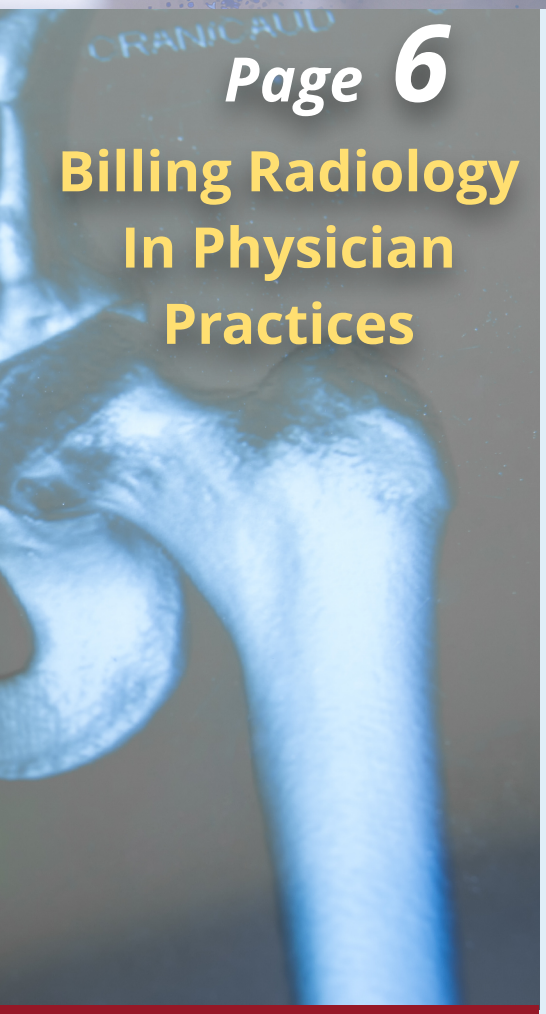
PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

March 11, 2020

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS



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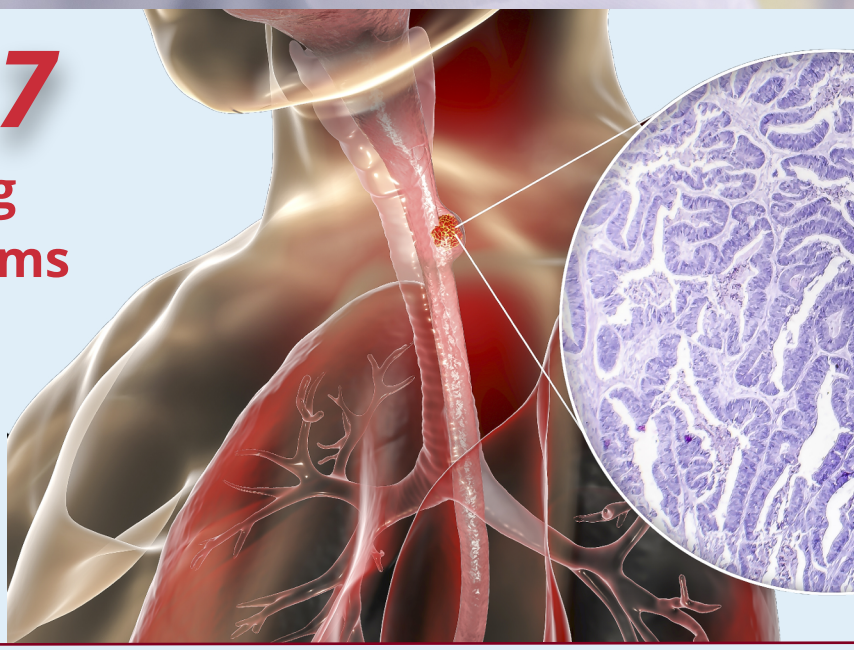
Billing Radiology In Physician Practices



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- **PDE Training Opportunties**
- Key Opportunities For Hospitals To Boost Margins In The Era Of Price Transparency
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PARA

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FAST LINKS

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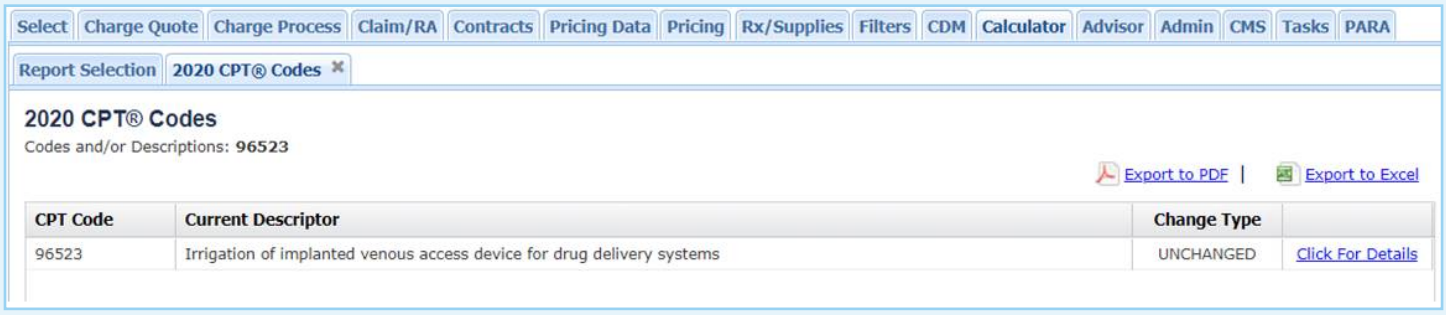
CENTRAL LINE FLUSH

