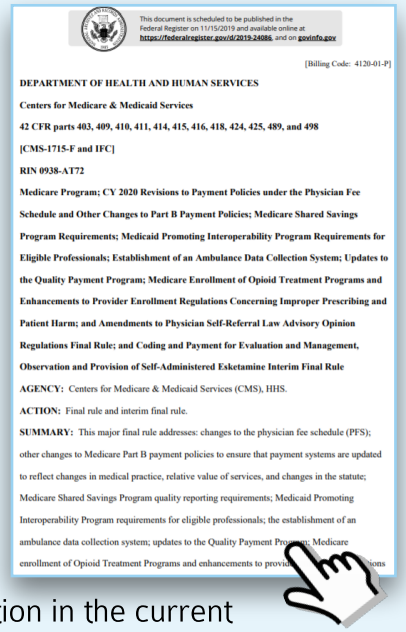
PARA expects that Medicare will issue a National Coverage Determination soon to clarify the restrictions on coverage as discussed in the final rule.

NEW 2020 MEDICARE COVERAGE FOR ESKETAMINE FOR TRD

https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf

V. Interim Final Rule with Comment Period [CMS-1715-IFC]

A. Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine (HCPCS codes G2082 and G2083)



This document is scheduled to be published in the Federal Register on 11/15/2019 and available online at https://federalregister.gov/d/2019-24086, and on govinfo.gov

[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR parts 403, 409, 410, 411, 414, 415, 416, 418, 424, 425, 489, and 498

[CMS-1715-F and IFC]

RIN 0938-AT72

Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule

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

ACTION: Final rule and interim final rule.

SUMMARY: This major final rule addresses: changes to the physician fee schedule (PFS); other changes to Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, relative value of services, and changes in the statute; Medicare Shared Savings Program quality reporting requirements; Medicaid Promoting Interoperability Program requirements for eligible professionals; the establishment of an ambulance data collection system; updates to the Quality Payment Program; Medicare enrollment of Opioid Treatment Programs and enhancements to provi...

On March 5, 2009, the U.S. Food and Drug Administration (FDA) approved Spravato™ (esketamine) nasal spray, used in conjunction with an oral antidepressant, for treatment of depression in adults who have tried other antidepressant medicines but have not benefited from them (treatment-resistant depression (TRD)).

Because of the risk of serious adverse outcomes resulting from sedation and dissociation caused by Spravato administration, and the potential for abuse and misuse of the product, it is only available through a restricted distribution system under a Risk Evaluation and Mitigation Strategy (REMS). A REMS is a drug safety program that the FDA can require for certain medications with serious safety concerns to help ensure the benefit of the medication outweigh its risks.

Patients with major depression disorder who, despite trying at least two antidepressant treatments given at adequate doses for an adequate duration in the current episode, have not responded to treatment are considered to have TRD. TRD is especially relevant for Medicare beneficiaries.

Depression in the elderly is associated with suicide more than at any other age; adults 65 or older constitute 16 percent of all suicide deaths. The decrease in average life expectancy for those with depressive illness, including Medicare beneficiaries, is 7 to 11 years. Depression is a major predictor of the onset of stroke, diabetes, and heart disease; it raises patients' risk of developing coronary heart disease and the risk of dying from a heart attack nearly threefold. There has also been a longstanding need for additional effective treatment for TRD, a serious and life-threatening condition.

A treatment session of esketamine consists of instructed nasal self-administration by the patient, followed by a period of post-administration observation of the patient under direct supervision of a health care professional. Esketamine is a non-competitive N-methyl D-aspartate (NMDA) receptor antagonist.

It is a nasal spray supplied as an aqueous solution of esketamine hydrochloride in a vial with a nasal spray device. This is the first FDA approval of esketamine for any use. Each device delivers two sprays containing a total of 28 mg of esketamine. Patients would require either two (2) devices (for a 56mg dose) or three (3) devices (for an 84 mg dose) per treatment.

After reviewing the Spravato Prescribing Information, Medication Guide, and REMS requirements, we have concluded that effective and appropriate treatment of TRD with esketamine requires discrete services of a medical professional, meaning those that may furnish and report E/M services under the PFS, both during an overall course of treatment and at the time the drug is administered.

Because of the risk of serious adverse outcomes resulting from sedation and dissociation caused by Spravato administration, and the potential for abuse and misuse of the product: the product is only available through a restricted distribution system under a REMS; patients must be monitored by a health care provider for at least 2 hours after receiving their Spravato dose; the prescriber and patient must both sign a Patient Enrollment Form; and the product will only be administered in a certified medical office where the health care provider can monitor the patient.

Further information regarding certification of medical offices is available at www.SPRAVATOrems.com or 1-855-382-6022

NEW 2020 MEDICARE COVERAGE FOR ESKETAMINE FOR TRD

Because this newly available treatment regimen addresses a particular and urgent need for people with TRD, including Medicare beneficiaries, we recognize that it is in the public interest to ensure appropriate patients have access to this potentially life-saving treatment.

We recognize, however, that the services and resources involved in furnishing this treatment are not adequately reflected in existing coding and payment under the PFS, or otherwise under Medicare Part B. Given the FDA approval conditions/requirements including that the drug is only available as an integral component of a physicians' service, the absence of existing HCPCS coding that would adequately describe the service with the provision of the product, and our understanding based on review of the Spravato Prescribing Information, Medication Guide, and REMS requirements, we do not believe the Medicare beneficiaries in the greatest medical need of this treatment would be likely to have access to it until such time that Medicare coding and payment are updated.

Medicare coding and payment policies are generally adopted through annual updates to the PFS. Unless we adopt coding and payment changes for this treatment beginning January 1, 2020, we believe that the next practicable alternative would be either standalone rulemaking or PFS rulemaking for 2021. Both of these alternatives would risk the lives of Medicare beneficiaries with TRD for several months to over a year.

We note that we have historically established coding and payment on an interim final basis for truly new services when it is in the public interest to do so.

Therefore, to facilitate prompt beneficiary access to the new, potentially life-saving treatment for TRD using esketamine, we are creating two new HCPCS G codes, G2082 and G2083, effective January 1, 2020 on an interim final basis. For CY 2020, we are establishing RVUs for these services that reflect the relative resource costs associated with the evaluation and management (E/M), observation and provision of the self-administered esketamine product using HCPCS G codes. We note that we have historically established coding and payment on an interim final basis for truly new services when it is in the public interest to do so.

