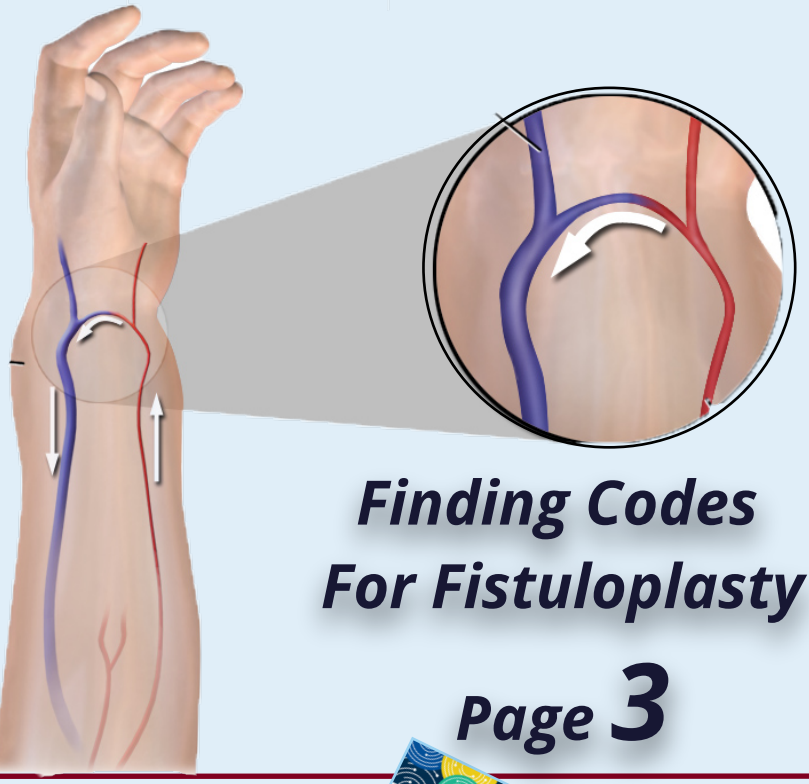
PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

June 24, 2020

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS



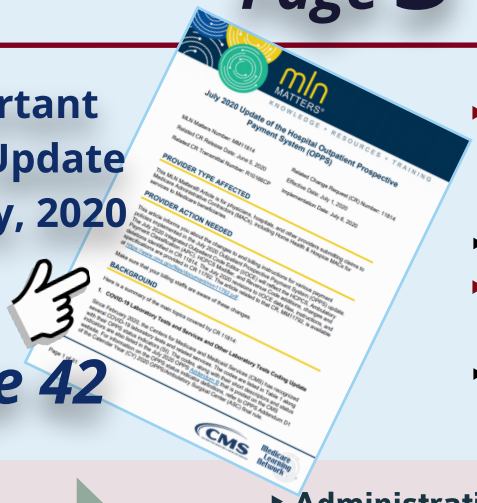
Finding Codes For Fistuloplasty

Page 3

How Can This Button Change Your Hospital's Future?

Page 11

Important OPPS Update For July, 2020



Page 42

- **Prior Authorization Not Applicable To CAHs**
- Reporting Drug Wastage
- **Balance Billing For COVID-19**
- PARA Coronavirus Coding Update
- **Wound Care Charge Process**
- CMS Cardiac Stress Test Supervision Requirements
- **Hydration, IV Therapy, Injections & Vaccine Charge Processes**

FAST LINKS

PRIOR AUTHORIZATION NOT APPLICABLE TO CAHS

Q. We watched a webinar where the presenters stated that Critical Access Hospitals (CAHs) were exempt from the new Prior Authorization rules outlined by CMS. Can you verify that CAHs are exempt from these prior authorization requirements?

A. **Answer:** Yes, we confirmed with CMS that CAHs are not required to comply with the new Prior Authorization requirements. Since we had only heard CMS representatives say this verbally, and hadn't seen it in writing, Nikki Graves from **PARA** emailed CMS to verify it in writing–and they confirmed.

Our **PARA** paper (attached) on the topic has been updated to reflect this news.

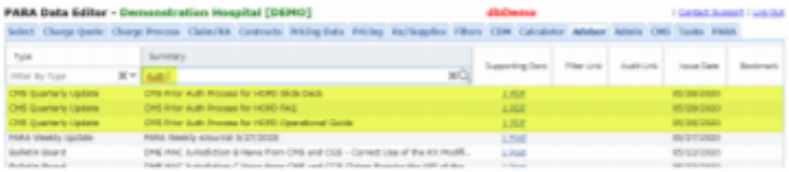
More details are found in a thorough article in this week's eJournal. (Page 43)

CMS Imposes Prior Auth On Certain Outpatient Procedures Effective July 1, 2020 – (Updated 6-10-2020)

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 services which it deems to have been at risk for incorrect payment due to medical necessity, primarily services that are sometimes performed for cosmetic purposes. The prior authorization process is not required of procedures performed in Ambulatory Surgery Centers.

Critical Access Hospitals are exempt from the prior auth requirement.

On May 28, 2020 CMS presented a webinar on the Prior Auth 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**

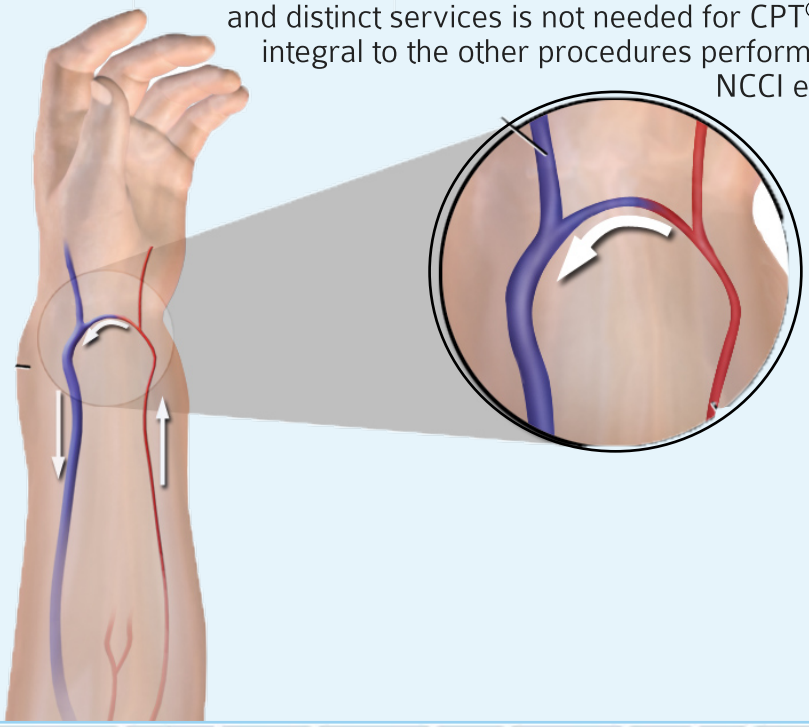
Providers and hospitals may start submitting Prior Authorization Requests (PARs) to the regional MAC **beginning June 17, 2020 for services rendered on or after July 1, 2020**. The requests need to include

 Page 1

AV FISTULA WITH VENOPLASTY/FISTULOPLASTY

Q. Can you confirm the proper CPT® codes for arteriovenous fistula with fistulogram, fistuloplasty and venoplasty? We are considering codes 76937 -XS x 3, 36902-XS, 36907-XS, 37248, 36558-XU.

A. **Answer:** Report CPT® codes 36902-XS, 37248, 36558, 76937. The peripheral segment of the dialysis circuit underwent angioplasty which supports CPT® code 36902. This code includes the fistulogram. This is for the procedure to angioplasty the axillary and cephalic veins of the dialysis fistula. The documentation indicates a central venous catheter tunneled, therefore supporting CPT® code 36558. A modifier for separate and distinct services is not needed for CPT® code 36558 since it is not integral to the other procedures performed and does not trigger a NCCI edit.



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 | CPT® Assistant

2020 CPT® Codes

Codes and/or Descriptions: **36902,37248,36558,76937**

Export to PDF | Export to Excel

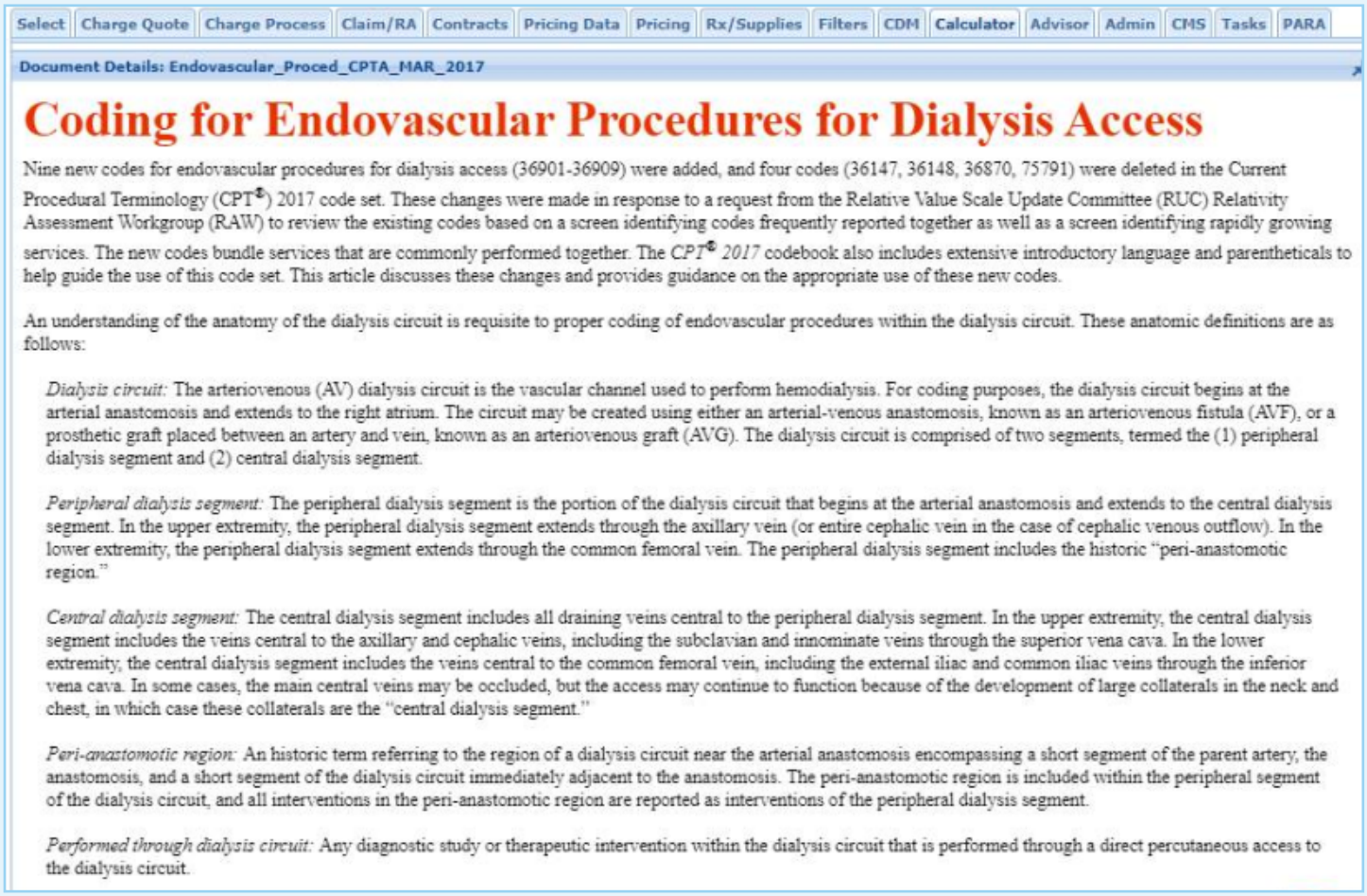
CPT Code	Current Descriptor	Change Type	
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older	UNCHANGED	Click For Details
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	UNCHANGED	Click For Details
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	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

AV FISTULA WITH VENOPLASTY/FISTULOPLASTY

The procedure to angioplasty the brachiocephalic vein was not performed via the dialysis circuit. Therefore, CPT® code 37248 is reported rather than 36907. Append modifier XS to 36907 to override the NCCI edit when reported with 37248. The documentation supports separate and distinct services since they are different anatomic sites.

Please refer to the **PARA Data Editor** reference AMA CPT® Assistant March 2017 page 3-5,9. This reference discusses the arteriovenous dialysis circuit. The ultrasound guidance was performed at the left internal jugular vein access, left upper extremity and the right external jugular vein. Report 76937 with three units.

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



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

Document Details: Endovascular_Proced_CPTA_MAR_2017

Coding for Endovascular Procedures for Dialysis Access

Nine new codes for endovascular procedures for dialysis access (36901-36909) were added, and four codes (36147, 36148, 36870, 75791) were deleted in the Current Procedural Terminology (CPT®) 2017 code set. These changes were made in response to a request from the Relative Value Scale Update Committee (RUC) Relativity Assessment Workgroup (RAW) to review the existing codes based on a screen identifying codes frequently reported together as well as a screen identifying rapidly growing services. The new codes bundle services that are commonly performed together. The *CPT® 2017* codebook also includes extensive introductory language and parentheticals to help guide the use of this code set. This article discusses these changes and provides guidance on the appropriate use of these new codes.

An understanding of the anatomy of the dialysis circuit is requisite to proper coding of endovascular procedures within the dialysis circuit. These anatomic definitions are as follows:

Dialysis circuit: The arteriovenous (AV) dialysis circuit is the vascular channel used to perform hemodialysis. For coding purposes, the dialysis circuit begins at the arterial anastomosis and extends to the right atrium. The circuit may be created using either an arterial-venous anastomosis, known as an arteriovenous fistula (AVF), or a prosthetic graft placed between an artery and vein, known as an arteriovenous graft (AVG). The dialysis circuit is comprised of two segments, termed the (1) peripheral dialysis segment and (2) central dialysis segment.

Peripheral dialysis segment: The peripheral dialysis segment is the portion of the dialysis circuit that begins at the arterial anastomosis and extends to the central dialysis segment. In the upper extremity, the peripheral dialysis segment extends through the axillary vein (or entire cephalic vein in the case of cephalic venous outflow). In the lower extremity, the peripheral dialysis segment extends through the common femoral vein. The peripheral dialysis segment includes the historic "peri-anastomotic region."

Central dialysis segment: The central dialysis segment includes all draining veins central to the peripheral dialysis segment. In the upper extremity, the central dialysis segment includes the veins central to the axillary and cephalic veins, including the subclavian and innominate veins through the superior vena cava. In the lower extremity, the central dialysis segment includes the veins central to the common femoral vein, including the external iliac and common iliac veins through the inferior vena cava. In some cases, the main central veins may be occluded, but the access may continue to function because of the development of large collaterals in the neck and chest, in which case these collaterals are the "central dialysis segment."

Peri-anastomotic region: An historic term referring to the region of a dialysis circuit near the arterial anastomosis encompassing a short segment of the parent artery, the anastomosis, and a short segment of the dialysis circuit immediately adjacent to the anastomosis. The peri-anastomotic region is included within the peripheral segment of the dialysis circuit, and all interventions in the peri-anastomotic region are reported as interventions of the peripheral dialysis segment.

Performed through dialysis circuit: Any diagnostic study or therapeutic intervention within the dialysis circuit that is performed through a direct percutaneous access to the dialysis circuit.

REPORTING DRUG WASTAGE

Q. Can you please provide guidance on utilizing, billing, and reporting waste for multi-dose vials to Medicare? And what is the best way to build this drug so it bills correctly? We do not use multi-dose vials as multi-dose, meaning that we use the vial as a single dose (one vial per patient and the remainder is wasted). If we are using MDV as SDV, is it appropriate to bill and report the waste and report the waste for reimbursement?