Q. If a patient comes in for a central line flush with heparin once a month due to diagnosis of diffuse large B-cell lymphoma, how should this be charged? They don't have any other services done. Can we use an E&M code? G0463? Do you have any papers on Central Line Flush? I am unable to find one.

A. **Answer:** Report CPT code 96523 for the flushing of the vascular access device. CPT® code 96523 describes "irrigation of implanted venous access device for drug delivery system".

This code may be reported only if no other service is reported for the patient encounter. AMA Coding Clinic for HCPCS - First Quarter 2014 supports this coding advice and is provided below. Please refer to the **PARA Data Editor** code description. **PARA** is in the process of creating a paper on this subject.



AMA Coding Clinic for HCPCS - First Quarter 2014 Page: 4:

If the documentation in the health record supports the presence of a clot, CPT® code 36593 may be reported for the declotting of an implanted device or catheter when a thrombolytic agent is used. However, if chemotherapy services are performed, the flushing is inherent and is not separately reported.

Please note that routine flushing of vascular access devices with saline or heparin would not be reported separately with certain services (i.e., injection or infusion procedures). CPT® code 96523 may be reported if the patient is seen only for the irrigation/flushing of the vascular access device.

READMISSION DISCHARGE DISPOSITIONS

Q. Does **PARA** have any information on when to report discharge status code range 81-95?

A. **Answer:** Patient discharge status code range 81-95 are utilized to note that there is a planned readmission. The codes correlate with the established "Base codes" 01-06, 21, 43,61-66, and 70. The patient discharges status code range from 81-95 are effective for dates of service on or after October 13, 2013.

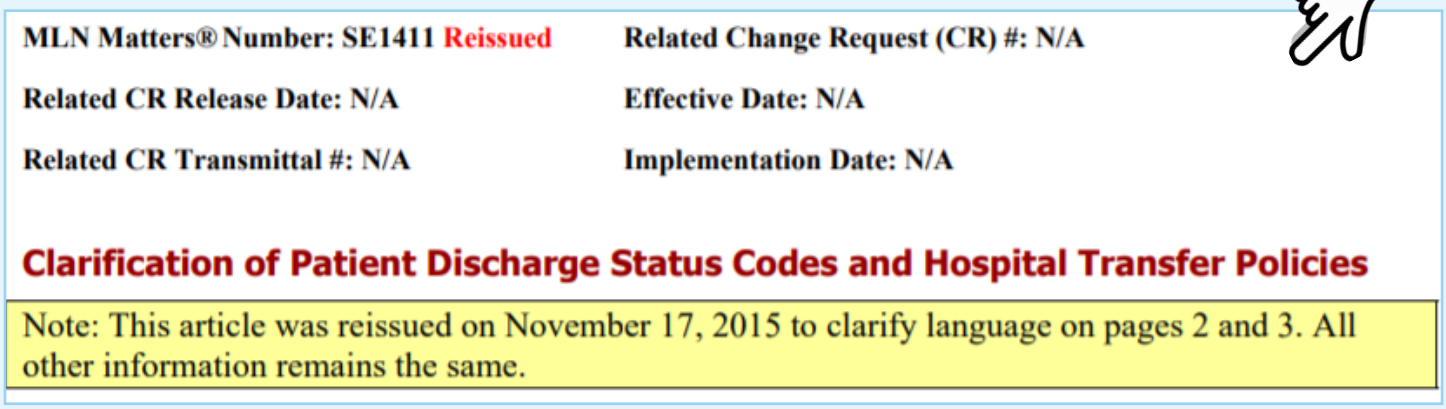
These codes apply to the original discharge claim. These codes are not intended to replace any old discharge codes but the codes are only to be reported if there is a planned acute care re-admission in the future. CMS defines a re-admission as "An intentional re-admission after discharge from an acute care hospital that is a scheduled part of the patient's plan of care."

As referenced in the UB Editor regarding these codes: "CMS has an algorithm to identify readmissions and will continue to use it. CMS will accept any codes submitted, but they will not be incorporated into the readmission algorithm. There is no defined time period of a readmission.

A readmission is defined as "an intentional readmission after discharge from an acute care hospital that is a scheduled part of the patient's plan of care." These codes would be more for internal records and as a comparison to Medicare rates of readmissions.