Like most other truly new services, we expect diffusion of this kind of treatment into the market will take place over several years, even though we expect some people to benefit immediately. Consequently, the expected impact on other PFS services is negligible for 2020, and we will consider the public comments we receive on this interim final policy as we consider finalizing coding or payment rules for this treatment beginning in 2021.

The HCPCS G-codes are described as follows:

- **HCPCS code G2082:** Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal selfadministration, includes 2 hours post-administration observation

- **HCPCS code G2083:** Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal selfadministration, includes 2 hours post-administration observation

NEW 2020 MEDICARE COVERAGE FOR ESKETAMINE FOR TRD

In developing the interim final values for these codes, we used a building block methodology that sums the values associated with several codes. For the overall E/M and observation elements of the services, we are incorporating the work RVUs, work time and direct PE inputs associated with a level two office/outpatient visit for an established patient, CPT® code 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. 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 self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family), which has a work RVU of 0.48 and a total work time of 16 minutes, which is based on a pre-service evaluation time of 2 minutes, an intraservice time of 10 minutes, and a postservice time of 4 minutes. We are also incorporating CPT® codes 99415 (Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)) and 99416 (Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)) in which neither code has a work RVU, but includes direct PE inputs reflecting the prolonged time for clinical staff under the direct supervision of the billing practitioner.

Additionally, to account for the cost of the provision of the self-administered esketamine as a direct PE input, we are incorporating the wholesale acquisition cost (WAC) data from the most recent available quarter. For HCPCS code G2082, we are using a price of $590.02 for the supply input that describes 56 mg (supply code SH109) and for HCPCS code G2083, we are using a price of $885.02 for the supply input describing 84 mg of esketamine (supply code SH110).

We note that we are valuing these two HCPCS codes, in part, on the basis of a level 2 established patient office/outpatient E/M visit; consequently, for purposes of relevant Medicare conditions of payment, reporting these codes is similar to reporting a level 2 office/outpatient E/M visit code. In addition to seeking comment on the interim final values we are establishing for HCPCS codes G2082 and G2083, we also seek comment on the assigned work RVUs, work times, and direct PE inputs.

Under circumstances where the health care professional supervising the self-administration and observation does not also provide the esketamine product, the provider cannot report HCPCS codes G2082 or G2083.

Rather, the visit and the extended observation (by either the billing professional or clinical staff) could be reported using the existing E/M codes that describe the visit and the prolonged service of the professional or the clinical staff. CMS will monitor claims data to safeguard against duplicative billing for these services and items.Historically, supply input prices are updated on a code by code basis and periodically through annual notice and comment rulemaking. The prices, including for a variety of pharmaceutical products, are not routinely updated like Part B drugs paid under the ASP methodologies.

For the supply inputs for the esketamine product, used in developing rates for HCPCS codes G2082 and G2083, we are using the most recent available quarter of WAC data for 2020 pricing, but we anticipate using either data that is reported for determining payments under section 1847A of the Act (such as ASP) or compendia pricing information (such as WAC) in future years and expect to address this issue in further rulemaking.

We seek comments on how to best establish input prices for the esketamine product, as well as other potential self-administered drugs that necessitate concurrent medical services, under PFS ratesetting in future years.

14 QUESTIONS AND ANSWERS ABOUT FAMILIES FIRST AID PART 42

Q1. Which types of group health plans and health insurance coverage are subject to section 6001 of the FFCRA, as amended by section 3201 of the CARES Act?

Section 6001 of the FFCRA, as amended by section 3201 of the CARES Act, applies to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in section 1251(e) of the Patient Protection and Affordable Care Act).

The term "group health plan" includes both insured and self-insured group health plans. It includes private employment-based group health plans (ERISA plans), non-federal governmental plans (such as plans sponsored by states and local governments), and church plans.

"Individual health insurance coverage" includes coverage offered in the individual market through or outside of an Exchange, as well as student health insurance coverage (as defined in 45 CFR 147.145).

Section 6001 does not apply to short-term, limited-duration insurance (as defined in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103), or to a plan or coverage in relation to its provision of excepted benefits (as defined in 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), and 45 CFR 146.145(b) and 148.220). It also does not apply to group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate).

Q2. When are plans and issuers required to comply with section 6001 of the FFCRA and for how long?

Plans and issuers are required to comply with section 6001 of the FFCRA as of March 18, 2020, the date of enactment of the FFCRA. This means that, beginning March 18, 2020, plans and issuers must provide coverage for the items and services described in section 6001(a) of the FFCRA and Q3 below that were furnished on or after March 18, 2020, and must not impose any cost-sharing requirements, prior authorization, or other medical management requirements with respect to those items and services.

Plans and issuers must continue to comply with section 6001 of the FFCRA for applicable items and services furnished during the public health emergency related to COVID-19.

Q3. What items and services must plans and issuers provide benefits for under section 6001 of the FFCRA?

Section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act, requires plans and issuers to provide coverage for the following items and services:

> (1) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—
>
> A. Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);
>
> B. The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
>
> C. Is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or
>
> D. Other tests that the Secretary of HHS determines appropriate in guidance.

14 QUESTIONS AND ANSWERS ABOUT FAMILIES FIRST AID PART 42

(2) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Q4. Do "in vitro diagnostic tests" described in section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act, include serological tests for COVID-19?

Yes. Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19.

The Food and Drug Administration (FDA) currently believes such tests should not be used as the sole basis for diagnosis. FDA has advised the Departments that serological tests for COVID-19 meet the definition of an in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of COVID-19. Therefore, plans and issuers must provide coverage for a serological test for COVID-19 that otherwise meets the requirements of section 6001(a)(1) of the FFCRA, as amended by section 3201 of the CARES Act.

Q5. The FFCRA requires plans and issuers to cover items and services provided during a visit that "relate to the furnishing or administration" of COVID-19 diagnostic testing or that relate "to the evaluation of such individual for purposes of determining the need" for diagnostic testing. What types of items and services must be covered pursuant to this requirement?

Plans and issuers must cover items and services furnished to an individual during visits that result in an order for, or administration of, a COVID-19 diagnostic test, but only to the extent that the items or services relate to the furnishing or administration of the test or to the evaluation of such individual for purposes of determining the need of the individual for the product, as determined by the individual's attending healthcare provider.

The Centers for Disease Control and Prevention (CDC) advises that clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. In addition, the CDC strongly encourages clinicians to test for other causes of respiratory illness.

Therefore, for example, if the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit (which term here includes in-person visits and telehealth visits) to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests under section 6001(a) of the FFCRA.

This coverage must be provided without cost sharing, when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.