A. **Answer:** Medicare requires that hospitals report wastage for OPPS Status K or G drugs or biological on single-dose or single-use packages only. The hospital must document in the patient's record that it wasted the drug, and it did not administer the remaining drug to another patient. Report the amount of the drug administered to the patient with its HCPCS on one claim line. Report the wasted amount of the drug appending modifier JW to the same HCPCS code on a separate claim line.

In CMS Transmittal 3538, CMS advises providers to purchase drugs and biologicals in the most efficient means. Below are the link and an excerpt to the transmittal:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3538CP.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3538	Date: June 9, 2016
	Change Request 9603

Transmittal 3530, dated May 24, 2016, is being rescinded and replaced by Transmittal 3538 to update the Effective and Implementation dates. All other information remains the same.

SUBJECT: JW Modifier: Drug amount discarded/not administered to any patient

I. SUMMARY OF CHANGES: Effective January 1, 2017, claims for discarded drug or biological amount not administered to any patient, shall be submitted using the JW modifier. Also, effective January 1, 2017, providers must document the discarded drugs or biologicals in patient's medical record. This CR updates the Section 40 - Discarded Drugs and Biologicals of Chapter 17 of the Claims Processing Manual 100-04.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

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
	17/40/Discarded Drugs and Biologicals

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

B. Policy: Effective January 1, 2017, when processing claims for Part B drugs and biologicals (except those provided under CAP), the use of the JW modifier to identify unused drugs or biologicals that are appropriately discarded is required.

Also, effective January 1, 2017, providers are required to document the discarded drug or biological in the patient's medical record. CMS is removing the contractors' discretion to determine whether the JW modifier is required for claims with discarded drugs and biologicals.

The JW modifier is not used on claims for CAP drugs and biologicals.

CMS encourages physicians, hospitals and other providers and suppliers to care for and administer drugs and biologicals to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.

REPORTING DRUG WASTAGE

Chapter 17 Drugs and Biologicals of the CMS Medicare Claims Processing Manual, Paragraph 40, "Discarded Drugs and Biologicals" provides instructions on billing. Below are a link and excerpts from the manual.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf#

40 - Discarded Drugs and Biologicals
(Rev. 3538, 06-09-16, Effective: 01-01-17, Implementation: 01-03-17)

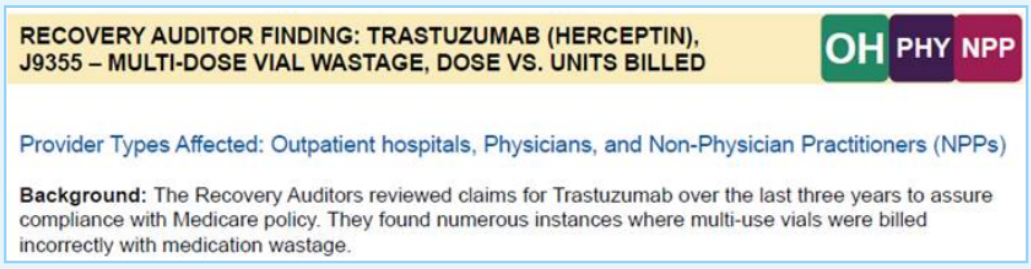
The CMS encourages physicians, hospitals and other providers and suppliers to care for and administer drugs and biologicals to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.

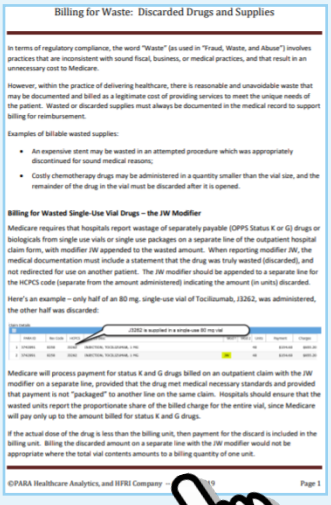
When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

...

NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

In the January 2020, Medicare Quarterly Provider Compliance Newsletter (attached), Medicare RAC auditors found billing errors with drug wastage reported on multi-use vials. While the topic focused around the specific drug Trastuzamab, Medicare reminds providers that multi-dose vial wastage is not subject to payment. We have attached related papers from our **PARA** library.



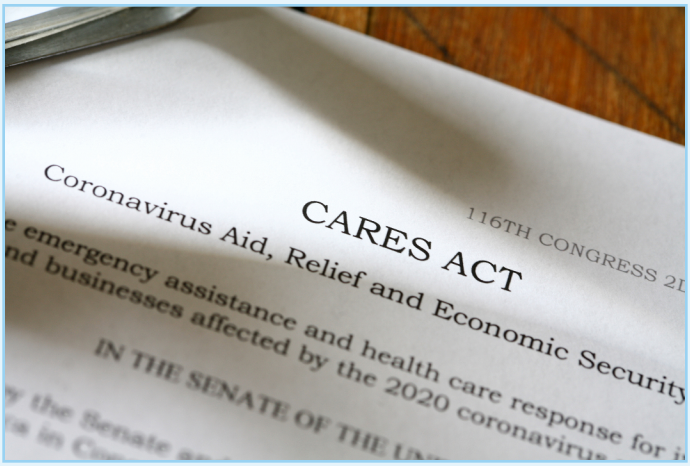


BALANCE BILLING FOR COVID-19 UNDER CARES ACT RULES

Q. Can you provide some more guidance on the prohibition on balance billing patients who received care or testing for COVID-19?

A. **Answer:** For the record, your question arises from the following entry in the "Terms and Conditions" for provider relief funds authorized by the CARES Act and the Families First Corona Virus Relief Act:

https://www.hhs.gov/sites/default/files/terms-and-conditions-provider-relief-20-b.pdf



"...The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient. ..."

Balance billing refers to the healthcare provider's practice of rejecting a commercial plan's contractual discount if no contract exists between the insurer and the provider. Some commercial plans will attempt to take a "contractual" discount on the remittance advice even if the plan has no contract. However, unless state law precludes balance billing, providers are not required to accept the non-contracted plan's discount and may simply bill the patient for the balance after insurance payment, including any amount the commercial carrier asked the provider to write off.

HealthCare.gov offers the following layperson's definition:

https://www.healthcare.gov/glossary/balance-billing/

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

The CARES/FFCRA funding restrictions against balance billing for COVID-19 patient care does not necessarily mean the hospital has to accept whatever amount the insurer adjudicates without recourse, but it removes the most effective recourse (balance billing the patient) from the facility's options. It means mainly that the dispute is between the provider and the plan, and the patient's pocketbook cannot be used as leverage.

BALANCE BILLING FOR COVID-19 UNDER CARES ACT RULES

Incidentally, under the Affordable Care Act (Public Health Service Act ("PHSA") §2719A), most plans are required to cover emergency treatment expenses billed by an out-of-network provider using one of the following methods (commonly referred to as the "Greatest of Three"):

1. The median amount negotiated with in-network providers for the emergency service provided
2. The amount paid for the service according to the generally utilized method for out-of-network services (such as the Usual, Customary, and Reasonable amount); or
3. The amount that would be otherwise paid to Medicare for the emergency service

The plan is required to disclose the process used to calculate the amount under the minimum payment standards.

Our responses to your specific questions are provided in italics after each question:

We are trying to gain a better understanding of billing for COVID-19 services under the CAREs Act. In the Terms and Conditions of the CAREs Act, the hospital is not allowed to balance bill a patient for COVID-19 related services for actual and presumptive cases of COVID-19.

1.Does **PARA** have any advice in regards to balance billing of COVID-19 services? Who or what can be balance billed?

Answer: For patient care that is clearly non-COVID-19 (i.e. trauma, elective procedures, emergency appendectomy, heart attack, etc.) no change is necessary to current hospital billing processes for insured patients.

If the patient is insured, and receives care that results in testing for COVID-19 and/or treatment following a positive COVID-19 test, the hospital may bill the patient only that amount which the insurer adjudicates to patient liability, whether or not the insurer has a contract with the hospital.

If the patient is uninsured, and receives care that results in testing for COVID-19 and/or treatment following a positive COVID-19 test, the hospital should submit its claim to HRSA at the link below – and refrain from billing the patient -- accept payment from HRSA as payment in full.

https://www.hrsa.gov/CovidUninsuredClaim

BALANCE BILLING FOR COVID-19 UNDER CARES ACT RULES

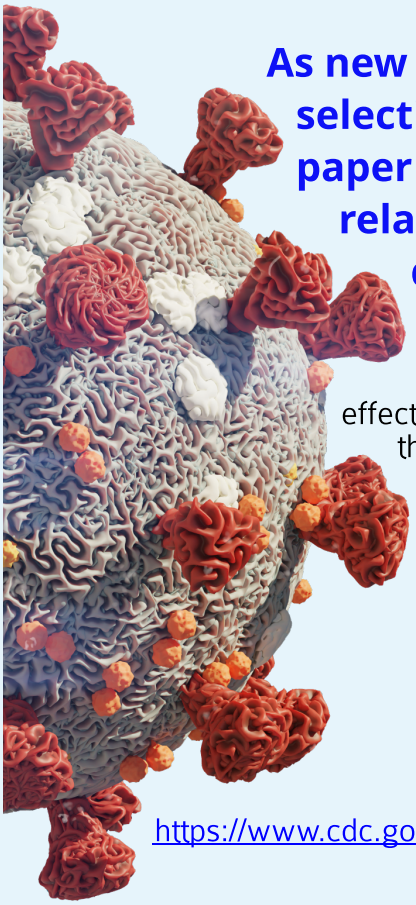
2. What is your advice about the definition of "Presumptive" COVID-19? Does this include all patients who have signs and symptoms that may indicate a possible COVID-19 diagnosis but that test negative for COVID-19? Is it only patients with a diagnosis of U07.1 – COVID-19 in the medical record? (Even if they do not have a positive COVID-19 test at our facility.)

Answer: PARA views the phrase "presumptive or actual case of COVID-19" to include patient balances for the evaluation and treatment of symptoms that caused a physician/non-physician practitioner to order a test for COVID-19, or express the desire to test when testing was either unavailable or was not performed because the case did not meet the strict criteria imposed on testing at the outset of the National Health Emergency.

Treatment provided under these circumstances would be covered by the clause, whether or not the testing was positive, to include all treatment until the time that testing determined the patient to be negative for COVID-19.

For the record, HHS has not yet offered elaboration on this topic, and our interpretation may or may not meet the expectations of that agency.

PARA CORONAVIRUS CODING -- UPDATED 6-5-2020



As new clinical information becomes available, coding selection may be revised. The codes referenced in this paper provide information on the coding of encounters related to Coronavirus. Medical record documentation needs to support all coding selections.

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

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

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

g. Coronavirus Infections

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

https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

Confirmed Cases

For confirmed cases of COVID-19, report ICD-10 CM **code U07.1 (COVID-19)**. On Wednesday, March 18, 2020, the Centers for Disease Control (CDC) announced that the ICD-10-CM diagnosis code, previously slated to be effective October 1, 2020, will now be effective April 1, 2020. Report U07.1 for confirmed or presumptive positive COVID-19 cases.Presumptive positive tests are those that have shown positive at the state or local level; the Centers for Disease Control does not have to confirm the result.

Except in cases of obstetric patients, sequence U07.1 first, followed by appropriate codes for associated manifestation(s). Patients who are admitted or present for a healthcare encounter because of confirmed COVID-19 during pregnancy, childbirth, or post-partum should be reported with a principal diagnosis of **O98.5 (Other viral diseases complicating pregnancy, childbirth and the puerperium.)** U07.1 should follow O98.5 then any appropriate codes for associated manifestation(s).

- Pneumonia confirmed as due to the COVID-19 - assign codes U07.1 (COVID-19) and **J12.89** (other viral pneumonia)
- Acute bronchitis confirmed as due to COVID-19, assign codes U07.1 (COVID-19) and **J20.8** (acute bronchitis due to other specified organisms)
- Bronchitis Not Otherwise Specified (NOS) due to the COVID-19, assign codes U07.1 (COVID-19) and **J40** (bronchitis, not specified as acute or chronic)
- Lower respiratory infection NOS confirmed as due to COVID-19, assign codes U07.1 (COVID-19) and **J22** (unspecified acute lower respiratory infection)
- Respiratory infection NOS confirmed as due to COVID-19, assign codes U07.1 (COVID-19) and **J98.8** (other specified respiratory disorders.)

PARA CORONAVIRUS CODING -- UPDATED 6-5-2020

Exposure to COVID-19

Report **Z03.818 (encounter for observation for suspected exposure to other biological agents ruled out)** when there is a concern of possible exposure to COVID-19, but after evaluation of the patient was ruled out.

Report **Z20.828 (contact with and (suspected) exposure to other viral communicable diseases)** when there is actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19 and the test on the patient is either negative or unknown. Report any signs or symptoms associated with COVID-19 if present in the patient.

Screening for COVID-19

Report **Z11.59 (encounter for screening for other viral diseases)** for COVID-19 screening of asymptomatic patients who have had no known virus exposure and the test results are either unknown or negative.

Signs and symptoms without a definitive diagnosis of COVID-19

For patients presenting with signs or symptoms of COVID-19 but do not have a definitive diagnosis of COVID-19, report the appropriate code(s) for any associated manifestations.

PARA Data Editor

ICD10 Codes

ICD10 Code	Description
R05	Cough
R0602	Shortness of breath
R509	Fever, unspecified
J1289	Other viral pneumonia
J208	Acute bronchitis due to other specified organisms
J22	Unspecified acute lower respiratory infection
J40	Bronchitis, not specified as acute or chronic
J80	Acute respiratory distress syndrome
J9601	Acute respiratory failure with hypoxia
J988	Other specified respiratory disorders

PARA CORONAVIRUS CODING -- UPDATED 6-5-2020

COVID-19 Swab Collection

Effective March 1, 2020, HCPCS **C9803** (hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source)) may be reported by outpatient hospitals for collecting COVID-19 test swabs.

Free-standing physician practices may report evaluation and management code CPT® **99211** for COVID-19 swab collection for both new and established patients when no other E/M service is rendered.

Independent labs may report G2023(specimen collection for severe acute respiratory syndrome coronavirus 2(SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source) and G2024 (specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source.

COVID-19 Lab Tests

Code selection depends on the payer and the test performed. Contact your local third-party payer directly to determine their specific reporting guidelines.

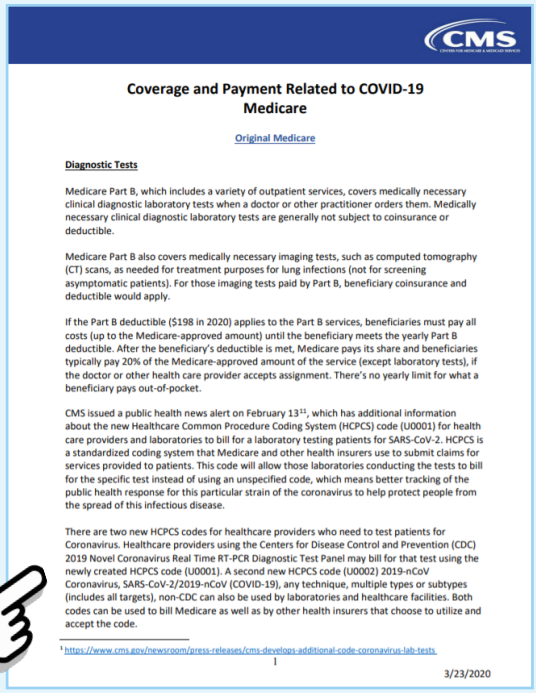
For Medicare, report the code that matches the test source (CDC or non-CDC) or the technique. They offer guidance at the link below:

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

"There are two new HCPCS codes for healthcare providers who need to test patients for Coronavirus. Healthcare providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the newly created HCPCS code (U0001). A second new HCPCS code (U0002) 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC can also be used by laboratories and healthcare facilities. Both codes can be used to bill Medicare as well as other health insurers that choose to utilize and accept the code.