The issue of planned versus unplanned readmissions is not considered by CMS for Medicare patients. (NUBC July 31-August 1, 2012 Conference Call Minutes)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/SE1411.pdf



MLN Matters® Number: SE1411 Reissued | **Related Change Request (CR) #: N/A**

Related CR Release Date: N/A | **Effective Date: N/A**

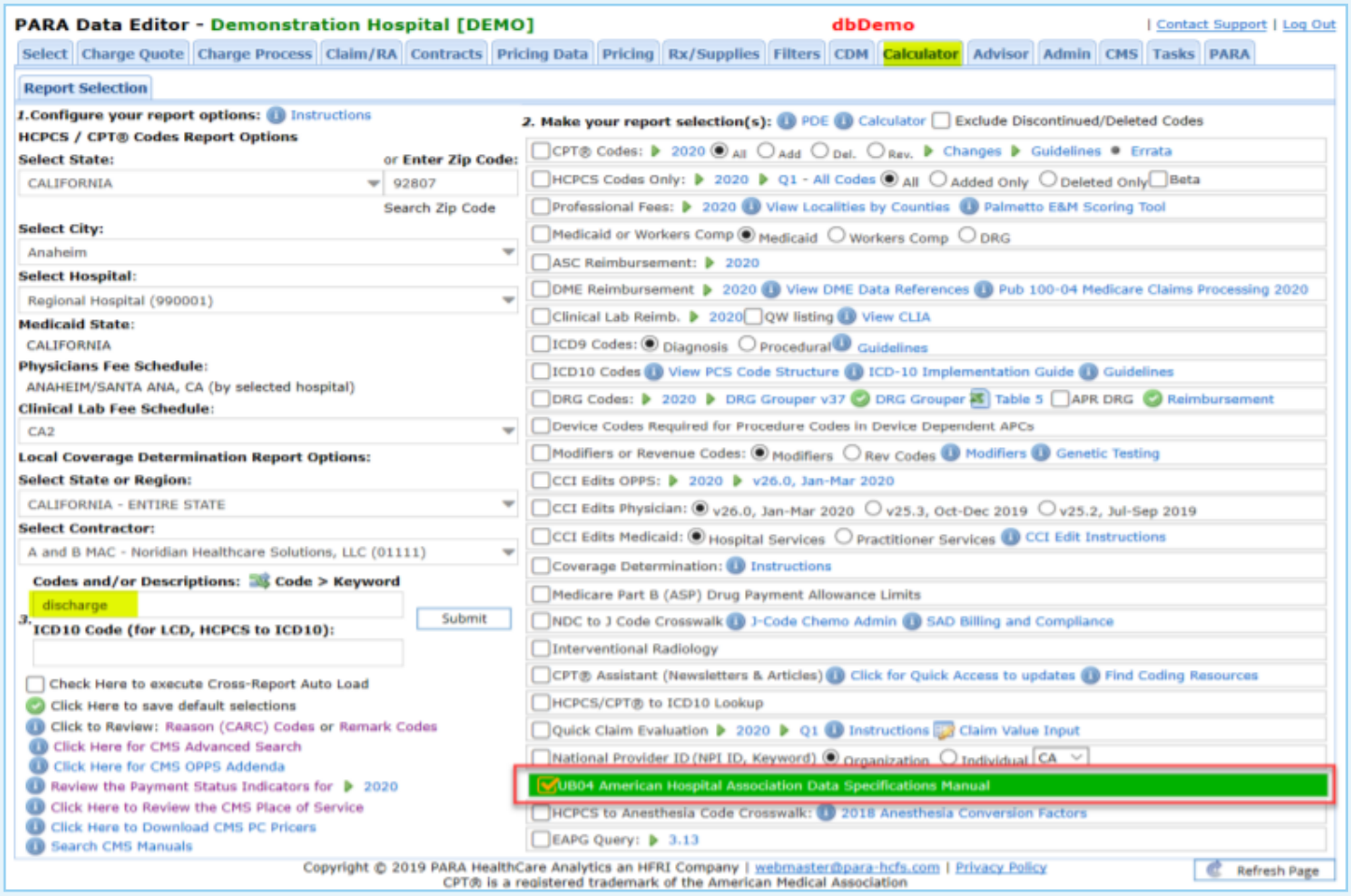
Related CR Transmittal #: N/A | **Implementation Date: N/A**