14 QUESTIONS AND ANSWERS ABOUT FAMILIES FIRST AID PART 42

Q6. May a plan or issuer impose any cost-sharing requirements, prior authorization requirements, or medical management requirements for benefits that must be provided under section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act?

No. Section 6001(a) of the FFCRA provides that plans and issuers shall not impose any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization requirements, or other medical management requirements for these items and services. These items and services must be covered without cost sharing when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice.

Q7. Are plans and issuers required to provide coverage for items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers)?

Yes. Section 3202(a) of the CARES Act provides that a plan or issuer providing coverage of items and services described in section 6001(a) of the FFCRA shall reimburse the provider of the diagnostic testing as follows:

1. If the plan or issuer has a negotiated rate with such provider in effect before the public health emergency declared under section 319 of the PHS Act, such negotiated rate shall apply throughout the period of such declaration.

2. If the plan or issuer does not have a negotiated rate with such provider, the plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website, or the plan or issuer may negotiate a rate with the provider for less than such cash price.

Section 3202(b) of the CARES Act also requires providers of diagnostic tests for COVID-19 to make public the cash price of a COVID-19 diagnostic test on the provider's public internet website. Section 3202(b) of the CARES Act also grants the Secretary of HHS authority to impose civil monetary penalties on any provider that does not comply with this requirement and has not completed a corrective action plan, in an amount not to exceed $300 per day that the violation is ongoing.

Q8. Section 6001(a)(2) of the FFCRA requires plans and issuers to provide benefits for certain items and services that are furnished during healthcare provider office visits, which include in-person and telehealth visits, as well as visits to urgent care centers and emergency rooms. Under what circumstances are items or services considered to be furnished during a visit?

The Departments construe the term "visit" in section 6001(a)(2) of the FFCRA broadly to include both traditional and non-traditional care settings in which a COVID-19 diagnostic test described in section 6001(a)(1) of the FFCRA is ordered or administered, including COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing.

Therefore, the items and services described in section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act, must be covered when furnished in non-traditional settings, as well as when provided in traditional settings.

14 QUESTIONS AND ANSWERS ABOUT FAMILIES FIRST AID PART 42

Q9. In light of the COVID-19 public health emergency, will the Departments permit plans and issuers to amend the terms of a plan or coverage to add benefits, or reduce or eliminate cost sharing, for the diagnosis and treatment of COVID-19 prior to satisfying any applicable notice of modification requirements and without regard to otherwise applicable restrictions on mid-year changes to health insurance coverage in the group and individual markets?

Yes. Section 2715(d)(4) of the PHS Act and final rules issued by the Departments regarding the Summary of Benefits and Coverage (SBC) provide that if a plan or issuer makes a material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective.

However, to help facilitate the nation's response to COVID-19, the Departments will not take enforcement action against any plan or issuer that makes such modification to provide greater coverage related to the diagnosis and/or treatment of COVID-19, without providing at least 60 days advance notice.

Plans and issuers must provide notice of the changes as soon as reasonably practicable. HHS encourages states to take a similar approach and will not consider a state to have failed to substantially enforce section 2715(d)(4) of the PHS Act if it takes such an approach.

Additionally, issuers are generally not permitted to modify the health insurance coverage for a product mid-year under section 2703 of the PHS Act and 45 CFR 147.106, subject to certain exceptions. However, HHS will not take enforcement action against any health insurance issuer that changes the benefits or cost-sharing structure of its plans mid-year to provide increased coverage for services related to the diagnosis and/or treatment of COVID-19.

HHS encourages states to take a similar approach, and will not consider a state to have failed to substantially enforce section 2703 of the PHS Act if it takes such an approach.

These non-enforcement policies will apply with respect to changes made during the period during which a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act, related to COVID-19 is in effect. Although enforcement relief is being provided during this period for the advance notice requirements of section 2715(d)(4) of the PHS Act, to the extent a plan or issuer maintains any such changes beyond the emergency period, plans and issuers must comply with all other applicable requirements to update plan documents or terms of coverage.

The Departments would continue to take enforcement action against any health insurance issuer or plan that attempts to limit or eliminate other benefits, or to increase cost-sharing, to offset the costs of increasing the generosity of benefits related to the diagnosis and/or treatment of COVID-19.

Q10. May states impose additional requirements on health insurance issuers to respond to the COVID-19 public health emergency?

Yes. Nothing in the FFCRA prevents a state from imposing additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent that such standards or requirements do not prevent the application of a federal requirement.

14 QUESTIONS AND ANSWERS ABOUT FAMILIES FIRST AID PART 42

Excepted Benefits

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to the provision of certain types of benefits, known as "excepted benefits."

Excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code. The parallel statutory provisions establish four categories of excepted benefits, of which only the first and second are relevant here. The first category, under section 2791(c)(1) of the PHS Act, section 733(c)(1) of ERISA, and section 9832(c)(1) of the Code, includes benefits that are generally not health coverage, including on-site medical clinics. The benefits in this category are excepted in all circumstances.

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home healthcare, or community-based care. The benefits in this category are excepted only if certain conditions are met.

Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of HHS, Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain employee assistance programs (EAPs).23 Under the Departments' final regulations, EAPs are excepted if they satisfy all of the following requirements24:

(A) The EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the EAP are not coordinated with benefits under another group health plan:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the EAP.

(D) There is no cost sharing under the EAP.

Q11. May an employer offer benefits for diagnosis and testing for COVID-19 under an EAP that constitute an excepted benefit?

Yes. The Departments' final regulations provide that for the purpose of determining whether an EAP provides benefits that are significant in the nature of medical care, the amount, scope, and duration of covered services are taken into account. An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act, related to COVID-19 is in effect.

14 QUESTIONS AND ANSWERS ABOUT FAMILIES FIRST AID PART 42

Q12. May an employer offer benefits for diagnosis and testing for COVID-19 at an on-site medical clinic that constitute an excepted benefit?

Yes. Coverage of on-site medical clinics is an excepted benefit in all circumstances.

Q13. How can plans and issuers use telehealth and other remote care services to mitigate the impact of the COVID-19 public health emergency?

The widespread availability and use of telehealth and other remote care services are vital to combat the COVID-19 public health emergency. By using these services, patients are able to seek treatment from a healthcare professional in their home, without having to go to a medical office or hospital, helping minimize the risk of exposure to and community spread of COVID-19.

The Departments recognize that many plans and issuers are currently offering benefits for telehealth and/or other remote care services in some form. Many states have encouraged issuers to cover robust telehealth and other remote care services without cost sharing, and many plans and issuers have taken steps to promote the use of these services by providing expanded access to them without cost sharing.