"Additionally, on March 13, 2020, the American Medical Association (AMA) Current Procedural Terminology (CPT®) Editorial Panel has created CPT® code 87635 (Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique).

Laboratories can also use this CPT® code to bill Medicare if your laboratory uses the method specified by CPT® 87635."



CMS

Coverage and Payment Related to COVID-19
Medicare

Original Medicare

Diagnostic Tests

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

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

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

CMS issued a public health news alert on February 13[1], which has additional information about the new Healthcare Common Procedure Coding System (HCPCS) code (U0001) for health care providers and laboratories to bill for a laboratory testing patients for SARS-CoV-2. HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. This code will allow those laboratories conducting the tests to bill for the specific test instead of using an unspecified code, which means better tracking of the public health response for this particular strain of the coronavirus to help protect people from the spread of this infectious disease.

There are two new HCPCS codes for healthcare providers who need to test patients for Coronavirus. Healthcare providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the newly created HCPCS code (U0001). A second new HCPCS code (U0002) 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC can also be used by laboratories and healthcare facilities. Both codes can be used to bill Medicare as well as by other health insurers that choose to utilize and accept the code.

[1] https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests

1

3/23/2020

PARA CORONAVIRUS CODING -- UPDATED 6-5-2020

HCPCS	Description	Effective Date
U0001	CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel	02-04-2020
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC	02-04-2020
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique	03-13-2020

High throughput COVID-19 testing. A high-throughput machine requires specialized technical training. It can process more than 200 specimens a day.

U0003 (Infectious agent detection by nucleic acid (DNA or RNA) severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique), making use of high throughput technologies as described by CMS-2020-01-R).

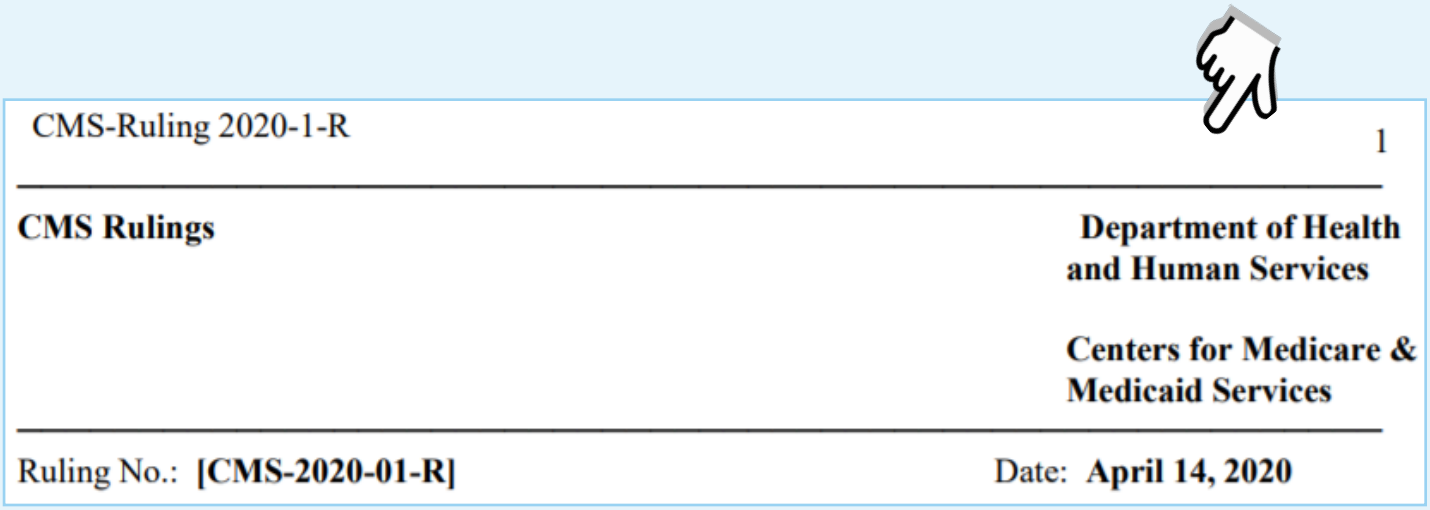
Report U0003 in place of tests normally reported as 87635(infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique)when high-throughput technology is used.

U0004 (2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.)

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

Medicare will pay $100 under the Clinical Lab Fee Schedule for Part B services. These codes should not be used when testing for COVID-19 antibodies.CMS provides a partial list of accepted technology high-throughput machines In Ruling **2020-1-R** dated April 14, 2020:

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



CMS-Ruling 2020-1-R 1

CMS Rulings

Department of Health and Human Services

Centers for Medicare & Medicaid Services

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

PARA CORONAVIRUS CODING -- UPDATED 6-5-2020

COVID-19 Antibody Testing.

Medicare instructs that for COVID-19 antibody testing performed in a single step (often a strip) with all critical components for the assay, 86328 is the most appropriate code to report.COVID-19 antibody testing reported as 86769 may involve multi-steps where a diluted sample is incubated in a sample plate.

HCPCS	Description	Effective Date
86328	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	04-10-2020
86769	Antibody; severa acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]}	04-10-2020

Payment rates for U0001, U0002, 87635, and the antibody testing are set at the MAC level and may vary by a few cents until Medicare establishes national payment rates using its annual process later this year. Payment information, by MAC, is at the following link:

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

MAC Jurisdiction	MAC States/Territories	U0001 Test Price	U0002 Test Price	87635 Test Price	86769 Test Price	86328 Test Price
J6 – NGS	Illinois, Minnesota, Wisconsin	$35.91	$51.31	$51.31	$42.13	$45.23
JK – NGS	Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	$35.91	$51.31	$51.31	$42.13	$45.23
JH – Novitas	Arkansas, Colorado, New Mexico, Oklahoma, Texas Louisiana, Mississippi	$35.92	$51.31	$51.31	$42.13	$45.23
JL – Novitas	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania; Part B services include Arlington and Fairfax counties in VA, and the city of	$35.92	$51.31	$51.31	$42.13	$45.23

Modifiers and Condition Codes during the PHE

Modifier CS

Effective March 18, 2020, under the under the Families First Coronavirus Response Act (FFCRA), Medicare will waive cost-sharing liability for certain evaluation and management services related to COVID-19 testing. The services must result either in an order or administration of COVID-19 testing or were provided to determine the need for a COVID-19 test. The evaluation and management may be provided either in person or through telehealth services.

PARA CORONAVIRUS CODING -- UPDATED 6-5-2020

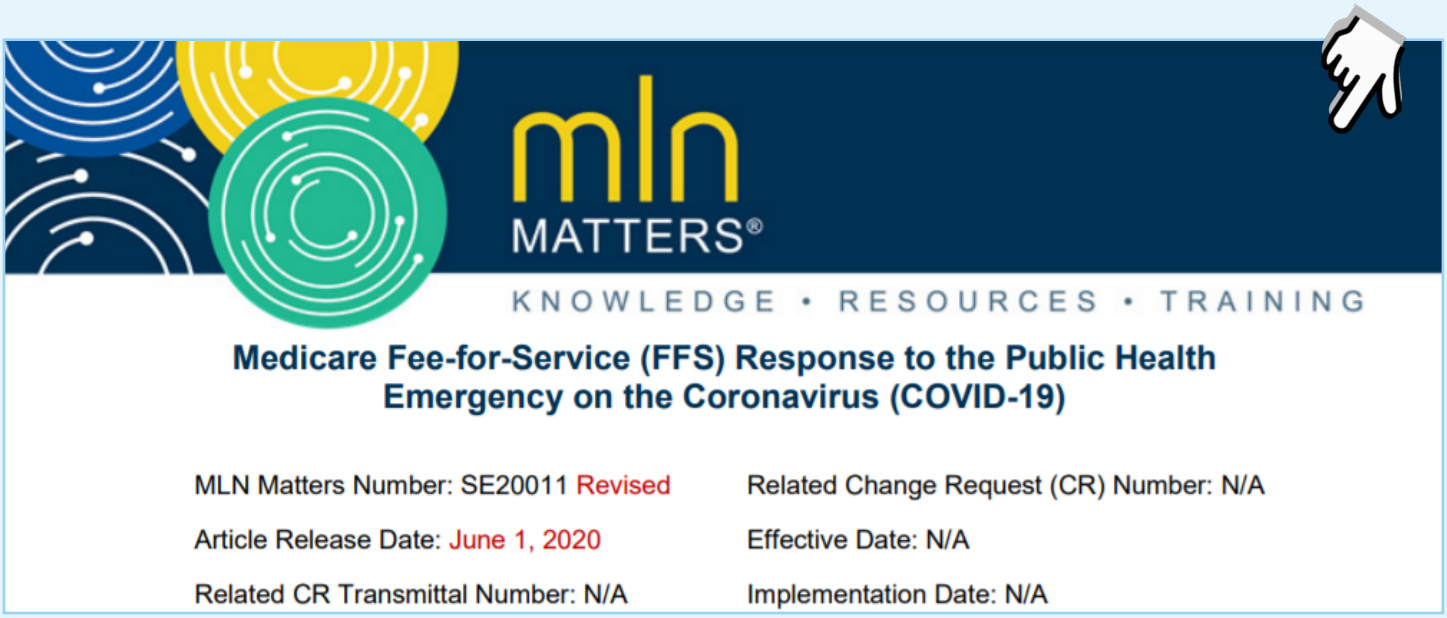
Condition Code DR/Modifier CR

CMS has instructed providers to report these codes when care is provided under one of the Section 1135 waivers to address the Public Health Emergency. These codes do not affect payment. They are not necessary on Medicare telehealth services.

When all services or items billed on the claim are related to a COVID-19 waiver, Condition Code DR is used by institutional providers and Modifier CR is for both institutional and non-institutional providers.

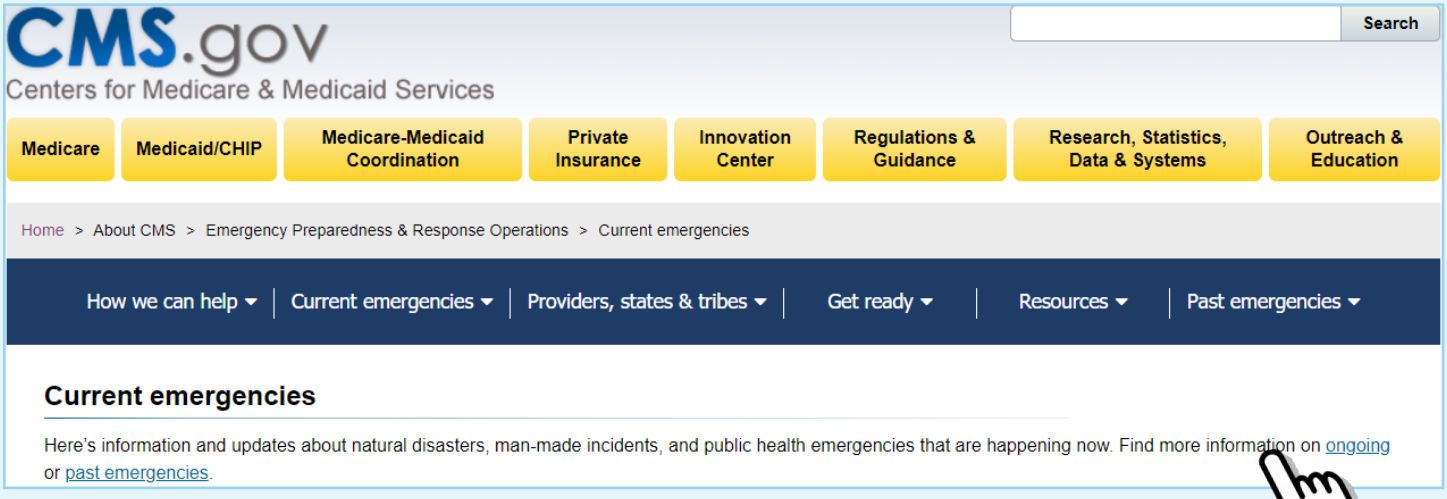
On June 1, 2020, CMS provided clarification on the use of these modifiers and condition code DR in MLN SE20011 "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19).

"This can be accessed at the following link: https://www.cms.gov/files/document/se20011.pdf



CMS continues to update billing and coding guidance through their "Frequently Asked Questions to Assist Medicare Providers" document published on their Current Emergencies page:

https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page



WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Several new charge processes for wound care take effect in July. This paper details how to determine coding and billing and provides various scenarios.

Visit – Evaluation and Management Levels

E&M levels are divided into two types of patient, new and established.For facility fee billing, a new patient is one who has not been a patient at the facility within the last three years. There are five levels for both the new and established patient visits; for facility fee billing, the E/M level assignment is determined by hospital policy. **PARA** recommends facility fee E/M level assignment in keeping with time spent in delivering face-to-face care.Although the level of E/M is important for commercial billing, Medicare requires OPPS facilities to report only one code regardless of the visit level, G0463.

HCPCS/CPT®
99201 - Office or other outpatient visit for the evaluation and management of a new patient, which requires 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.
99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded 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 of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99211 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
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.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

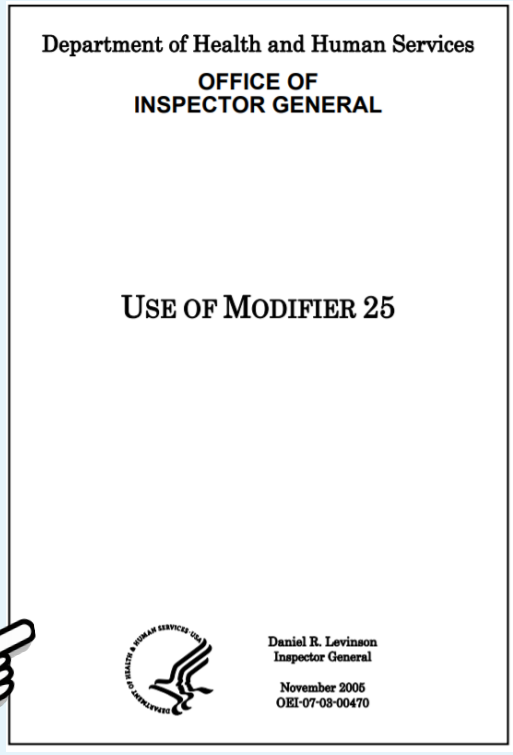
HCPCS/CPT® - continued
99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling 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. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214 - 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 detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215 - 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 comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
G0463 - hospital outpatient clinic visit for assessment and management of a patient

Modifier 25: In general, an E&M level should not be charged if the visit is scheduled to perform a procedure.If there is a separate and distinct reason for an E&M service which is beyond the routine patient interaction required to properly perform a procedure, such as a new diagnosis or condition or a new wound, a separate E&M may be billed.If an E&M is billed on the same date as a procedure, modifier "25 - separate and distinct" must be appended to the E&M code to qualify for payment.

Due to inappropriate use of modifier 25, the Health and Human Services Office of the Inspector General performed an investigation and issued a report of its findings.

http://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

"Medicare payments for medical procedures include payments for certain evaluation and management (E/M) services that are necessary prior to the performance of a procedure. The Centers for Medicare & Medicaid Services (CMS) does not normally allow additional payments for separate E/M services performed by a provider on the same day as a procedure. However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure, modifier 25 may be attached to the claim to allow additional payment for the separate E/M service. In calendar year 2002, Medicare allowed $1.96 billion for approximately 29 million claims using modifier 25."


Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

USE OF MODIFIER 25

Daniel R. Levinson
Inspector General

November 2005
OEI-07-03-00470

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Physician, Nursing and Rehab Therapists Procedures

Primary Wound Care (debridement & Negative Pressure Wound Therapy) Physicians, non-physician practitioners, nurses, and rehab therapists may report the following seven primary wound care procedures. (Rehab therapists and nurses charge a facility fee only in the hospital setting.)

97597 - Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598 - Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602 - Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session *[the word "larval" was added in 2017 CPT.]*
97605 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97607 - Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97608 - Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

There are several additional procedures performed by the Wound Care Staff on the referral of a physician or non-physician practitioner:

29445 - Application of rigid total contact leg cast
29580 - Strapping; Unna boot
29581 - Application of multi-layer venous wound compression system, below knee
29584 - Application of multi-layer compression system; upper arm, forearm, hand, and fingers

(Note -- Medicare considers the treatment of lymphedema with the application of high compression bandage system to be non-covered.)

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Physician and Non-Physician Practitioner Procedures

There are many procedures performed by physicians on wound care patients in the hospital outpatient setting.Non-physician practitioners (i.e. ARNP, PA) may also perform these if acting within state scope of practice laws applicable to their professional licensure.

These procedure HCPCS are eligible to be "split billed" in the outpatient hospital setting, meaning that both a professional and a technical component may be billed. The professional fee is reported on a CMS1500/837p claim form with a site of service indicator for a hospital outpatient (i.e. 18, 9, or 22); and the hospital charge is submitted on a facility fee claim form (UB04/837i) for the "technical" component of the procedure, as well as any separately billable supplies.

HCPCS/CPT®
11042 - Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043 - Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
11044 - Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
11045 - Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11046 - Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11047 - Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Attention to CPT® code definitions for debridement is important. Please note:

- CPT® codes 11042, 11043, 11044, 11045, 11046, and 11047 are used to report surgical removal (debridement) of devitalized tissue from wounds. CPT® codes 11042, 11043, 11044, 11045, 11046, and 11047 are payable to physicians and qualified non-physician practitioners licensed by the state to perform the services
- CPT® codes 97597 and 97598 are used to report selective (including sharp) debridement of devitalized tissue and are payable to physicians and qualified non-physician practitioners, licensed physical therapists and licensed occupational therapists
- CPT® code 97602 is used to report non-selective debridement
- Removal of non-tissue integrated fibrin exudates, crusts, biofilms or other materials from a wound without removal of tissue does not meet the definition of any debridement code and may not be reported as such.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Documentation of the debridement procedure in the 11042-11047 CPT® range should include the following components:

- A statement affirming whether the debridement was excisional
- The location, size, and condition of the wound
- The depth to which the wound was debrided
- The removal of devitalized or necrotic tissue
- A list of the surgical instrumentation used

Hyperbaric Oxygen Therapy (HBO)

Both HBO codes 99183 and G0277 are required to enable billing for both Medicare and non-Medicare patients; Medicare uses the G0277 code (which replaced the former Medicare code C1300), and commercial payers the 99183.

99183 - Physician attendance and supervision of hyperbaric oxygen therapy, per session
G0277 - Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval

There will be visits for which a procedure is not billable, and the patient is not seen by a Physician.An example of this type of visit would be a dressing change.In this instance a low-level E/M visit, such as 99211 (G0463 for Medicare) would be an appropriate charge level.

Documentation

All Nursing and Therapist procedures require a physician order, detail progress notes, and review and sign off of the progress notes by the attending Physician.

The limits of coverage of HBO Therapy warrants special attention. Medicare coverage rules are published in the form of NCDs and LCDs.The HHS Office of the Inspector General 2017 Workplan included an investigation to determine whether Medicare payments related to HBO outpatient claims were reimbursed in accordance with Federal requirements.Prior OIG reviews expressed concerns that

- Beneficiaries received treatments for noncovered conditions
- Medical documentation did not adequately support HBO treatments, and
- Beneficiaries received more treatments than were considered medically necessary

There are a number of restrictive LCDs for hyperbaric therapy. Readers are advised to check the **PARA Data Editor** and inform the Wound Care Department Managers on the specific LCD requirements applicable to HBO therapy at each facility.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Diagnostic testing

Wound care patients receive a number of diagnostic tests, the tests which are commonly performed in the department are as follows:

HCPCS/CPT®
93922 - Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)
93923 - Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924 - Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study
93925 - Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926 - Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study
93930 - Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931 - Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93965 - Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970 - Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971 - Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

Note that blood glucose testing prior to HBO therapy using a hand-held glucometer is considered "integral to" the HBO procedure, and should not be separately reported.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Application of Skin Substitutes

Effective January 1, 2014, Medicare created 8 new C-Codes to be used by OPPS hospitals when billing low-cost skin substitute wound care procedures.The 8 new codes mirror the 15271 through 15278 codes:

HIGH COST SKIN SUBSTITUTE PROCEDURES APC 0328 – LEVEL III SKIN REPAIR	LOW COST SKIN SUBSTITUTE PROCEDURES APC 0327 – LEVEL II SKIN REPAIR
15271 - 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	**C5271** - Application of **low cost** 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
15272 - application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	**C5272** - Application of **low cost** skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15273 - 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	**C5273** - Application of **low cost** 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
15274 - application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; **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)	**C5274** - Application of **low cost** skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; **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)
15275 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	**C5275** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; **each additional** 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	**C5276** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; **each additional** 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15277 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, 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	**C5277** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, 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
15278 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; **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)	**C5278** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; **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)

A list of the corresponding high-and low-cost substitute HCPCS follows:

High Cost Skin Substitute HCPCS List As Of July 1, 2020

HIGH COST SKIN SUBSTITUTE CATEGORY ASSIGNMENT (Bill with 1527X HCPCS Codes)			
HCPCS	**CY 2020 Short Descriptor**	**HCPCS**	**CY 2020 Short Descriptor**
C1849	Skin substitute, synthetic	Q4173	Palingen or palingen xplus
C9363	Integra meshed bil wound mat	Q4175	Miroderm
Q4101	Apligraf	Q4176	Neopatch, per sq centimeter
Q4103	Oasis burn matrix	Q4178	Floweramniopatch, per sq cm
Q4104	Integra bmwd	Q4179	Flowerderm, per sq cm
Q4105	Integra drt or omnigraft	Q4108	Integra matrix
Q4106	Dermagraft	Q4110	Primatrix
Q4107	Graftjacket	Q4121	Theraskin
Q4116	Alloderm	Q4123	Alloskin
Q4122	Dermacell, awm, porous sq cm	Q4141	Alloskin ac, 1cm
Q4126	Memoderm/derma/tranz/integup	Q4157	Revitalon 1 square cm
Q4127	Talymed	Q4158	Kerecis omega3, per sq cm
Q4128	Flexhd/allopatchhd/matrixhd	Q4164	Helicoll, per square cm
Q4132	Grafix core, grafixpl core	Q4180	Revita, per sq cm
Q4133	Grafix stravix prime pl sqcm	Q4181	Amnio wound, per square cm
Q4137	Amnioexcel biodexcel 1sq cm	Q4182	Transcyte, per sq centimeter
Q4138	Biodfence dryflex, 1cm	Q4183	Surgigraft, 1 sq cm
Q4140	Biodfence 1cm	Q4184	Cellesta or duo per sq cm
Q4143	Repriza, 1cm	Q4186	Epifix 1 sq cm
Q4146	Tensix, 1cm	Q4187	Epicord 1 sq cm
Q4147	Architect ecm px fx 1 sq cm	Q4188	Amnioarmor 1 sq cm
Q4148	Neox rt or clarix cord	Q4190	Artacent ac 1 sq cm
Q4150	Allowrap ds or dry 1 sq cm	Q4191	Restorigin 1 sq cm
Q4151	Amnioband, guardian 1 sq cm	Q4193	Coll-e-derm 1 sq cm
Q4152	Dermapure 1 square cm	Q4194	Novachor 1 sq cm
Q4153	Dermavest, plurivest sq cm	Q4195+	Puraply 1 sq cm
Q4154	Biovance 1 square cm	Q4196+	Puraply am 1 sq cm
Q4156	Neoxflo or clarixflo 1 mg	Q4197	Puraply xt 1 sq cm
Q4159	Affinity1 square cm	Q4198	Genesis amnio membrane 1 sqcm
Q4160	Nushield 1 square cm	Q4200	Skin te 1 sq cm
Q4161	Bio-connekt per square cm	Q4201	Matrion 1 sq cm
Q4163	Woundex, bioskin, per sq cm	Q4203	Derma-gide, 1 sq cm
Q4169	Artacent wound, per sq cm	Q4204	Xwrap 1 sq cm

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

HIGH COST SKIN SUBSTITUTE CATEGORY ASSIGNMENT (continued) (Bill with 1527X HCPCS Codes)			
Q4205	Membrane graft or wrap sq cm	Q4226	Myown harv prep proc sq cm
Q4208	Novafix per sq cm	Q4217	Woundfix biowound plus xplus
Q4209	Surgraft per sq cm	Q4218	Surgicord per sq cm
Q4210	Axolotl graf dualgraf sq cm	Q4219	Surgigraft dual per sq cm
Q4211	Amnion bio or axobio sq cm	Q4220	Bellacell hd, surederm sq cm
Q4214	Cellesta cord per sq cm	Q4221	Amniowrap2 per sq cm
Q4216	Artacent cord per sq cm	Q4222	Progenamatrix, per sq cm

+Q4195 and Q4196 are status G "pass-through" under OPPS; these will be paid separately, and the reimbursement rate for the high-cost application code 1527X will be reduced accordingly.

Low Cost Skin Substitute HCPCS List As Of July 1, 2020

Since these codes are OPPS APC status N, the reimbursement under OPPS APC methodology is made solely on the application code, not the skin substitute:

LOW COST SKIN SUBSTITUTE CATEGORY ASSIGNMENT (Bill with C527X HCPCS Codes)			
HCPCS	Description	HCPCS	Description
Q4101	Skin Substitute, NOS (Use this code for products without an assigned HCPCS)		
Q4102	Oasis Wound Matrix	Q4180	Revita, per sq cm
Q4111	Gammagraft	Q4181	Amnio wound, per sq cm
Q4115	Alloskin	Q4182	Transcyte, per sq cm
Q4117	Hyalomatrix	Q4227	Amniocore per sq cm
Q4124	Oasis Tri-layer Wound Matrix	Q4228	Bionextpatch, per sq cm
Q4134	hMatrix	Q4229	Cogenex amnio memb per sq cm
Q4135	Mediskin	Q4232	Corplex, per sq cm
Q4136	Ezderm	Q4234	Xcellerate, per sq cm
Q4165	Keramatrix, per square cm	Q4235	Amniorepair or altiply sq cm
Q4166	Cytal, per square cm	Q4236	Carepatch per sq cm
Q4167	Truskin, per square cm	Q4237	cryo-cord, per sq cm
Q4170	Cygnus, per square cm	Q4238	Derm-maxx, per sq cm
Q4176	Neopatch, per sq cm	Q4239	Amnio-maxx or lite per sq cm
Q4178	Floweramniopatch, per sq cm	Q4247	Amniotext patch, per sq cm
Q4179	Flowerderm, per sq cm	Q4248	Dermacyte Amn mem allo sq cm

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Medications

The majority of medications provided to a wound care patient in an outpatient setting are topical and oral drugs which are considered by Medicare to be "self-administered drug" (SAD).SADs are non-covered under the Medicare program and must be billed to the patient if separately charged.Injections are usually billed to the Program as a covered benefit, but each MAC may publish a list of injectable drugs deemed "self-administered."Certain medications may be considered "integral to" a procedure and not separately billed, or reported as a supply, without a HCPCS code, under revenue code 0270.

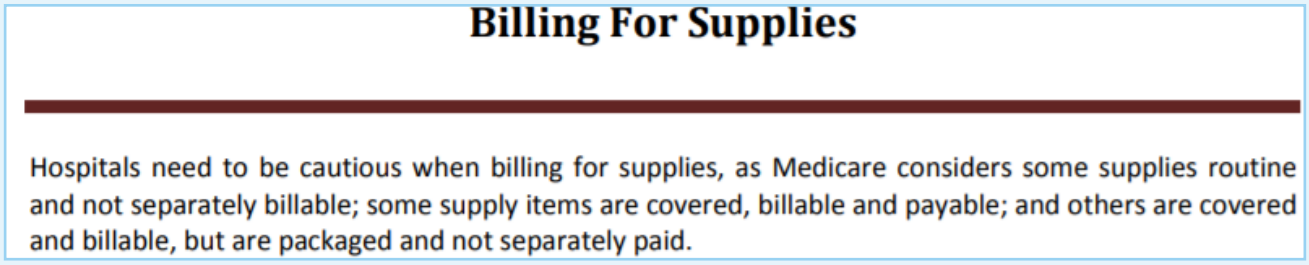
Medical supplies/Dressings

Medical supplies provided to a patient in an outpatient setting are billable to the program, there is very little reimbursement associated with the billing of supplies for an OPPS hospital, as the supply cost is "packaged" into the reimbursement for the procedure.

Dressings which are routine and commonly used should be considered covered by the procedure facility fee.Expensive dressings, such as silver-impregnated or other medicated dressings, may be separately charged in revenue code 0270 (general supplies) or revenue code 0272 (sterile supplies.)

Refer to **PARA's** "Billing for Supplies" document for further information at

https://apps.para-hcfs.com/pde/documents/Billing_For_Supplies_April_2014.pdf



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.

Mechanically Powered Negative Pressure Wound Therapy

NPWT using Durable Medical Equipment (not disposable cartridge dressings) are billed by providers with CPT®s 97605-97606 – the NPWT durable medical equipment is billed by a DME provider:

Hcpcs/CPT®
97605 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Negative pressure wound therapy using disposable devices are not covered under the Medicare DME benefit but covered under Part B medical benefits. These two codes (97607 and 97608) provide payment to cover both the device and the procedure to apply it. On facility claims, the supply of the disposable NPWT cartridge is reported under revenue code 0272 (Sterile Supply) without a HCPCS. On a professional fee claim, no separate reporting for the supply is necessary or appropriate.

HCPCS/CPT®
97607 - Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97608 - Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Local Coverage Determinations

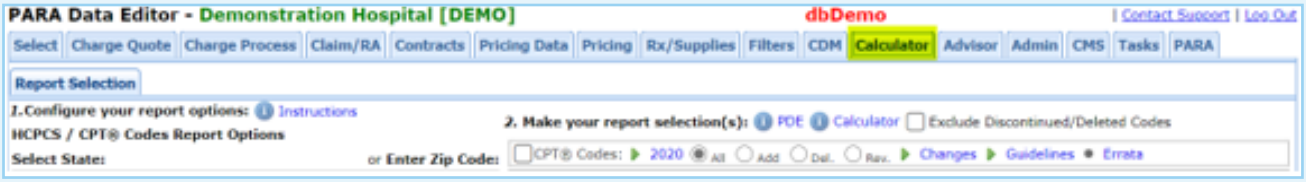
Medicare LCDs are a "must read" for the Wound Care Manager.

Medicare Administrative Contractors (MACs) are authorized to establish payment policies which are published in "Local Coverage Determination" (LCD) documents.It is important to review LCDs published by the jurisdiction MAC to fully understand Medicare coverage restrictions, billing requirements and payment policies.