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies

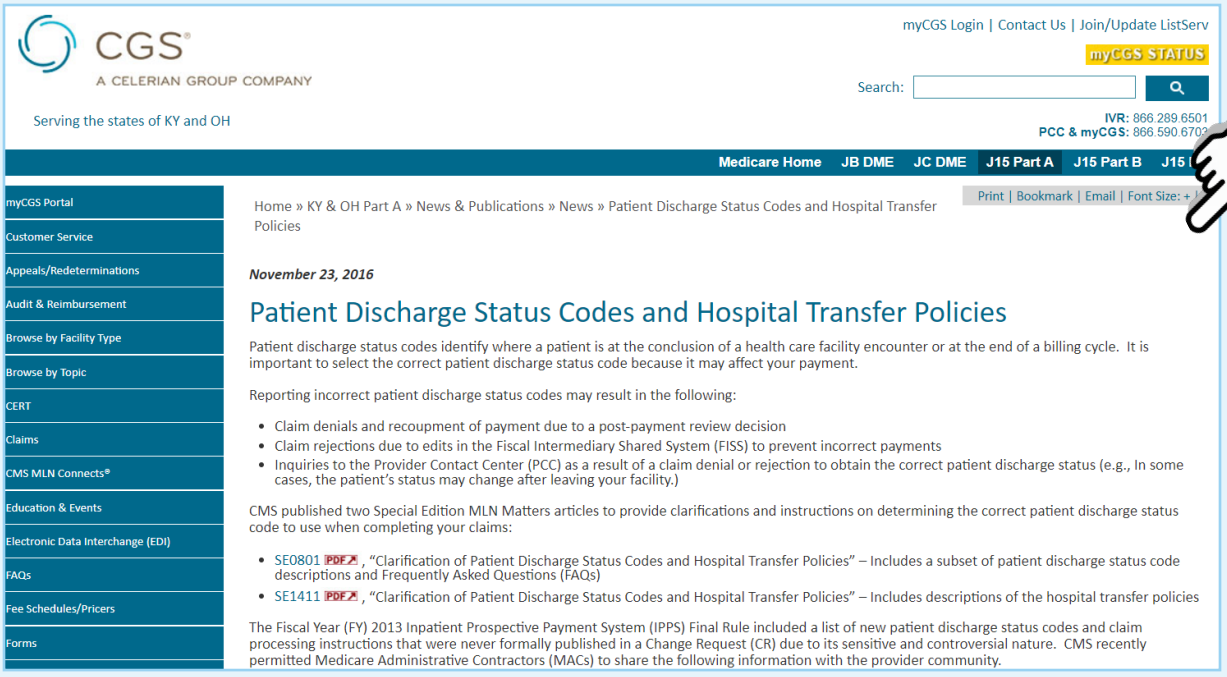
Note: This article was reissued on November 17, 2015 to clarify language on pages 2 and 3. All other information remains the same.

A list of the Uniform Billing Committee's discharge codes is available on the **PARA Data Editor Calculator** tab; enter "Discharge" in the description field on the left, and select the UB04 report on the right. (See example on next page).

READMISSION DISCHARGE DISPOSITIONS



https://www.cgsmedicare.com/parta/pubs/news/2016/11/cope1187.html



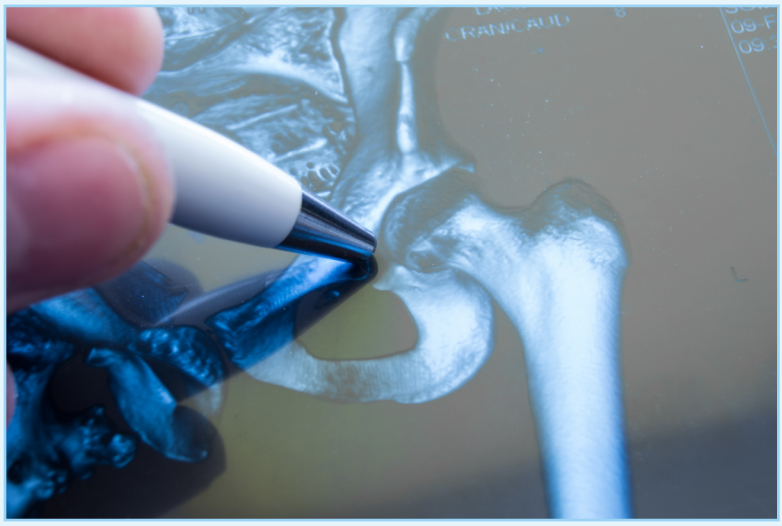
READMISSION DISCHARGE DISPOSITIONS

This table is a crosswalk for the Planned Re-admission discharge codes:

Crosswalk for Planned Re-Admission Discharge Codes 81-95			
Discharge Status Codes		**Discharge Status Codes w/ Planned Readmit**	
01	Discharged to home or self-care	81	Discharged to home or self-care w Planned Re-Admission
02	Discharged or transferred to a short-term general hospital	82	Discharged to Short-Term Hospital w Planned Re-Admission
		89	Discharged to Swing-Bed w Planned Re-Admission
03	Discharged or transferred to a skilled nursing facility	83	Discharged to SNF w Planned Re-Admission
04	Discharged or transferred to an intermediate care facility	84	Discharged to Cust/supp care w Planned Re-Admission
05	Discharged or transferred to a designated cancer center or Children's Hospital	85	Discharged to Cancer/Children's Hospital w Planned Re-Admission
06	Discharged or transferred to home under care of home health care organization	86	Discharged to Home Health Service w Planned Re-Admission
07	Left this hospital against medical advice (AMA) or discontinued care	N/A	
20	Expired		
21	Discharged or transferred to Court/Law Enforcement	87	Discharged to Court/law enforcement w Planned Re-Admission
50	Hospice - Home	N/A	
51	Hospice – medical facility (certified) providing hospice level care		
62	Discharged or transferred to an inpatient rehabilitation facility (IFC) including rehabilitation distinct part units of a hospital	90	Discharged to Rehabilitation facility/Unit w Planned Re-Admission
63	Discharged or transferred to a Medicare certified long-term care hospital	91	Discharged to LTCH w Planned Re-Admission
64	Discharged or transferred to a Nursing Facility certified under Medicaid but not Medicare certified	92	Discharged to Nursing Facility-Medicaid Certified w Planned Re-Admission
65	Discharged or transferred to a psychiatric hospital including psychiatric distinct part units of a hospital	93	Discharged to Psych Hospital/Unit w Planned Re-Admission
66	Discharged or transferred to a Critical Access Hospital (CAH)	94	Discharged to CAH w Planned Re-Admission
70	Discharged or transferred to another type of health care institution not defined elsewhere in this code list	95	Discharged to Other institution w Planned Re-Admission
		88	Discharged to Federal Hospital w Planned Re-Admission
		69	Discharged to Designated Disaster Alternative Care Site

BILLING RADIOLOGY FOR PHYSICIAN PRACTICE

Q. We have a radiology department in which patients come to have out-patient x-rays performed. The contracted radiologists interpret the x-rays, and their report becomes a part of the hospital medical records. The contracted radiologists bill for their interpretation separately.



Recently we started providing radiology services to our Medical Group which is our physician practice partner. Our contracted radiologists do not interpret the x-rays. The orthopedic doctors who are on our medical staff interpret the x-rays but their interpretation goes into their clinic note. I do not get a copy of the interpretation for the hospital. To provide outpatient radiology services, must that include an interpretation that is filed within the medical record of the hospital?

A. **Answer:** The hospital bills the technical portion only which includes the costs of staffing, facility and equipment, and administrative expenses. It isn't clear if the physicians are billing for interpretation or that the reading physician produces a written document specific to the radiology service provided at the hospital.

PARA recommends that a copy of the interpretation of diagnostic services provided to a beneficiary accompanies the imaging as part of the hospital medical record. If it is not, it should be available from the interpreting practitioner every time requested.

PARA recommends the hospital work with the physicians to ensure that the physician group can extract a written interpretation from the patient's clinic medical record. Best practice would be to implement a procedure where a copy is forwarded to the hospital radiology department and added to the hospital medical record.

For a physician to receive payment from Medicare for the professional component, the hospital medical record must include an interpretation and written report for the radiology procedure.

https://www.govregs.com/regulations/title42_chapterIV_part415_subpartC_section415.110

§ 415.130 - Conditions for payment: Physician pathology services.

(a) *Definitions.* The following definitions are used in this section.

(1) *Covered hospital* means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for this technical component directly to a Medicare carrier.

(2) *Fee-for-service Medicare beneficiaries* means those beneficiaries who are entitled to benefits under Part A or are enrolled under Part B of Title XVIII of the Act or both and are not enrolled in any of the following:

(i) A Medicare + Choice plan under Part C of Title XVIII of the Act.

(ii) A plan offered by an eligible organization under section 1876 of the Act;

(iii) A program of all-inclusive care for the elderly (PACE) under 1894 of the Act; or

(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987.

ICD10 CM NEOPLASM

Q. We recently listened to a webinar that discussed the w/ rule and it stated that "anemia and neoplastic disease is coded to D63.0, anemia in neoplastic disease. This linkage can be assumed because the neoplastic disease is listed under the subterm in (due to) (with)" This raised the question, in a patient with an adenomatous colon polyp D12.0 and anemia would this be coded to D63.0? Does D63.0 apply to both benign and malignant neoplasms?

A. **Answer:** Report ICD-10 CM code D63.0 when anemia is documented with a malignant or benign neoplasm. The neoplasm section of ICD-10 CM includes both malignant and benign. The instructional note in the tabular index of ICD-10 CM code D63.0 states "Code first neoplasm C00-D49". The benign neoplasm (D12.0) falls under categories C00-D49.

Please refer to the **PARA Data Editor ICD-10 CM** code description and the ICD-10 CM Tabular index instructional note.