The Departments strongly encourage all plans and issuers to promote the use of telehealth and other remote care services, including by notifying consumers of their availability, by ensuring access to a robust suite of telehealth and other remote care services, including mental health and substance use disorder services, and by covering telehealth and other remote care services without cost sharing or other medical management requirements.

Section 3701 of the CARES Act amends the laws applicable to high deductible health plans (HDHPs) and Health Savings Accounts (HSAs) to provide flexibility with respect to telehealth and other remote care services.

Specifically, section 3701 of the CARES Act amends section 223(c) of the Code to provide a temporary safe harbor for providing coverage for telehealth and other remote care services. As added by section 3701 of the CARES Act, section 223(c)(2)(E) of the Code allows HSA-eligible HDHPs to cover telehealth and other remote care services without a deductible or with a deductible below the minimum annual deductible otherwise required by section 223(c)(2)(A) of the Code. Section 3701 also amends section 223(c)(1)(B)(ii) of the Code to include telehealth and other remote care services as categories of coverage that are disregarded for purposes of determining whether an individual who has other health plan coverage in addition to an HDHP is an eligible individual who may make tax-favored contributions to his or her HSA under section 223 of the Code.

Thus, an otherwise eligible individual with coverage under an HDHP may also receive coverage for telehealth and other remote care services outside the HDHP and before satisfying the deductible of the HDHP and still contribute to an HSA. The amendments to section 223 of the Code under section 3701 of the CARES Act are effective March 27, 2020, and apply to plan years beginning on or before December 31, 2021.

The Departments expect that the flexibilities provided through the amended provisions under section 223 of the Code will increase healthcare access for patients who may have signs or symptoms compatible with COVID-19 and protect other individuals from potential exposure.

However, the Departments note that the amendments to section 223 of the Code apply generally to coverage for healthcare provided through telehealth and other remote care services and are not limited to coverage for COVID-19-related telehealth and other remote care services.

The Departments also encourage states to support efforts to increase access to telehealth and other remote care services. In particular, the Departments urge states to consider whether state licensing laws could be relaxed during the period in which a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies

14 QUESTIONS AND ANSWERS ABOUT FAMILIES FIRST AID PART 42

Act, 50 U.S.C. section, 1601 et seq., related to COVID-19 is in effect, to enable more in-state and out-of-state providers to offer telehealth and other remote care services in the state.

Q14. In light of the public health emergency posed by COVID-19, will the Departments allow plans and issuers to add benefits, or reduce or eliminate cost sharing, for telehealth and other remote care services prior to satisfying any applicable notice of modification requirements and without regard to restrictions on mid-year changes to provide coverage for telehealth services?

Yes. The Departments will apply the same non-enforcement policies described in Q8 to situations where a plan or issuer adds benefits, or reduces or eliminates cost sharing, for telehealth and other remote care services.

These non-enforcement policies will apply with respect to changes made for the period during which a public health emergency declaration under section 319 of the PHS Act related to COVID-19 or a national emergency declaration under the National Emergencies Act, related to COVID-19 is in effect.

Plans and issuers must provide notice of the changes as soon as reasonably practicable. Although enforcement relief is being provided for the advance notice requirements of section 2715(d)(4) of the PHS Act, to the extent a plan or issuer maintains any such changes beyond the emergency period, plans and issuers must comply with all other applicable requirements to update plan documents or terms of coverage.

The Departments would continue to take enforcement action against any health insurance issuer or plan that attempts to limit or eliminate other benefits, or to increase cost-sharing, to offset the costs of increasing the generosity of benefits related to the diagnosis and/or treatment of COVID-19.

CMS WAIVER DETAILS HOSPITAL THERAPIST REMOTE SERVICES

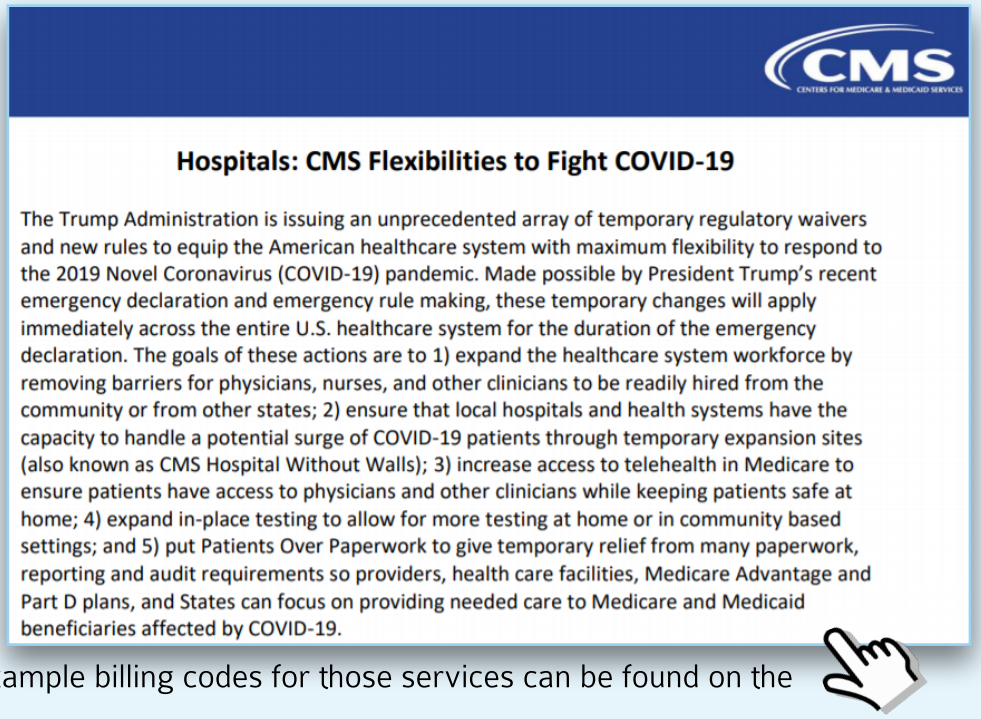
A CMS publication at the following link discusses this topic on pages 3 and 4:

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

- **Hospital-Only Remote Outpatient Therapy and Education Services:** Consistent with the CMS Hospitals without Walls Initiative, we have announced that hospitals may provide behavioral health and education services furnished by hospital-employed counselors or other professionals that cannot bill Medicare directly for their professional services.