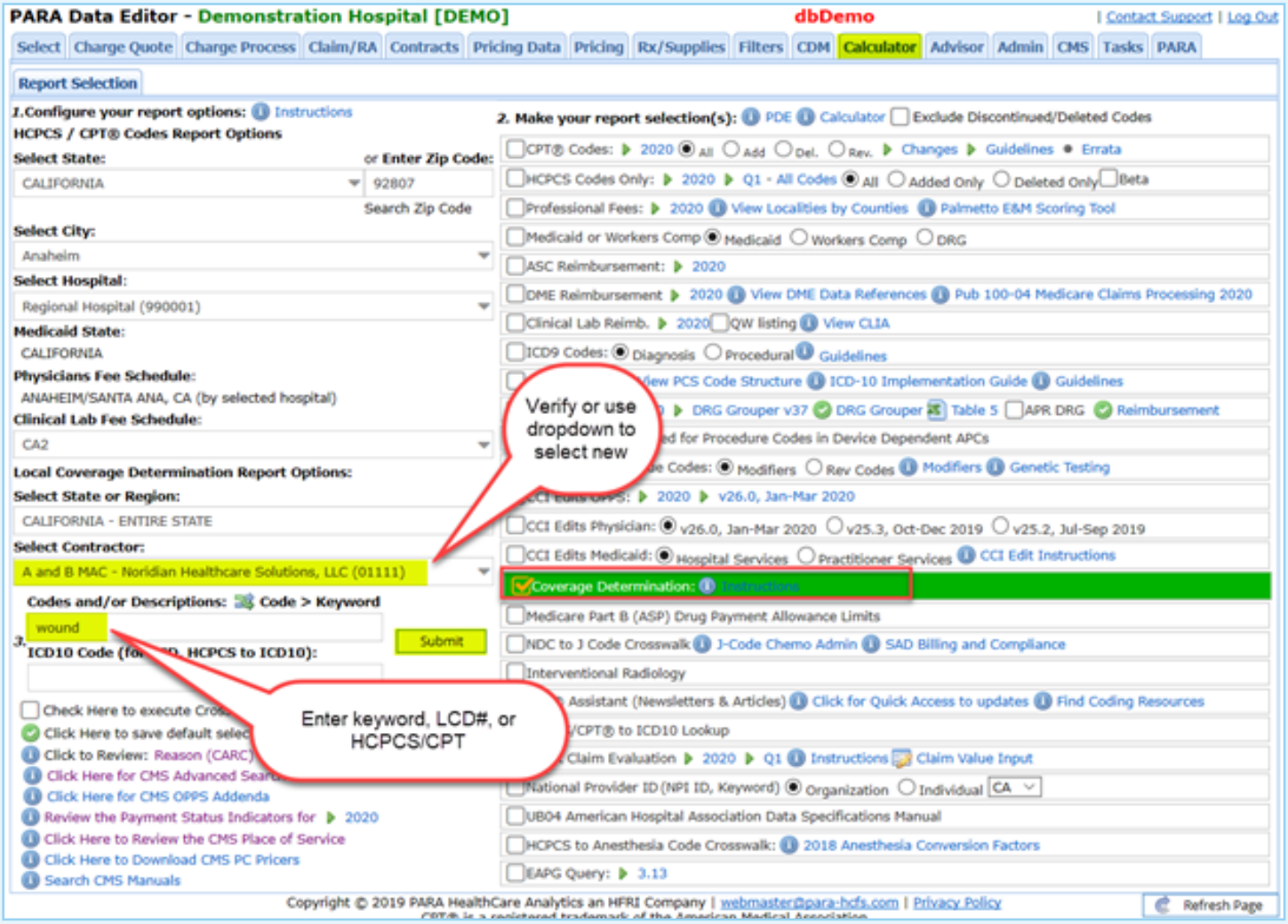
There are many LCDs for wound care procedures including strapping, casting, Unna boot application, muscle testing, range of motion testing and physical therapy evaluation and procedure codes.
The **PARA Data Editor Calculator** tab offers users a convenient means of accessing:

- Local Coverage Determinations – documents which specify coverage limitations and, in many cases, diagnosis codes which satisfy medical necessity standards;
- Local Coverage Articles – informational publications offered by Medicare Administrative Contractors as companion documents to LCD's which provide coding and billing codes
- National Coverage Determinations – General Medicare policy toward coverage of a particular service

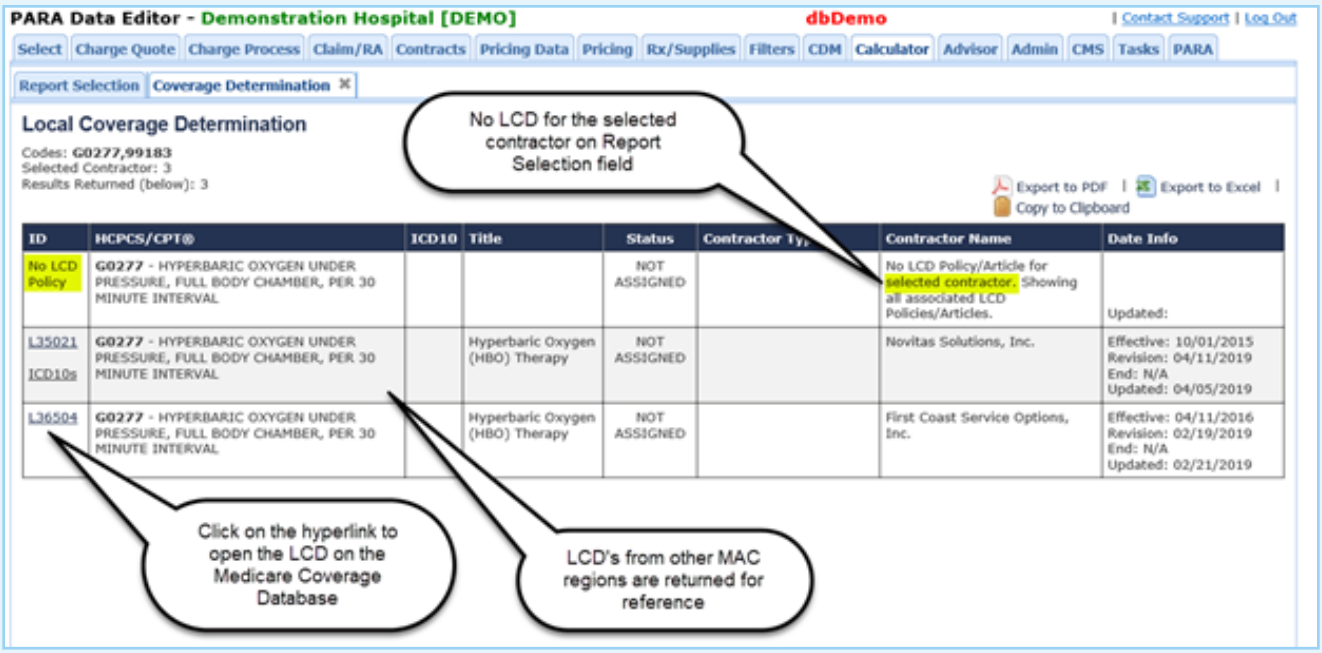
The **PARA Data Editor Calculator** tab offers a search function for LCDs, LCAs, and NCs:



WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

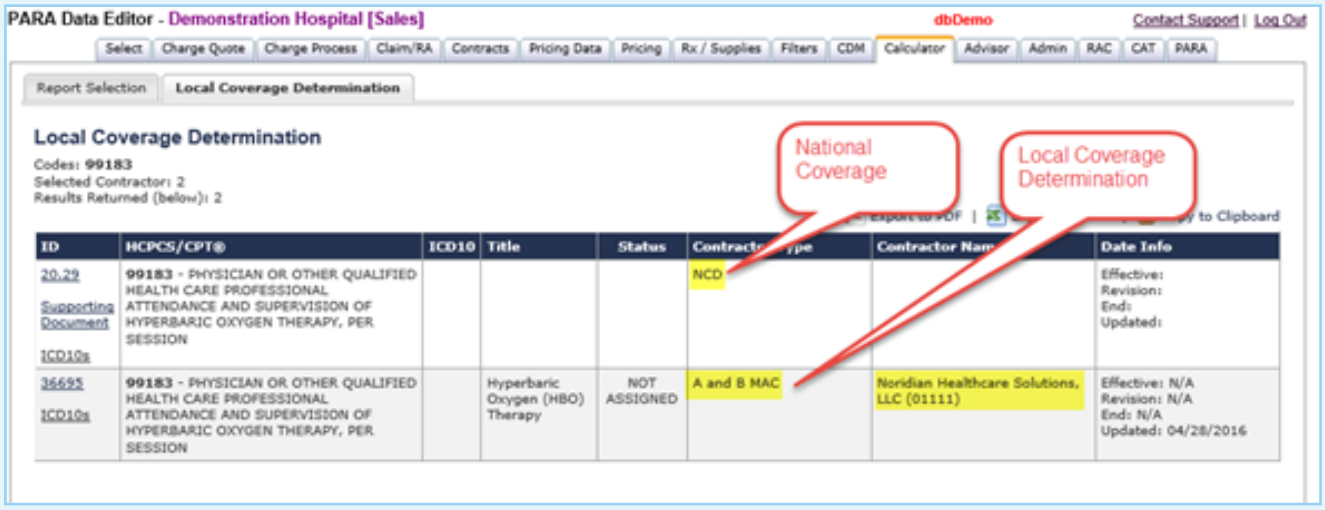


The report returned offers a hyperlink and summary information about the effective date.



WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

In addition to LCDs, the **PARA Data Editor Calculator** search will return National Coverage Determinations.For example, a search for HCPCS 99183 (Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session) reveals both a local and a national coverage determination:



Links to a few LCDs pertaining to wound care in effect by various MACs are provided below.

The MAC for JH and JL, Novitas applies LCD L35125:

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35125&ver=71&articleId=53781&SearchType=Advanced&CoverageSelection=Local&ArticleType=BC%7cSAD%7cRTC%7cReg&PolicyType=Both&s=All&CntrctrType=12&KeyWord=Wound&KeyWordLookUp=Title&KeyWordSearchType=Exact&kq=true&bc=EAAAABAAAAAA&

Local Coverage Determination (LCD): WOUND Care (L35125)

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

This LCD does not address specific wound care procedures described by NCD's and other items such as:

- Hyperbaric Oxygen (HBO) Therapy (See LCD L35021)
- Initial physical therapy or occupational therapy evaluations (See LCD L35036)
- Skin Substitutes for Wound Care (See LCD L35041)
- Electrical Stimulation and Electromagnetic Therapy of Specified Wounds (See NCD 270.1)
- Strapping (See LCD L36423)
- Treatment of burns

For the purposes of this LCD, wound care is defined as care of wounds that are refractory to healing or have complicated healing cycles either because of the nature of the wound itself or because of complicating metabolic and/or physiological factors. This definition excludes the following:

- Management of acute wounds, or
- The care of wounds that normally heal by primary intention such as clean, incised traumatic wounds, or
- Surgical wounds that are closed primarily and other postoperative wound care not separately covered during the surgical global period.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Palmetto offers specific guidance on billing the SNaP negative pressure wound care treatment:

https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=53781&ver=15&SearchType=Advanced&CoverageSelection=Local&ArticleType=BC%7cSAD%7cRTC%7cReg&PolicyType=Both&s=All&CntrctrType=12&KeyWord=Wound&KeyWordLookUp=Title&KeyWordSearchType=Exact&kq=true&bc=EAAAABAAAAAA&

Article Guidance

Article Text:

Effective for dates of service on and after January 1, 2013, Palmetto GBA will reimburse Smart Negative Pressure (SNaP®), a process that combines a suction device with an advanced hydrocolloid **WOUND** dressing. SNaP® delivers constant and controlled levels of negative pressure to facilitate the healing of the following types of open **WOUND**s:

•Stage III and IV pressure ulcer

•Neuropathic (diabetic) ulcer

•Chronic (present for at least 30 days) ulcer of mixed etiology

•Venous or arterial insufficiency ulcer

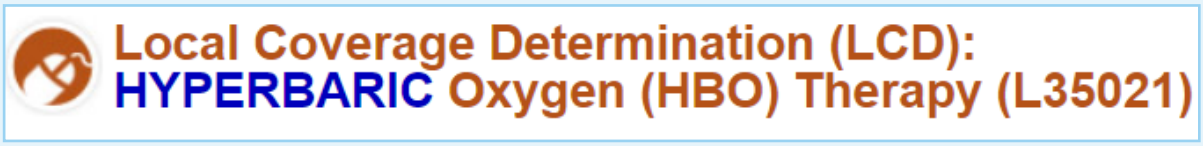
•Complications of a surgically created **WOUND**

•Traumatic **WOUND**

Palmetto GBA expects providers to utilize all accepted **WOUND** care standards prior to using SNaP®.

Novitas has published an LCD on hyperbaric therapy:

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35021&ver=162&SearchType=Advanced&CoverageSelection=Local&ArticleType=BC%7cSAD%7cRTC%7cReg&PolicyType=Both&s=All&KeyWord=hyperbaric&KeyWordLookUp=Title&KeyWordSearchType=Exact&kq=true&bc=EAAAABAAAAAA&



Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

For purposes of coverage under Medicare, **HYPERBARIC OXYGEN THERAPY (HBOT)** is a modality in which the ***entire body is exposed to oxygen under increased atmospheric pressure***. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O_2) at greater than one atmosphere pressure. Either a mono-place chamber pressurized with pure O_2 or a larger multi-place chamber pressurized with compressed air where the patient receives pure O_2 by mask, head tent, or endotracheal tube may be used.

HYPERBARIC OXYGEN therapy serves four primary functions:

1. It increases the concentration of dissolved OXYGEN in the blood, which augments oxygenation to all parts of the body; and
2. It replaces inert gas in the bloodstream with OXYGEN, which is then metabolized by the body; and
3. It may stimulate the formation of a collagen matrix and angiogenesis; and
4. It acts as a bactericide for certain susceptible bacteria.

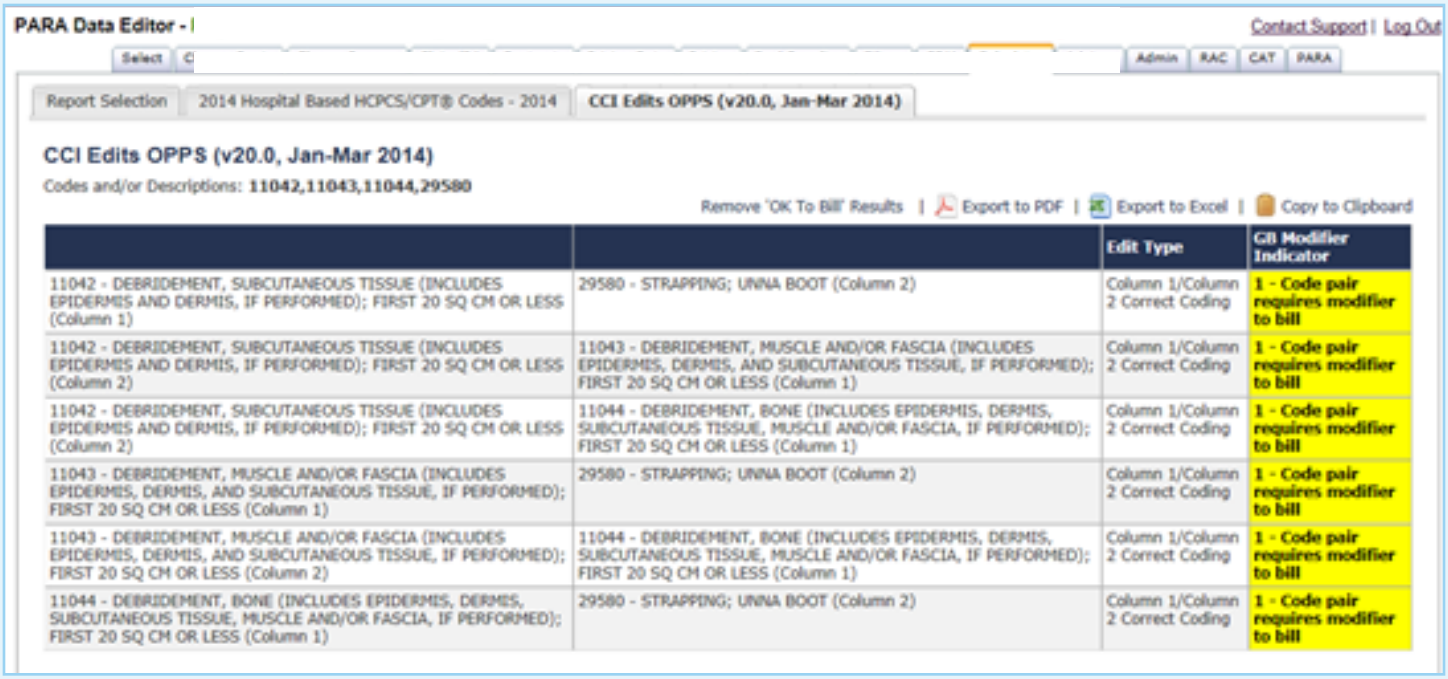
Developed as treatment for decompression illness, this modality is an established therapy for treating medical disorders such as carbon monoxide (CO) poisoning, gas gangrene, acute decompression illness and air embolism. Hyperbaric oxygen (HBO) therapy is also considered acceptable as adjunctive therapy in the treatment of sequella of acute vascular compromise and in the management of some disorders that are refractory to standard medical and surgical care or the result of radiation injury.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Wound Care Coding Scenarios

Scenario #1: An established patient presents with an open wound along an incision in the right lower extremity, and an open wound of the left lower extremity. Our usual weekly visit services include debridement of devitalized tissue to both sites, then application of Unna boots to both lower extremities. Usually we would charge one selective debridement and one Unna boot.