2020 ICD-10 CM Tabular Index

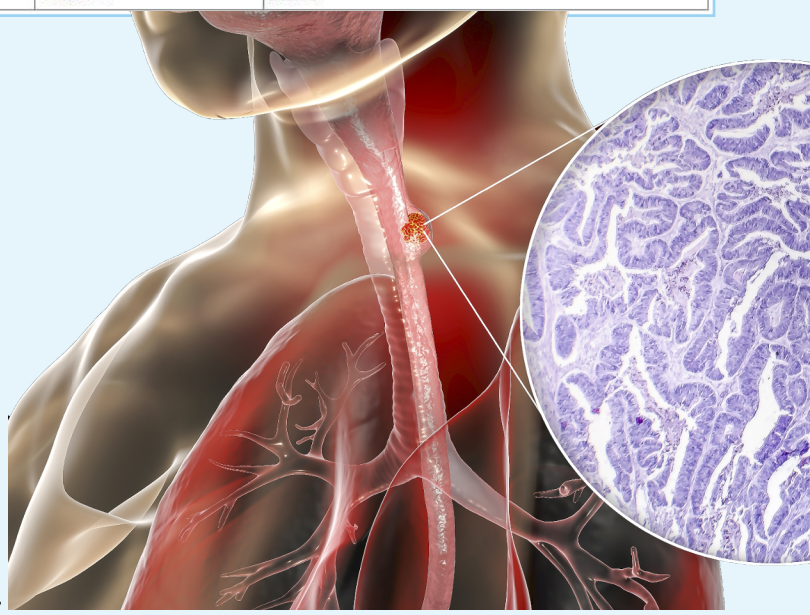
D63 - Anemia in chronic diseases classified elsewhere

D63.0 Anemia in neoplastic disease

Instructional Notes:

Code first neoplasm (C00-D49)

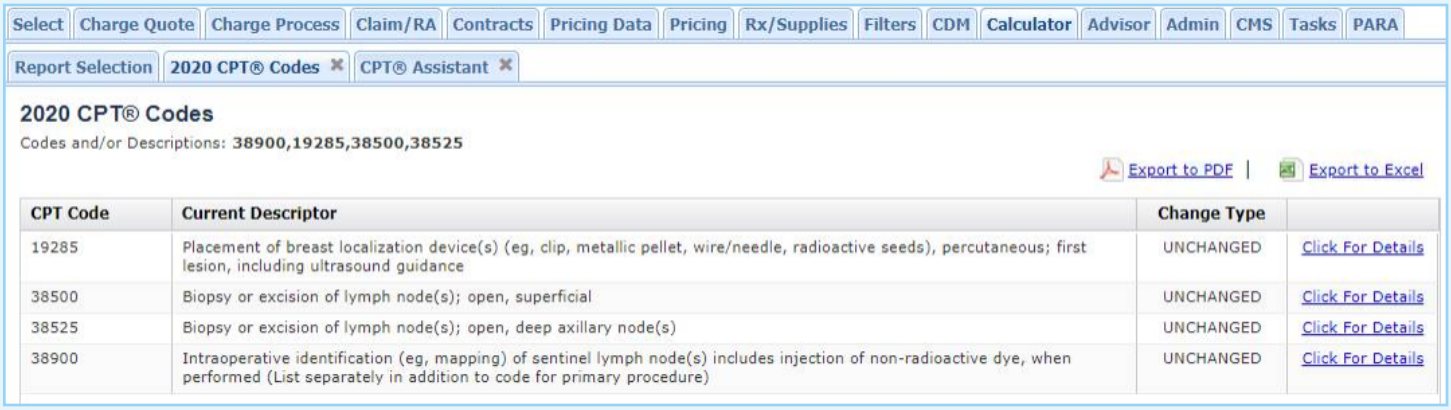
Excludes1: aplastic anemia due to antineoplastic chemotherapy (D61.1)Excludes2: anemia due to antineoplastic chemotherapy (D64.81)