  This includes partial hospitalization services. These services may be furnished to a beneficiary in their home when the beneficiary is registered as an outpatient of the hospital and the hospital considers the beneficiary's home to be a provider-based department of the hospital.

  - During the PHE, a subset of therapy and educational services are eligible to be provided remotely by the hospital clinical staff so long as they are furnished to a patient in the hospital, which may include the patient's home if that home is made provider-based to the hospital during the PHE. A list of example billing codes for those services can be found on the cms.gov website



  - Counselors and other employed hospital staff may furnish these services to the beneficiary, either through telecommunications technology or in person, in a temporary expansion location, which may include the beneficiary's home so long as it has been made provider-based to the hospital

  - For Partial Hospitalization Program services, hospitals can furnish and bill for certain partial hospitalization service—that is, individual psychotherapy, patient education, and group psychotherapy--that are delivered in temporary expansion locations, including patients' homes, so long as such locations have been made provider-based to the hospital, to ensure access to necessary services and maintain continuity of care and for purposes of infection control. When the patient is registered as an outpatient, PHP services furnished by hospital staff in that location are considered to be furnished in the hospital

  - The hospital may bill for these services as hospital outpatient services, as long as they are medically necessary and meet all requirements described by the HCPCS code, and as long as the service in furnished in a hospital outpatient department of the hospital

CMS WAIVER DETAILS HOSPITAL THERAPIST REMOTE SERVICES

Within the document linked on the previous page, CMS provided a chart of the various payment methodologies applicable to services performed at extension sites of a provider-based department of the hospital (e.g., patient homes) during the COVID-19 emergency is provided on this page.

Provider-Based Department (PBD) Type	Non-PHE Payment Policy Before Relocation	Non-PHE Payment Policy if PBD Relocates Off-Campus (Absent Extraordinary Circumstance Approval)	Payment Policy During PHE Following Off-Campus Relocation
On-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	Full OPPS*
Excepted* Off-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	Full OPPS*
Non-Excepted Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent
New (since pandemic) Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent

*PBD department relocations would need to receive extraordinary circumstances relocation approval and the relocation must not be inconsistent with state emergency preparedness or pandemic plan. Once the COVID-19 PHE ends, these relocated PBD would be expected to shut down or return to their original location; otherwise, they would be paid the PFS-equivalent rate unless, at the discretion of the CMS Regional Office, they are granted a permanent extraordinary circumstances relocation exception under our normal policy. We note that, during the COVID-19 PHE, hospitals would have flexibility to do partial relocations, and relocate their PBD to multiple new off-campus locations, including the patient's home.

CMS ADDS FACILITY PAY FOR TELEHEALTH HOPD PRO FEES

On April 30, 2020, CMS announced further expansions to meet the COVID-19 National Health Emergency that provides additional facility-fee reimbursement for outpatient telehealth professional services provided by hospital-based practitioners working through a hospital outpatient department (HOPD.)

Previously, CMS had indicated that during the National Health Emergency, professionals reporting telehealth services should indicate the Place of Service code that would have been reported if the provider had seen the patient in person.

The POS code drives higher Medicare Physician Fee Schedule reimbursement for physicians practicing at independent clinics, and less reimbursement for those who report a POS code for an outpatient department of the hospital.Regardless, the professional fee should report modifier 95 to indicate the service was provided over communications technology.

For example, a provider reporting a telehealth service during the COVID-19 emergency with CPT® 99213 (modifier 95) and POS code 11 (Office), would be reimbursed $83.73 under the Medicare Physician Fee Schedule (national unadjusted rate).

However, a physician reporting the same service with POS 22—Outpatient Hospital—would be paid less: $55.72.The lower facility-based reimbursement reflects the ordinary expectation that a hospital facility fee would be generated for a patient visit to the hospital. But under the first set of COVID-19 waivers, facilities were not permitted to be reimbursed for telehealth services delivered by provider-based practitioners.

	Current Descriptor	Fee Schedule	
☐	99213 - office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. counseling and 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. usua **B - Not paid under OPPS.**	GB (Physician Facility): GB (Physician Non-Facility):	$55.72 $83.73

This situation left facilities providing the scheduling, billing, and medical records for provider-based practitioners without any reimbursement for the facility's contribution toward the delivery of telehealth.

To rectify this imbalance, effective March 1, 2020, CMS will reimburse facilities reporting the Telehealth Originating Site Fee (HCPCS Q3014, paid at $26.65 nationally), when a professional fee for telehealth is reported by a hospital-based provider.

Here is a link and excerpts from the CMS Interim Final Rule published on April 30, 2020, pages 55 through 58: cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

CMS ADDS FACILITY PAY FOR TELEHEALTH HOPD PRO FEES

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

[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 412, 413, 414, 415, 424, 425, 440, 483, 484 and 600

Office of the Secretary

45 CFR Part 156

[CMS-5531-IFC]

RIN 0938-AU32

Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period (IFC) gives individuals and entities that provide services to Medicare, Medicaid, Basic Health Program, and Exchange beneficiaries needed flexibilities to respond effectively to the serious public health threats posed by the spread of the coronavirus disease 2019 (COVID-19). Recognizing the critical importance of expanding COVID-19 testing we are amending several Medicare policies on an interim basis to cover FDA-authorized COVID-19 serology tests, to allow any healthcare professional authorized to do so