Answer: Due to Correct Coding Initiative edits, an Unna Boot and a debridement cannot be billed together for treatment of the same area.



		Edit Type	GB Modifier Indicator
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	29580 - STRAPPING; UNNA BOOT (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 2)	11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 2)	11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	29580 - STRAPPING; UNNA BOOT (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 2)	11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	29580 - STRAPPING; UNNA BOOT (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill

Since both debridement and an Unna boot cannot be charged together for the same leg, charge the highest-paying completed service per leg.Medicare facility fee reimbursement (national unadjusted rates) indicate the debridement procedures offer higher reimbursement:

HCPCS/CPT®	OPPS Status	Physician Fee Schedule	OPPS Facility Reimbursement
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS	T	(P-Fac):$67.62 (P-NonFac):$144.86	$319.51
11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS	T	(P-Fac):$170.31 (P-NonFac):$262.40	$497.02
11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS	J1	(P-Fac):$248.91 (P-NonFac):$350.77	$1,372.60
29580 - STRAPPING; UNNA BOOT	T	(P-Fac):$29.67 (P-NonFac):$72.53	$133.74

If Unna Boot 29580 is reported for both legs, code one line of one unit each with the modifier 50 appended.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Scenario #2: Patient presents with five wounds and sutures on the right lower extremity. The physician examines the patient and orders sutures to be removed, continue the Unna boots. Can we charge an E/M level 3 (follow-up, 2-5 wounds, suture removal =60 points) AND for 2 Unna boot applications?

Answer: Since the scenarios imply an established patient ("continue the Unna boots"), no separate E/M code should be billed.Since the examination involved removing the Unna boots, examining the wounds, removing sutures, and re-applying Unna boots, the evaluation and management provided is covered within the reimbursement for the Unna boot procedure alone. The removal of sutures is insignificant and does not justify a separate E/M.

If this had been a new patient, the first-time evaluation by the physician coupled with suture removal could sufficiently support billing a separate and distinct E/M service.In that case, modifier -25 should be appended to the E/M.

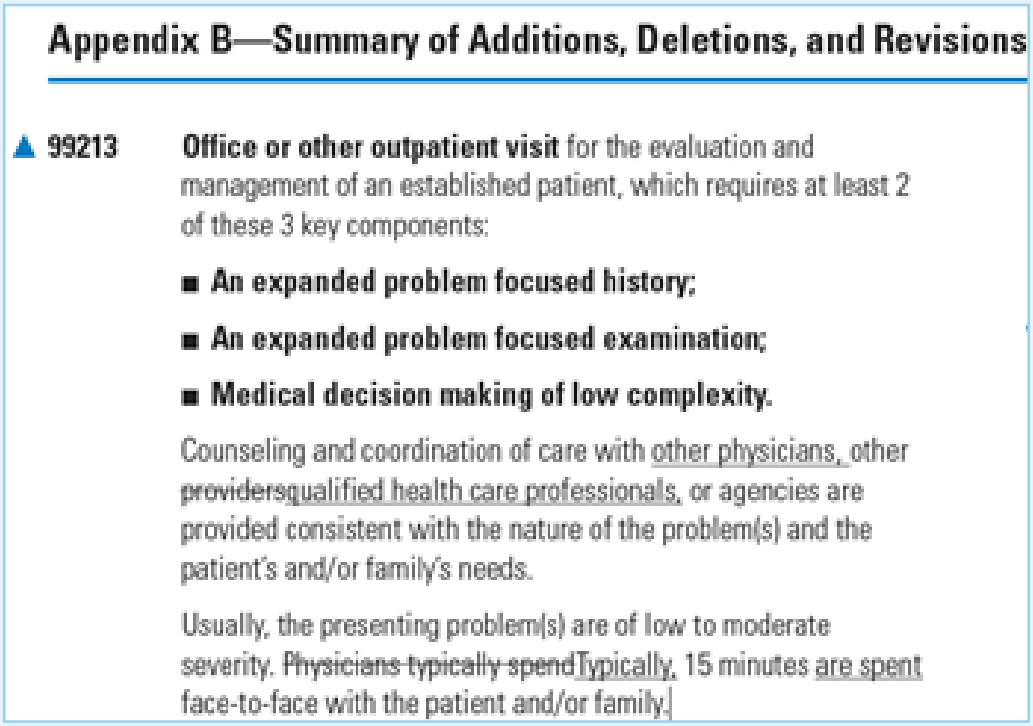
Scenario 3: An established patient came in for her first wound care visit, referred by her family physician.The wound clinic RN assessed and called the physician for orders. The patient requires a Hoyer lift, therefore additional staff is required, and patient is unable to assist with undressing or dressing. Culture was obtained, pulses assessed--care takes well over an hour, no procedure was performed.Are we limited to charge only a nursing visit E/M level 99211, or can we charge a higher level such as 99212-99215?

Answer: You are not necessarily limited to 99211; the facility may charge a higher level E/M if the facility point-based system for assigning the level supports it.The fact that the ordering physician has not personally examined the patient at the time of initial assessment does not affect the facility E/M code.In 2013, CPT® Evaluation and Management code descriptions were modified to remove physician-only language:

Code the level of the E/M according to the facility's E/M level assignment criteria. Note that effective 1/1/2014, Medicare requires G0463 in lieu of 99201-99215.

Code the level of the E/M according to the facility's E/M level assignment criteria.

Note that effective 1/1/2014, Medicare requires G0463 in lieu of 99201-99215.



Appendix B—Summary of Additions, Deletions, and Revisions

▲ **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 ~~providers~~qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. ~~Physicians typically spend~~Typically, 15 minutes are spent face-to-face with the patient and/or family.

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Scenario 4: We have been seeing a patient for debridement of lower extremity ulcers and application of Unna boots bilaterally. During the visit, the patient is measured for a pressure garment. The patient requires assistance in dressing, and additional staff to help transfer the patient to and from a wheelchair is required.Can we charge a level 3 E/M and the procedure code?

Answer: No; although additional resources were used to dress and move the patient, an E/M may not be billed because the services were not "separate and distinct" from the billable procedures.

Scenario 5: We have been seeing a patient who presents with no new signs or symptoms; we perform debridement to wounds on the lower extremities and apply Unna boots bilaterally.Additional staff is required due to the emotional state of the patient. During the visit, the physician examines the patient and decides to do a puncture biopsy. Can we charge a level 2 E/M (99212) and the puncture biopsy as well as the debridement?

Answer:For an established patient, you may charge the E/M for the additional resources above and beyond an ordinary patient encounter only if the additional resources (such as staff time) are documented as separate and distinct from the billable procedures. Nursing care addressing the emotional state of the patient may qualify if the documentation sufficiently demonstrates that the additional resources required were more than incidental in nature.

Among the three procedures described (debridement, puncture biopsy, Unna boot), only the debridement should be billed.CCI edits do not permit a puncture biopsy performed on the same site as the debridement to be separately billed. A modifier indicating the biopsy was performed on a site other than that of the debridement is required to bill 97597 with 11000.

Prime CPT©	Second CPT©	Modifier Indicator
11104 - PUNCH BIOPSY OF SKIN (INCLUDING SIMPLE CLOSURE, WHEN PERFORMED); SINGLE LESION (Column 1)	97597 - DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL AND FORCEPS), OPEN WOUND, ...PER SESSION, TOTAL WOUND(S) SURFACE AREA; FIRST 20 SQ CM OR LESS (Column 2)	1 - Code pair requires modifier to bill

Here is the pertinent excerpt from the 2020 National Correct Coding Initiative manual:

https://apps.para-hcfs.com/para/documents/Chapter3_CPTCodes10000-19999_Final_11.12.19.PDF

"The HCPCS/CPT® codes for lesion removal include the procurement of tissue from the same lesion by biopsy at the same patient encounter. CPT® codes 11100-11101 (biopsy of skin, subcutaneous tissue and/or mucous membrane) should not be reported separately. CPT® codes 11100-11101 may be separately reportable with lesion removal HCPCS/CPT® codes if the biopsy is performed on a different lesion than the removal procedure."

WOUND CARE CHARGE PROCESS -- UPDATE JULY, 2020

Scenario 5 - continued

Additionally, according to Medicare's 2014 Correct Coding Initiative Manual, the Unna boot application (HCPCS 29580) should not be reported separately when debridement is performed:

"...Casting/splinting/strapping should not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed.Additionally casting/splinting/strapping CPT® codes should not be reported for application of a dressing after a therapeutic procedure.

Several examples follow:

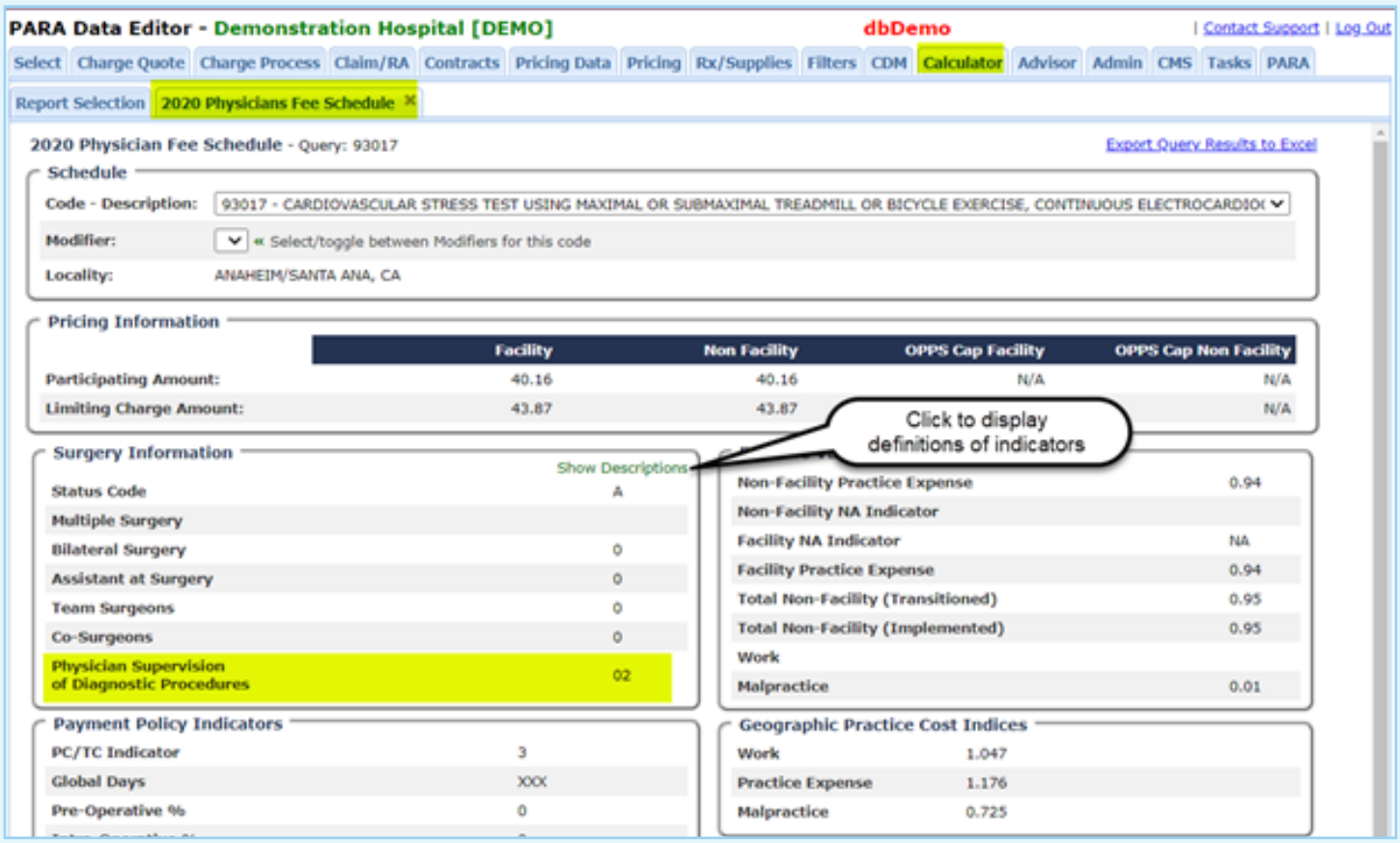
1) If a provider injects an anesthetic agent into a peripheral nerve or branch (CPT® code 64450), the provider should not report CPT® codes such as 29515, 29540, or 29580 for that anatomic area;

2) A provider should not report a casting/splinting/strapping CPT® code for the same site as an injection or aspiration (e.g., CPT® codes 20526-20615); Debridement CPT® codes (e.g., 11042-11044, 97597) and grafting CPT® codes (e.g.,15040-15776) should not be reported with a casting/splinting/strapping CPT® code (e.g., 29445, 29580, 29581) for the same anatomic area."

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%7cFAO&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.