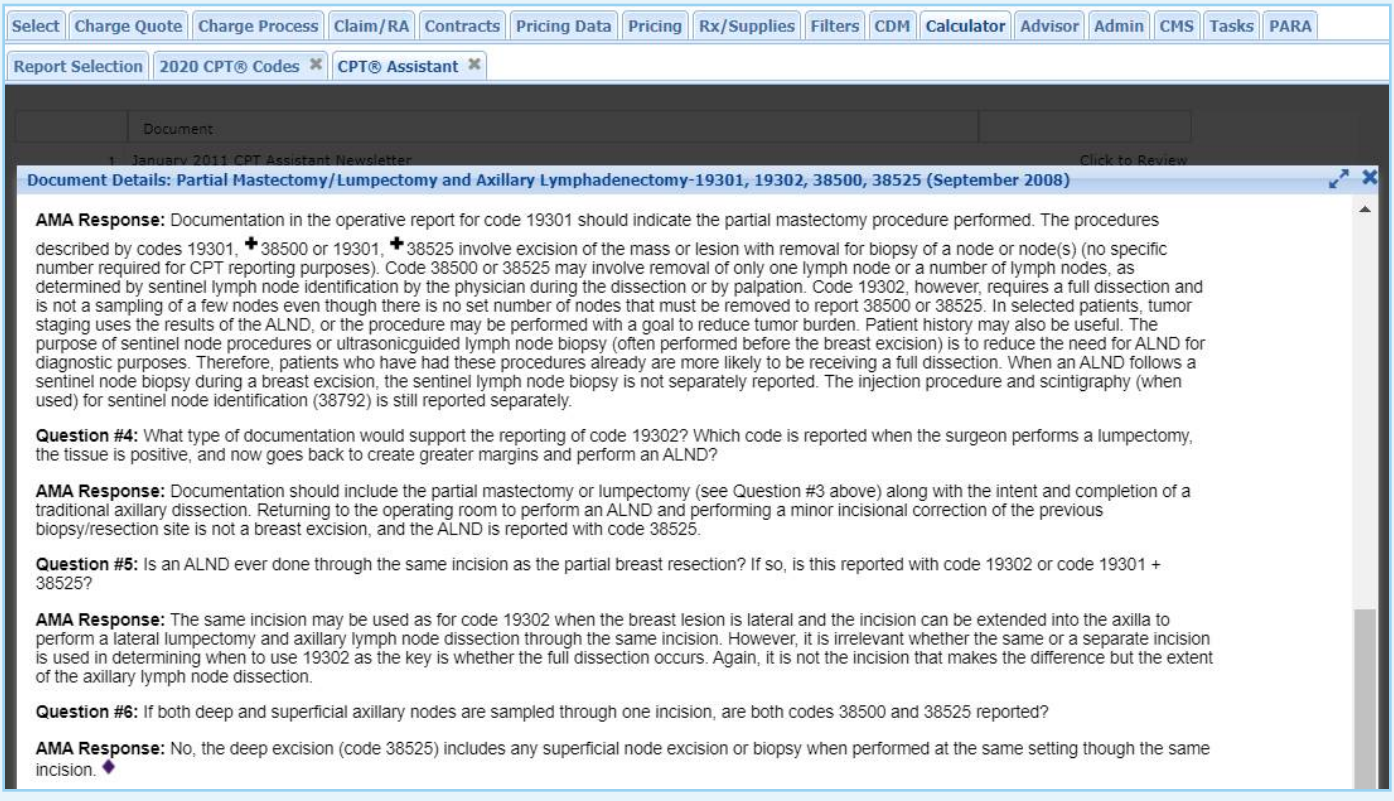


NODE BIOPSY

Q. Could you please review the attached operative note for a Lymphatic mapping and axillary sentinel node biopsy and advise if the codes HIM has listed (38500, 38525, 19285, 19318, 19101) are the most accurate to use?

A. **Answer:** Report CPT® code 38900 and 19285. The procedure note provided only supports removal of the sentinel nodes and intra-operative mapping. The documentation is not clear as to the depth of the lymph node excision. The pathology report may provide clarification on the depth. AMA CPT® Assistant September 2008 states CPT® code 38500 is reported for superficial node procedure and 38525 is reported for deep node procedure. There is no documentation to support a mastectomy or reduction procedure (19318, 19101). The specimen indicates that only sentinel nodes were removed. Please refer to the **PARA Data Editor** reference AMA CPT® Assistant September 2008 page 5,6 and the **PARA Data Editor** code descriptions.





MLN CONNECTS: SUPPLEMENTAL

Friday, March 6, 2020

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them.

At the same time, we are providing critical information to our 130 million beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus.

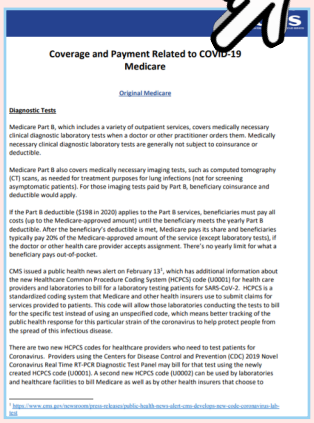
This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics.

This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

MLN CONNECTS: SUPPLEMENTAL

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies.



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. 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) can be used by laboratories and healthcare facilities to bill Medicare as well as by other health insurers that choose to

[1] https://www.cms.gov/newsroom/press-releases/public-health-news-alert-cms-develops-new-code-coronavirus-lab-test

Other Important Links:

Medicare Fact Sheet Highlights(PDF): In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights(PDF):Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage(PDF):Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

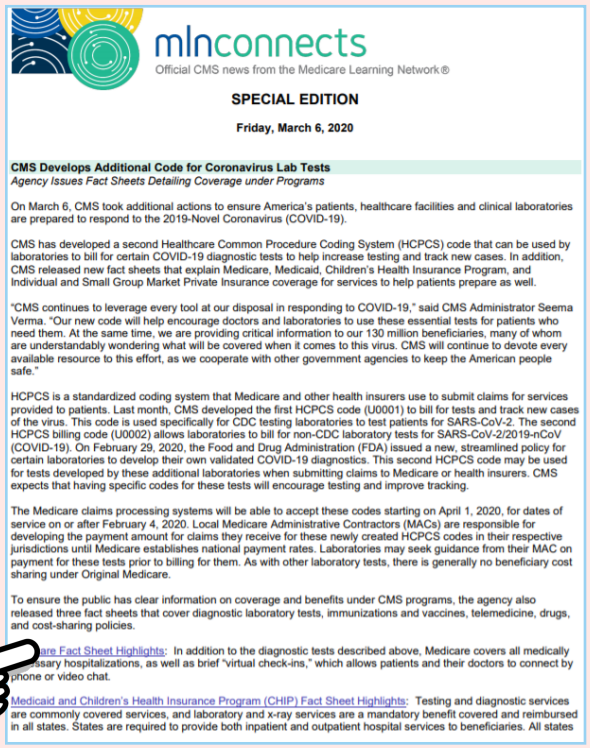
CMS Announces Actions to Address Spread of Coronavirus.