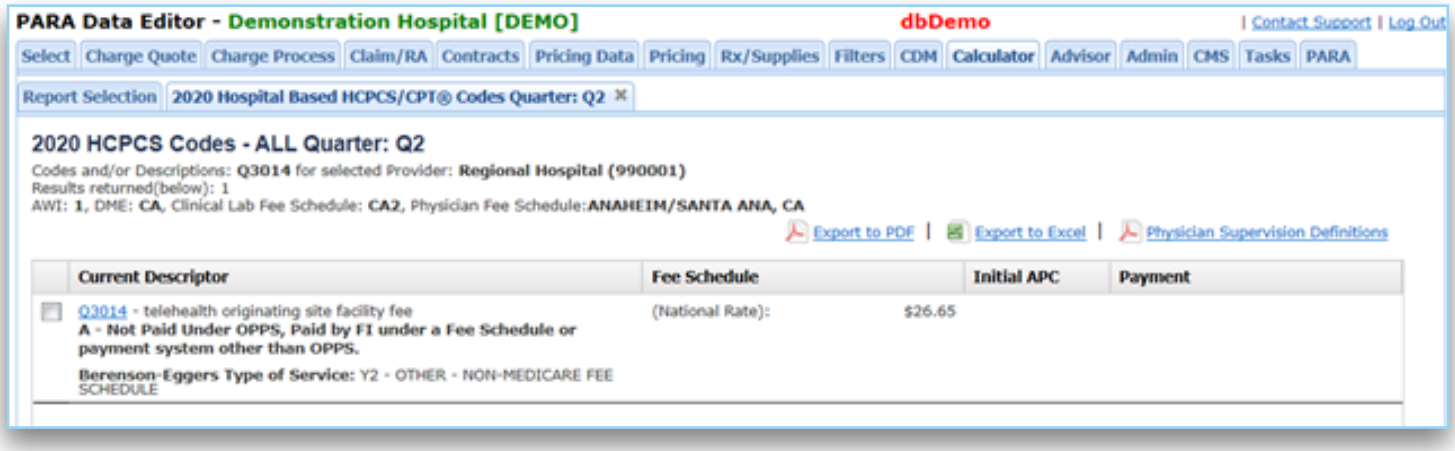
"We acknowledge that when a physician or practitioner who ordinarily practices in the HOPD furnishes a telehealth service to a patient who is located at home, the hospital would often still provide some administrative and clinical support for that service. When a registered outpatient of the hospital is receiving a telehealth service, the hospital may bill the originating site facility fee to support such telehealth services furnished by a physician or practitioner who ordinarily practices there.

This includes patients who are at home, when the home is made provider-based to the hospital (which means that all applicable conditions of participation, to the extent not waived, are met), under the current waivers in effect for the COVID-19 PHE.

...

"As such, for the duration of the COVID-19 PHE, we are making the public aware that under the flexibilities already in effect, when a patient is receiving a professional service via telehealth in a temporary expansion location that is a PBD of the hospital, and the patient is a registered outpatient of the hospital, the hospital in which the patient is registered may bill the originating site facility fee for the service.

As always, documentation in the medical record of the reason for the visit and the necessity of the visit is required."Consequently, hospitals should claim reimbursement for Q3014 (telehealth originating site facility fee) for each hospital-based practitioner's telemedicine encounter reporting Place of Service code 22 (outpatient hospital) provided on or after March 1, 2020



PARA'S PRICE TRANSPARENCY TOOL ADVANTAGES

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That's why PARA HealthCare Analytics has made it easy.

Here are 10 ways **PARA's Price Transparency** works for you.

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

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4. **A Web-based solution.** Simple implementation. No software to install.

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5. **Comprehensive tool** that pulls:
   - Top services at a facility
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   - Registration information to return usage statistics readily available to the facility

6. **Highly customizable.**
   - The style and functionality of the tool to be directly embedded on the facility website
   - The services available on the Decision Tree and how they are presented (i.e. descriptions, categories)
   - The Prices that are presented (e.g., Average Line Charge, Average Package Charge, Average CDM Charge, etc.)
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7. **Always up to date** with the latest information for all users,with no additional work on behalf of the hospital once implemented.Fully serviced and managed on **PARA's** servers with all data and functionality accessible by the facility through the **PARA Data Editor**.

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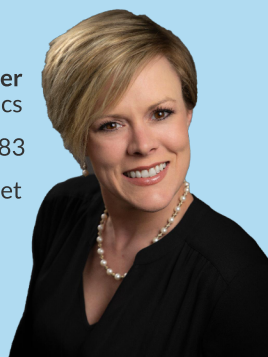

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COVID-19

june, twenty-twenty

Special publication

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

This Resource Guide is brought to you by **PARA HealthCare Analytics** and **Healthcare Financial Resources (HFRI)**, the experts answer coding and financial questions.

PARA
HealthCare Analytics

HEALTHCARE
FINANCIAL
RESOURCES

COVID-19 Resource Guide

Coronavirus

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

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

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

Get waiver & flexibility information

General information & updates:

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

Clinical & technical guidance:

For all clinicians

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

For all health care providers

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

For health care facilities

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

COVID-19 Resource Guide

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

For Labs

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

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

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

Billing And Coding Guidance:

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

For Health Care Facilities

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

COVID-19 Resource Guide

Survey And Certification Guidance:

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

Coverage Guidance:

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

Provider Enrollment Guidance:

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

Medicaid & CHIP Guidance:

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

MLN CONNECTS

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

Thursday, June 4, 2020

News

·Trump Administration Unveils Enhanced Enforcement Actions Based on Nursing Home COVID-19 Data and Inspection Results

·Hospice Provider Preview Reports: Review Your Data by June 29

Claims, Pricers & Codes

·ICD-10-PCS Procedure Codes: FY 2021

Events

·COVID-19: Lessons from the Front Lines Call — June 5

MLN Matters® Articles

·Claim Status Category Codes and Claim Status Codes Update

·Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

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

·Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules

·Value-Based Insurance Design (VBID) Model – Implementation of the Hospice Benefit Component

·Supplier Education on Use of Upgrades for Multi-Function Ventilators — Revised

·Therapy Codes Update — Revised

·International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update — Rescinded