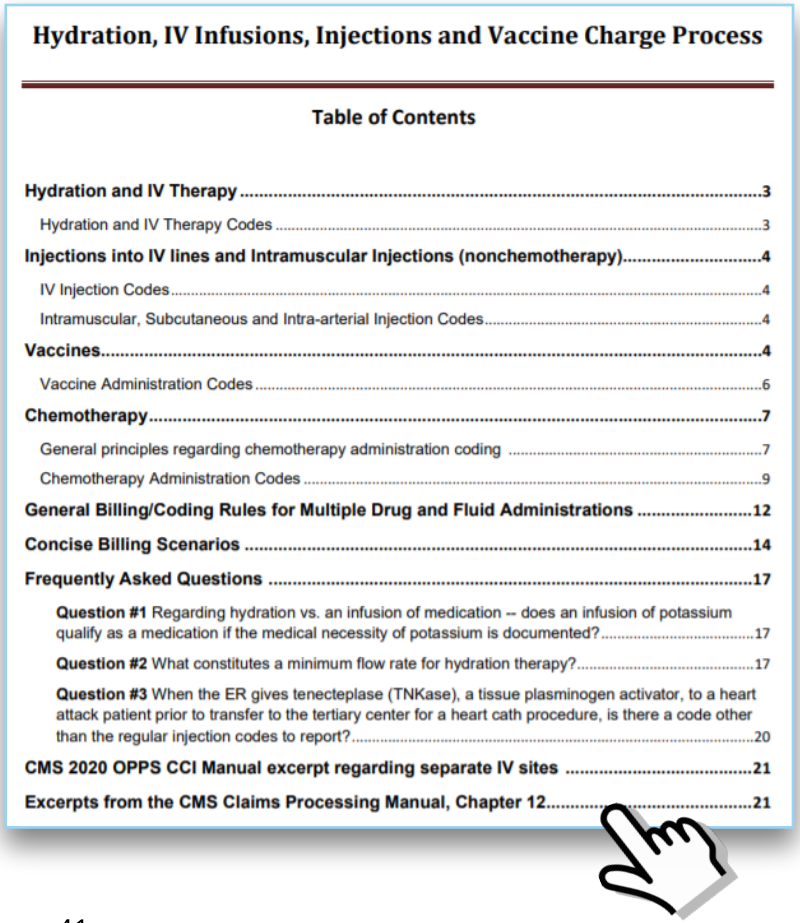
B) Training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty in the United States or must reflect equivalent education, training, and expertise endorsed by an academic institution in the United States 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

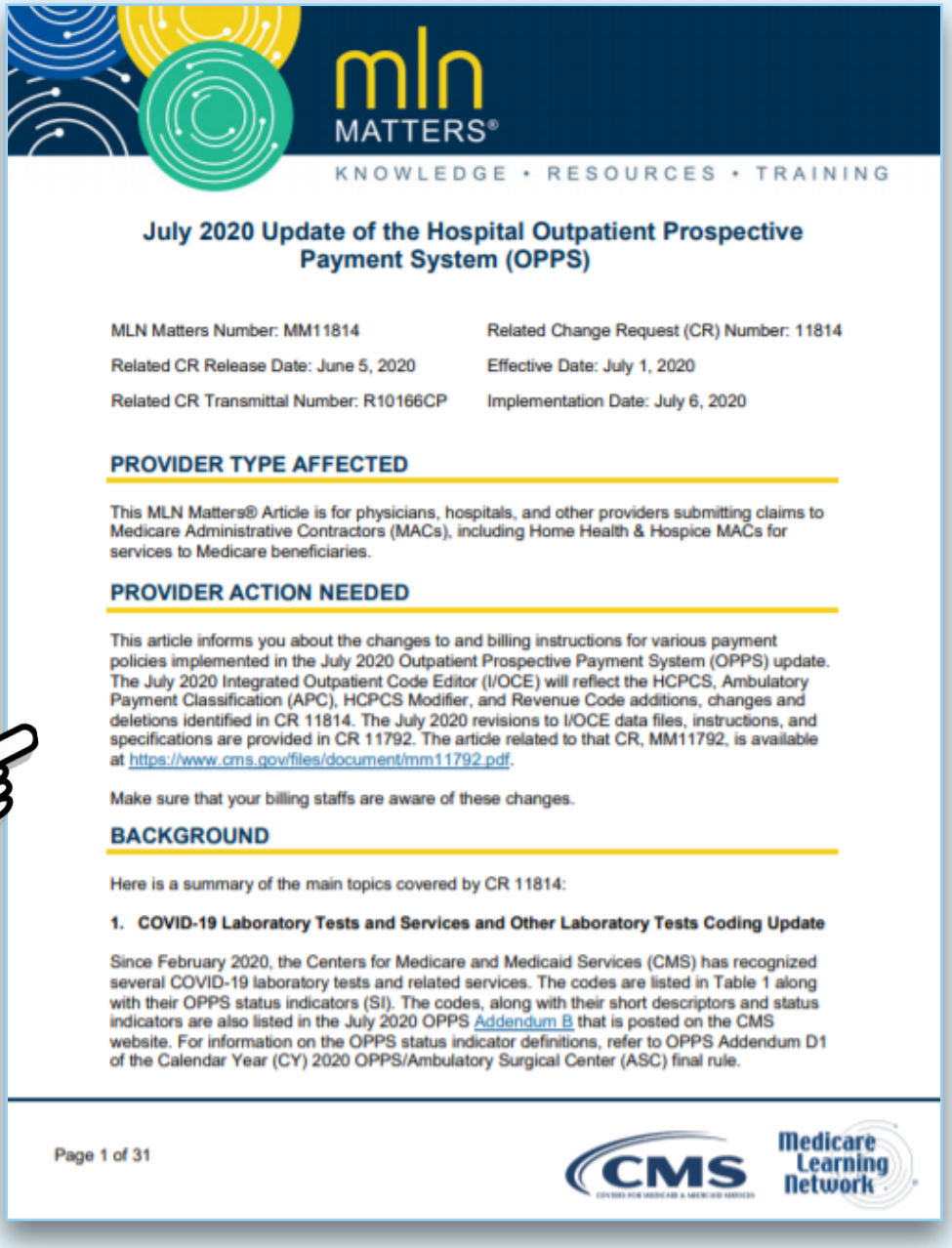
Table of Contents

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.



mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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.

Page 1 of 31

CMS Medicare Learning Network

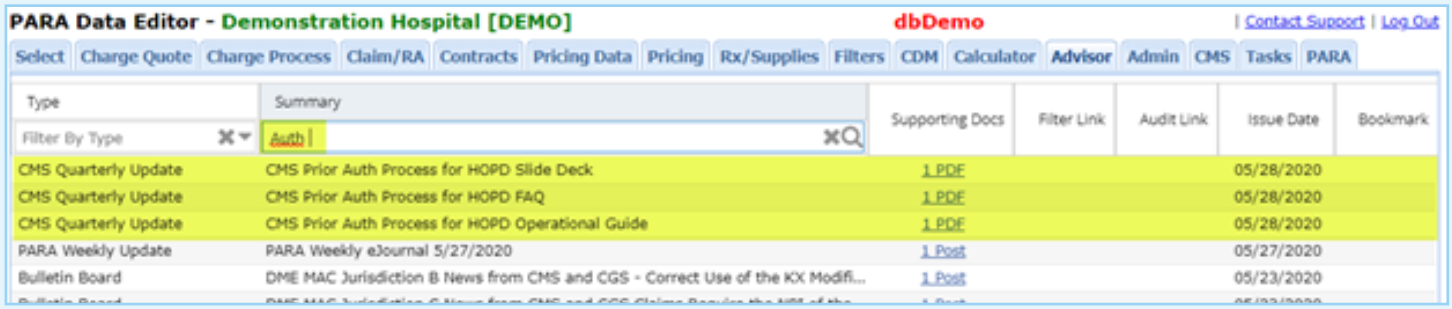
CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

Effective July 1, 2020 and Update 6-10-2020

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 services which it deems to have been at risk for incorrect payment due to medical necessity, primarily services that are sometimes performed for cosmetic purposes. The prior authorization process is not required of procedures performed in Ambulatory Surgery Centers.

Critical Access Hospitals are exempt from the prior auth requirement.

On May 28, 2020 CMS presented a webinar on the Prior Auth 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.**

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

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.

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 is 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

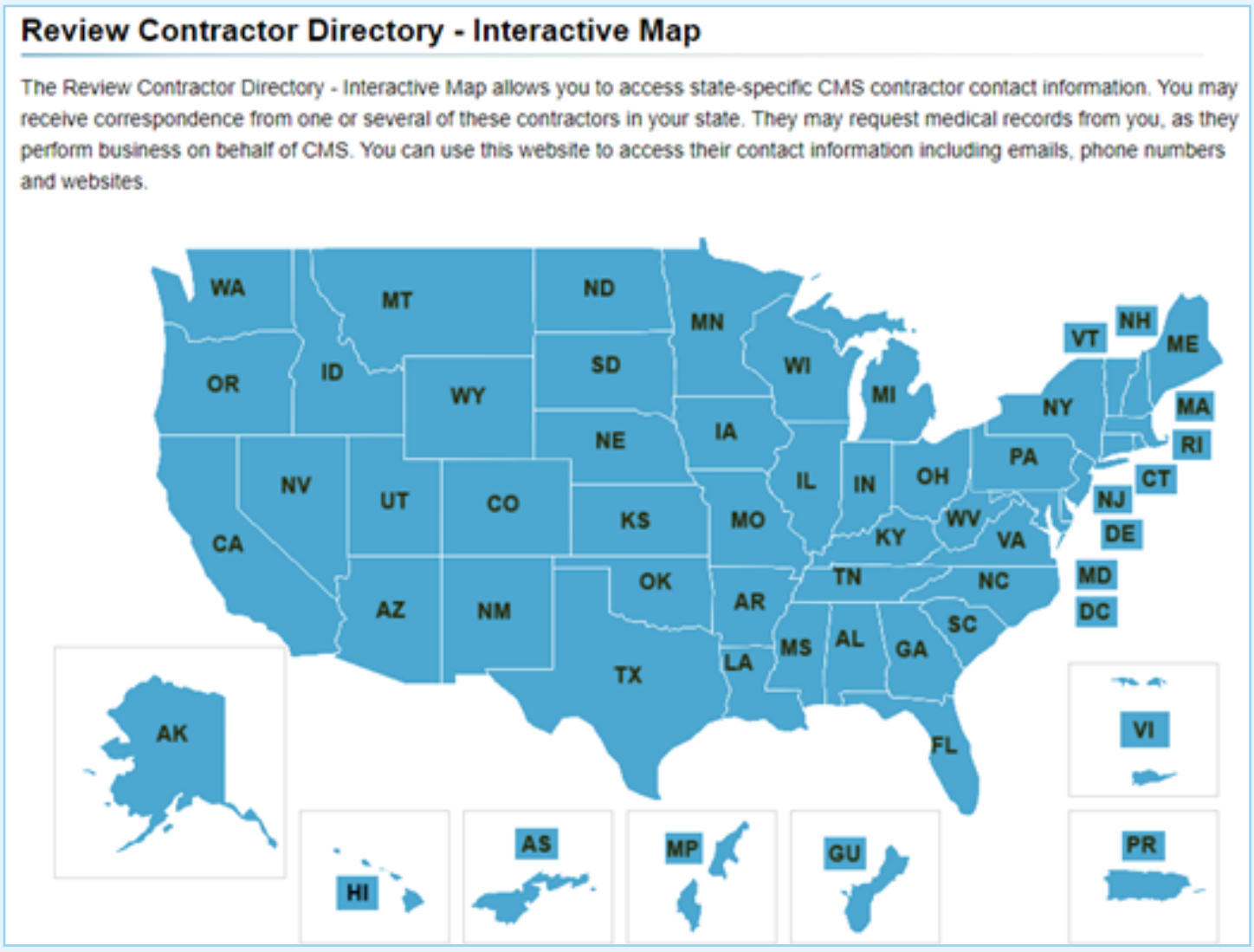
> "In sum, we are finalizing our proposed prior authorization policy as proposed, including our proposed regulation text, with the following modifications: we are adding additional language at § 419.83(c) regarding the notice of exemption or withdraw of an exemption. We are including in this process 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*
https://www.cms.gov/files/document/cpi-opps-pa-list-services.pdf

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

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

TABLE 65: Final List of Outpatient Services that Require Prior Authorization *(Continued)*

Code	(iii) Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure)
15877	Suction assisted removal of fat from trunk
Code	**(iv) Rhinoplasty, and related services**
20912	Nasal cartilage graft
21210	Repair of nasal or cheek bone with bone graft
21235	Obtaining ear cartilage for grafting
30400	Reshaping of tip of nose
30410	Reshaping of bone, cartilage, or tip of nose
30420	Reshaping of bony cartilage dividing nasal passages
30430	Revision to reshape nose or tip of nose after previous repair
30435	Revision to reshape nasal bones after previous repair
30450	Revision to reshape nasal bones and tip of nose after previous repair
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

CMS IMPOSES PRIOR AUTHORIZATION ON SOME OUTPATIENT PROCEDURES

TABLE 65: Final List of Outpatient Services that Require Prior Authorization
(Continued)

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

PARA'S PRICE TRANSPARENCY TOOL ADVANTAGES

Hospital price transparency is a requirement. And implementation can be a daunting task.

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

2. **Provides customized** and meaningful information for patients. Takes the guess work out of obtaining an estimate.

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

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

See A Demo By Clicking [The Button]

5. **Comprehensive tool** that pulls:
   - Top services at a facility
   - User's insurance information via Eligibility Checking
   - 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.)
   - The programming to meet all expectations and functionality

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

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

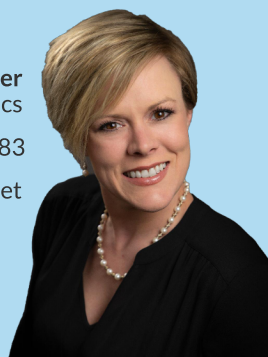
9. **Reporting capabilities** to review all activity on hospital website and what services are being shopped.

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

FOR DETAILS CONTACT OUR EXPERTS

Violet-Archuleta-Chiu
Senior Account Executive
800.999.3332 X219
varchuleta@para-hcfs.com

Sandra LaPlace
Account Executive
800.999.3332 X225
slaplace@para-hcfs.com



Randi Brantner
Vice President of Analytics
719.308.0883
rbrantner@hfri.net

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 18, 2020

News

·COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services

Events

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

·Medicare Part A Cost Report: New Online Status Tracking Feature Call — July 9

MLN Matters® Articles

·New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site

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

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

·Quarterly Update to Home Health (HH) Grouper

·NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR) — Revised

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

Publications

·CLIA Program and Medicare Laboratory Services — Revised

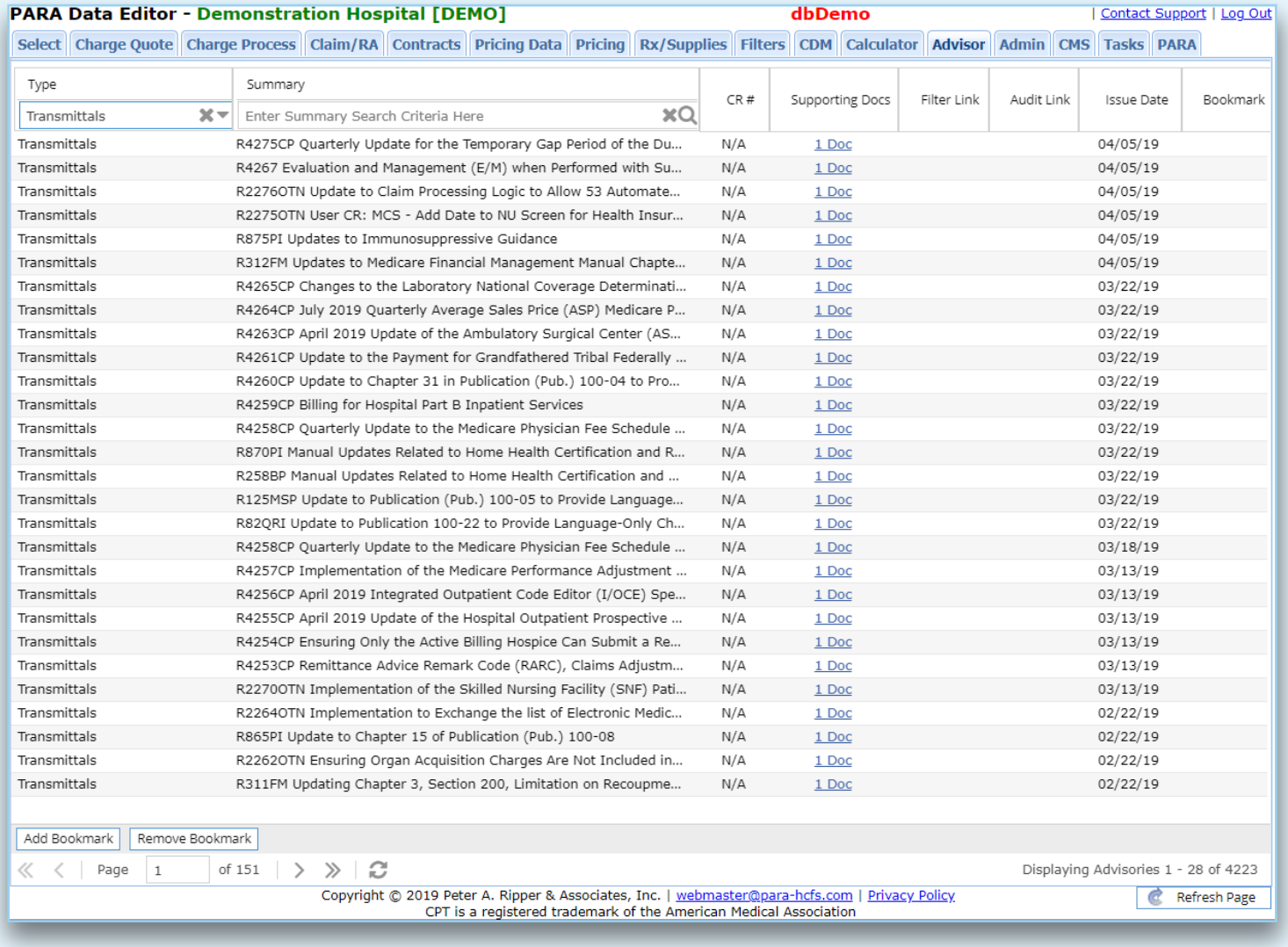
·Medicare Preventive Services — Revised

View this edition as PDF (PDF)

There were TWO 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** 2



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

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

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

Add Bookmark | Remove Bookmark

Page 1 of 151 Displaying Advisories 1 - 28 of 4223

Refresh Page

The link to this MedLearn MM11742

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer

MLN Matters Number: MM11742 Revised

Related CR Release Date: June 19, 2020

Related CR Transmittal Number: R10191CP

Related Change Request (CR) Number: 11742

Effective Date: For COVID-19 Payment Policies - Admissions on or after 1/27/2020; LTCH DPP - For cost reporting periods beginning on or after October 1, 2019

Implementation Date: July 6, 2020

Note: We revised this article to reflect a revised CR 11742, issued on June 19, 2020. CMS revised the CR to revise the COVID19 blanket waiver for the LTCH ALOS policy, to include revising the effective date and policy section. We updated that portion of this article. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by Long-Term Care Hospitals (LTCHs).