Publications

·Medicare Secondary Payer — Revised

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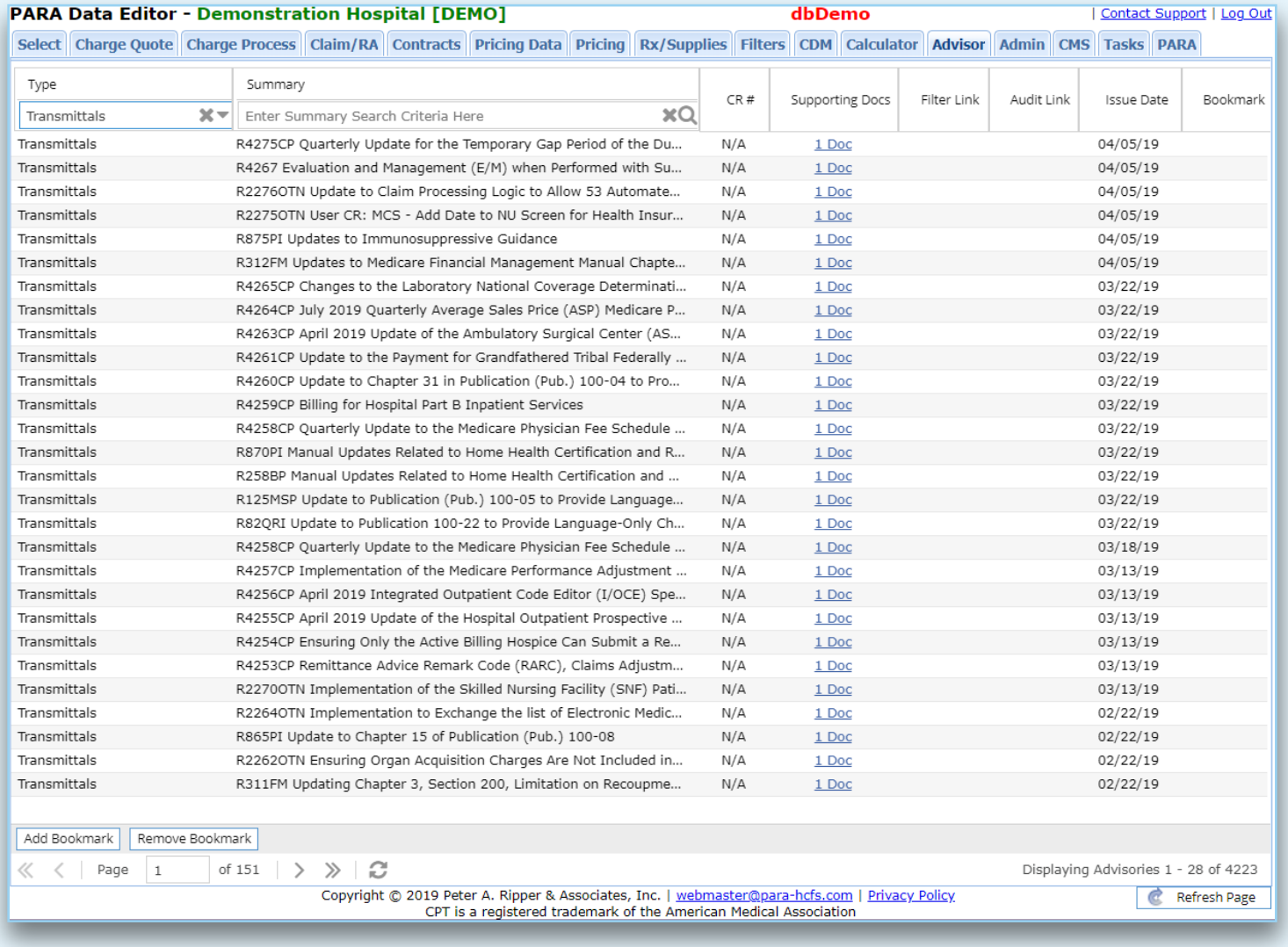
There were FOUR new or revised MedLearns released this week.

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

FIND ALL THESE MEDLEARNS IN THE **ADVISOR** TAB OF THE **PDE** 4



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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	
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Transmittals	R82QRI Update to Publication 100-22 to Provide Language-Only Ch...	N/A	1 Doc			03/22/19	
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July 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.2

MLN Matters Number: MM11792	Related Change Request (CR) Number: 11792
Related CR Release Date: June 5, 2020	Effective Date: July 1, 2020
Related CR Transmittal Number: R10165CP	Implementation Date: July 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospitals, other providers, and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article provides the I/OCE instructions and specifications for the I/OCE employed under the Outpatient Prospective Payment System (OPPS) and non-OPPS. The specifications are for:

- Hospital outpatient departments
- Community mental health centers
- All non-OPPS hospital providers
- For limited services when provided in a Home Health Agency (HHA) not under the HH Prospective Payment System (PPS) or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/.

Make sure your billing staffs are aware of these changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) informs you that the I/OCE update occurs July 1, 2020. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The summary of changes is in the following table. Readers should also review the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the update are retroactive to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

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Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2020

MLN Matters Number: MM11819

Related Change Request (CR) Number: CR 11819

Related CR Release Date: June 5, 2020

Effective Date: October 1, 2020

Related CR Transmittal Number: R10167CP

Implementation Date: October 5, 2020

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Medicare updates the DMEPOS Competitive Bidding Program (CBP) files on a quarterly basis to implement necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, and supplier files. CR11819 provides specific instruction for implementing the DMEPOS CBP files.

The Round 1 2017, Round 2 Recompete, and National Mail Order (NMO) Recompete CBP contracts expired on December 31, 2018. Due to a delay in the announcement of the next round of the CBP, contracts are not in effect in Round 1, Round 2, or the NMO Competitive Bidding Areas (CBAs) as of January 1, 2019, resulting in a temporary gap period in the CBP.

BACKGROUND

Through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress mandated the DMEPOS CBP. The statute required that Medicare replace the current fee schedule payment methodology for selected DMEPOS items with a competitive bidding process.

The intent is to improve the effectiveness of the Medicare methods for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses; and save the Medicare

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KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM11810	Related Change Request (CR) Number: 11810
Related CR Release Date: June 5, 2020	Effective Date: July 1, 2020
Related CR Transmittal Number: R10168CP	Implementation Date: July 5, 2020

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article informs DME MACs about the changes to the DMEPOS fees schedules that are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

BACKGROUND

Medicare pays for DME, prosthetic devices, orthotics, prosthetics and surgical dressings on a fee schedule basis per Sections 1834(a), (h), and (i) of the Social Security Act (the Act). Additionally, 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 1834(a)(1)(F) of the Act, as well as codes that are not subject to the fee schedule Competitive Bidding Program (CBP) adjustments.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not Competitive Bid Areas (CBAs), based on information from CBPs for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

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KNOWLEDGE • RESOURCES • TRAINING

Therapy Codes Update

MLN Matters Number: MM11791 Revised

Related Change Request (CR) Number: 11791

Related CR Release Date: May 26, 2020

Effective Date: March 1, 2020

Related CR Transmittal Number: R10161OTN

Implementation Date: MACs June 16, 2020
FISS - July 6, 2020

Note: We revised this article to reflect a revised CR11791. The CR revision changed the implementation date for the MACs and we revised that date in the article. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article informs you of updates to the list of codes that sometimes or always describe therapy services. The additions to the therapy code list reflect those made in the Calendar Year (CY) 2020 for the COVID-19 Public Health Emergency (PHE). Please make sure your billing staffs are aware of these changes.