WHAT YOU NEED TO KNOW

CR 11742 updates the LTCH Pricer software used in Original Medicare claims processing. The new version includes the payment policy for an LTCH that is subject to the Discharge Payment Percentage (DPP) payment adjustment described in CR 11616. In addition, the CR includes new payment policy for the Novel Coronavirus Disease, COVID-19. Make sure your billing staffs are aware of these changes.

BACKGROUND

On February 14, 2020, the Centers for Medicare & Medicaid Services (CMS) issued CR 11616 titled Implementation of the Long-Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment to prepare the Medicare claims processing systems to calculate the LTCH PPS payment when an LTCH is subject to the DPP payment adjustment. An MLN Matters Article, MM11616, related to the CR is available at https://www.cms.gov/files/document/mm11616.pdf.

CMS Medicare Learning Network

The link to this MedLearn MM11655

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) – July 2020 Update

MLN Matters Number: MM11655 Revised

Related Change Request (CR) Number: 11655

Related CR Release Date: June 19, 2020

Effective Date: July 1, 2020

Related CR Transmittal Number: R10193OTN

Implementation Date: March 24, 2020 – MACs; July 6, 2020 - Shared System Maintainers

Note: We revised this article to reflect a revised CR 11655. The CR was revised to remove Current Procedural Technology (CPT) code 0048U from the business requirement for NCD90.2 Next Generation Sequencing (NGS) and corresponding removals of CPT 0048U and its associated diagnosis codes from the NCD 90.2 NGS spreadsheet. This revision is necessary because the CPT code does not meet the policy criteria in NCD 90.2 for NGS. In this article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 11655 informs providers about updated International Classification of Diseases, 10th Revision (ICD-10) conversions as well as coding updates specific to National Coverage Determinations (NCDs). Please make sure your billing staffs are aware of these updates.

BACKGROUND

Previous NCD coding changes appear in ICD-10 quarterly updates at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. ICD-10 edits and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate.

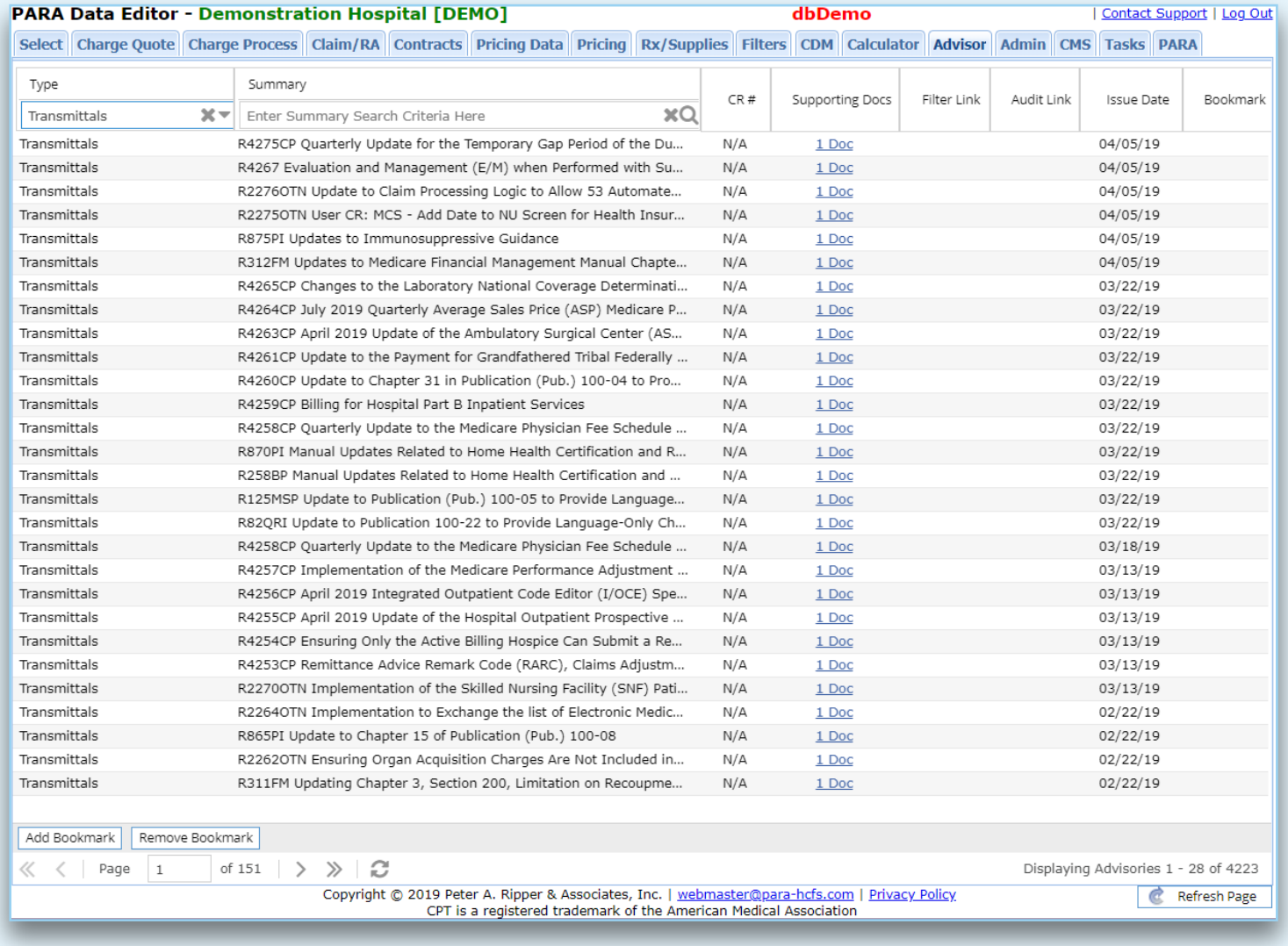
Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-

CMS Medicare Learning Network®

There were TEN new or revised
Transmittals released this week.

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

FIND ALL THESE TRANSMITTALS IN THE **ADVISOR** TAB OF THE **PDE** 10



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

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

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

Add Bookmark | Remove Bookmark

Page 1 of 151 Displaying Advisories 1 - 28 of 4223

Refresh Page

The link to this Transmittal R10190PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10190	**Date: June 19, 2020**
	Change Request 11599

SUBJECT: Revising Chapters 3 and 5 of Publication (Pub.) 100-08, to Reflect the Recent Final Rule CMS-1713-F

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise Chapters 3 and 5 of Pub. 100-08 to account for the regulatory updates we finalized, including those related to face-to-face encounter, written order requirements and instructions for Medicare contractors to consider the totality of the medical record when reviewing for order requirements. The changes made to Chapters 3 and 5 of Pub. 100-08 by this CR reflects the recent regulatory updates published in that Rule 1713-F. These policy changes and conditions of payment became effective on January 1, 2020.Chapter 5 will be renumbered accordingly, to account for revisions.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 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 R10191CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10191	**Date: June 19, 2020**
	Change Request 11742

Transmittal 10060, dated April 24, 2020, is being rescinded and replaced by Transmittal 10191, dated, June 19, 2020 to revise the COVID19 blanket waiver for the LTCH ALOS policy, to include revising the effective date and policy section, as well as to revise the Medicare Administrative Contractor instructions by adding a new requirement 11742.3 and revising requirement 11742.3.1. All other information remains the same.

SUBJECT: Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer

I. SUMMARY OF CHANGES: This Change Request (CR) updates the LTCH Pricer software used in Original Medicare claims processing. The new version includes new payment policy when an LTCH is subject to the discharge payment percentage payment adjustment described in CR 11616. In addition, new payment policy for the Novel Coronavirus Disease, COVID-19 is included. This recurring update notification applies to publication 100-04, chapter 3, section 20.3.4.

EFFECTIVE DATE: October 1, 2019 - For COVID-19 Payment Policies - Admissions on or after 01/27/2020; July 6, 2020 - LTCH DPP - For cost reporting periods beginning on or after October 1, 2019
**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.

The link to this Transmittal R202SOMA

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 202 **Date:June 19, 2020**

SUBJECT: State Operations Manual (SOM) Chapter 3, Additional Program Activities

I. SUMMARY OF CHANGES: The SOM Chapter 3 sections that provide instructions on voluntary termination work is revised. The revisions are part of an effort to streamline the enrollment process for certified providers/suppliers. Certain certification functions performed by the CMS regional locations are transitioning to CMS' Center for Program Integrity (CPI) Provider Enrollment Oversight Group (PEOG) and the Medicare Administrative Contractors (MACs). The voluntary termination work is the first phase of the certification work to transition. The MAC will process and finalize voluntary termination actions and will coordinate with the State Survey Agency directly as needed. The approval recommendation made to the CMS regional locations by the MAC has been removed. The MAC will notify the provider or supplier of approval of voluntary termination and send copies of the letter to the State Survey Agency, CMS regional locations and Accrediting Organizations.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 19, 2020
IMPLEMENTATION DATE: July 27, 2020

Or

MANUALIZATION/CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATES:

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
R	3/3046A/General
R	3/3046B/Decision by Provider or Supplier to Remain in the Medicare Program
R	3/3046C/Notice to Public
R	3/3046D/Effective Date of Voluntary Termination
R	3/3047/Notice to MAC-Voluntary Termination
R	3/3048A/Voluntary Termination
R	3/3048B/Close of Business

The link to this Transmittal R201SOMA

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal 201 **Date: June 19, 2020**

SUBJECT: State Operations Manual (SOM) Chapter 2, The Certification Process

I. SUMMARY OF CHANGES: The SOM Chapter 2 sections that provide instructions on Vvoluntary termination work is revised. The revisions are part of an effort to streamline the enrollment process for certified providers/suppliers. Certain certification functions performed by the CMS regional locations are transitioning to CMS' Center for Program Integrity (CPI) Provider Enrollment Oversight Group (PEOG) and the Medicare Administrative Contractors (MACs). The voluntary termination work is the first phase of the certification work to transition. The MAC will process and finalize voluntary termination actions and will coordinate with the State Survey Agency directly as needed. The approval recommendation made to the CMS regional locations by the MAC has been removed. The MAC will notify the provider or supplier of approval of voluntary termination and send copies of the letter to the State Survey Agency, CMS regional locations and Accrediting Organizations. Additionally, Community Mental Health Center (CMHC) sections 2252A through 2252F are being deleted sine they were mistakenly omitted from Transmittal 197.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 19 2020
IMPLEMENTATION DATE: July 27, 2020

Or

MANUALIZATION/CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATES:.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	2/Table of Contents
R	2/2005F/Voluntary Terminations
D	2/2252/Certification Process
D	2/2252A/General
D	2/2252B/Request to Participate
D	2/2252C/Information to be Sent to CMHC Applicant

The link to this Transmittal R10193OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10193	Date: June 19, 2020
	Change Request 11655

Transmittal 2439, dated February 21, 2020, is being rescinded and replaced by Transmittal 10193, dated, June 19, 2020 remove Current Procedural Technology (CPT) code 0048U from business requirement 11655.1 and corresponding removals of CPT 0048U and its associated diagnosis codes from the National Coverage Determination (NCD) 90.2 Next Generation Sequencing (NGS) spreadsheet. This revision is necessary because the CPT code does not meet the policy criteria in NCD 90.2 for NGS. All other information remains the same.

SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--July 2020 Update

I. SUMMARY OF CHANGES: This Change Request (CR) constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, longstanding NCD process.

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: A/B MACs BR 1-15 days from issuance of correction; March 24, 2020 - Medicare Administrative Contractors; July 6, 2020 - Shared System Maintainers

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

The link to this Transmittal R10186CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10186	**Date: June 19, 2020**
	Change Request 11820

SUBJECT: Updates to Chapter 1, Payer Only Codes in the Medicare Claims Processing Manual

I. SUMMARY OF CHANGES: This Change Request removes condition codes 60 and 61 from the payer only code list.

EFFECTIVE DATE: July 21, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 21, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/190 – Payer Only Codes Utilized by Medicare

III. FUNDING:

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

The link to this Transmittal R10185MPI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-15 Medicaid Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10185	**Date: June 19, 2020**
	Change Request 11813

SUBJECT: Update to Chapter 1 of Publication (Pub.) 100-15

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update section 1.19 within Chapter 1 in Pub. 100-15.

EFFECTIVE DATE: July 21, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 21, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/1.19/Fraud Referrals

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

The link to this Transmittal R10184PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10184	**Date: June 19, 2020**
	Change Request 11812

SUBJECT: Updates to Chapters 4, 6, and 8 of Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update various sections within Chapters 4, 6, and 8 in Pub. 100-08

EFFECTIVE DATE: July 21, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 21, 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 R10188CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10188	**Date: June 19, 2020**
	Change Request 11842

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

I. SUMMARY OF CHANGES: This recurring update notification describes changes to the July 2020 ASC payment system update.

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 R10189CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10189	**Date: June 19, 2020**
	Change Request 11840

SUBJECT: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.3, Effective October 1, 2020

I. SUMMARY OF CHANGES: This is the quarterly update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to publication 100-04, chapter 23, section 20.9.

EFFECTIVE DATE: October 1, 2020
**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:

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

IV. ATTACHMENTS:

Recurring Update Notification

Get power on your side and maintain your cash flow.

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

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

BE EMPOWERED

PARA
HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

WHAT WE OFFER

- Guaranteed Results
- Improved Insurance Collections
- 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

CONTACT OUR EXPERTS

Violet-Archuleta-Chiu
Senior Account Executive
800.999.3332 X219
varchuleta@para-hcfs.com

Sandra LaPlace
Account Executive
800.999.3332 X225
slaplace@para-hcfs.com

Randi Brantner
Vice President of Analytics
719.308.0883
rbrantner@hfri.net