BACKGROUND

Section 1834(k)(5) of the Social Security Act (the Act) requires all claims for outpatient rehabilitation therapy services and all Comprehensive Outpatient Rehabilitation Facility (CORF) services be reported using a uniform coding system. The CY 2020 Current Procedural Terminology (CPT) and Level II HCPCS are the coding systems used for reporting these services. The therapy code listing is on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

CR 11791 implements policies reflective of those related to the interim final rule with comment (IFC) entitled Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 PHE (CMS-1744-IFC); and the IFC-entitled Medicare and Medicaid Programs Additional Policy and Regulatory Revisions in Response to the COVID-19 PHE (CMS-5531-IFC); and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). CR 11791 updates the therapy code list and associated policies effective March 1, 2020, for the duration of

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There were SIX 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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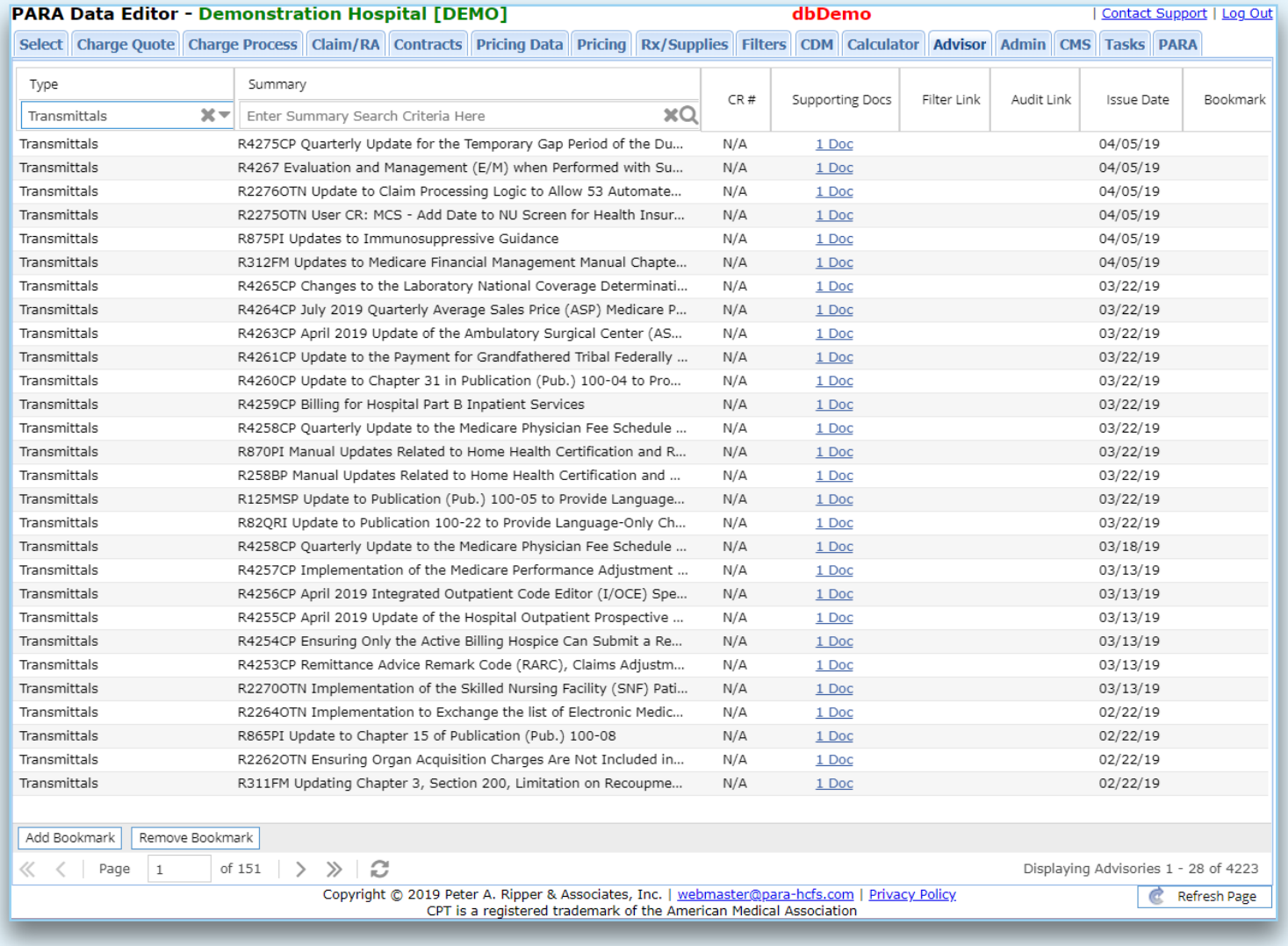

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The link to this Transmittal R1066CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10166	**Date: June 5, 2020**
	Change Request 11814

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

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

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

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

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

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

The link to this Transmittal R10165CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10165	**Date: June 5, 2020**
	Change Request 11792

SUBJECT: July 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.2

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

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

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 R10167CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10167	**Date: June 5, 2020**
	Change Request 11819

SUBJECT: Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2020

I. SUMMARY OF CHANGES: The DME CBP files are updated on a quarterly basis in order to implement necessary changes to the healthcare common procedure coding system, zip code, single payment amount, and supplier files. These requirements provide specific instruction for implementing the DMEPOS CBP files. This recurring update notification applies to chapter 23, section 100.

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

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

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10168CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10168	**Date: June 5, 2020**
	Change Request 11810

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

I. SUMMARY OF CHANGES: The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The update process for the DMEPOS fee schedule is located in publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

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

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

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

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10162OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10162	**Date: May 27, 2020**
	Change Request 11677

Transmittal 10076, dated May 1, 2020, is being rescinded and replaced by Transmittal 10162, dated, May 27, 2020, to update business requirement 11677.3 adding a clarification note. All other information remains the same.

SUBJECT: COBOL Version 6.2 Upgrade - Additional Analysis and Phase I Implementation

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

EFFECTIVE DATE: October 5, 2020 - Effective date is the date claims are processed
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

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

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

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

III. FUNDING:

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10161OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10161	**Date: May 26, 2020**
	Change Request 11791

Transmittal 10139, dated May 15, 2020, is being rescinded and replaced by Transmittal 10161, dated, May 26, 2020 to revise the implementation date for the MACs. All other information remains the same.

SUBJECT: Therapy Codes Update

I. SUMMARY OF CHANGES: This Change Request (CR) updates the list of codes that sometimes describe therapy services. The additions to the therapy code list reflect those made in the Calendar Year (CY) 2020 for the COVID-19 public health emergency (PHE).

EFFECTIVE DATE: March 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 16, 2020 - for the MACs; July 6, 2020 - for FISS

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

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

III. FUNDING:

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IV. ATTACHMENTS:

One Time Notification

Get power on your side and maintain your cash flow.

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

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

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- Contingency-Based Flat Rate Fee Schedule
- 25% Reduction In Account Lifecycle

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

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