On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code:

Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

View this edition as PDF (PDF)



mlnconnects
Official CMS news from the Medicare Learning Network®

SPECIAL EDITION

Friday, March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests
Agency Issues Fact Sheets Detailing Coverage under Programs

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"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

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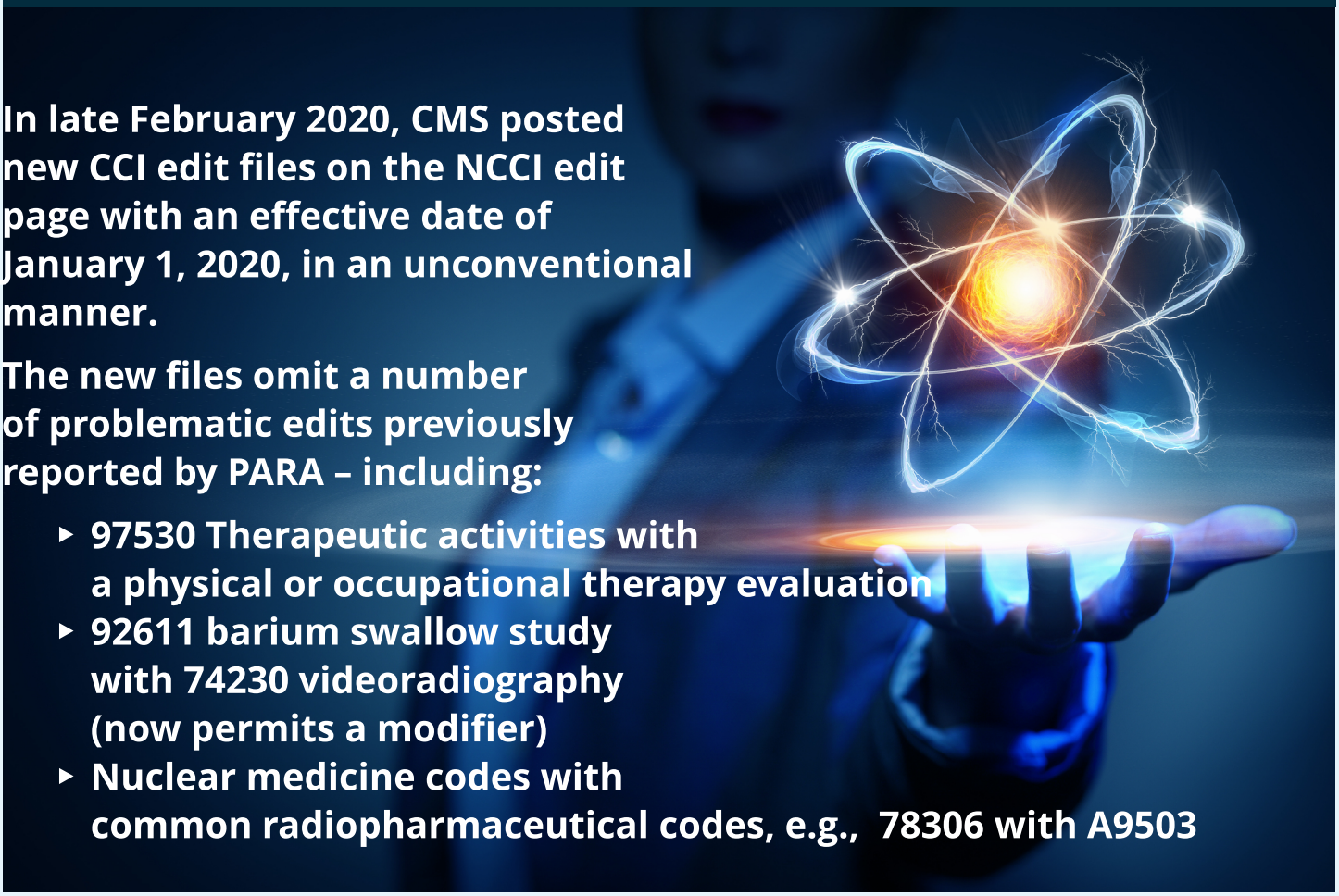
REVISED CCI EDIT FILES POSTED

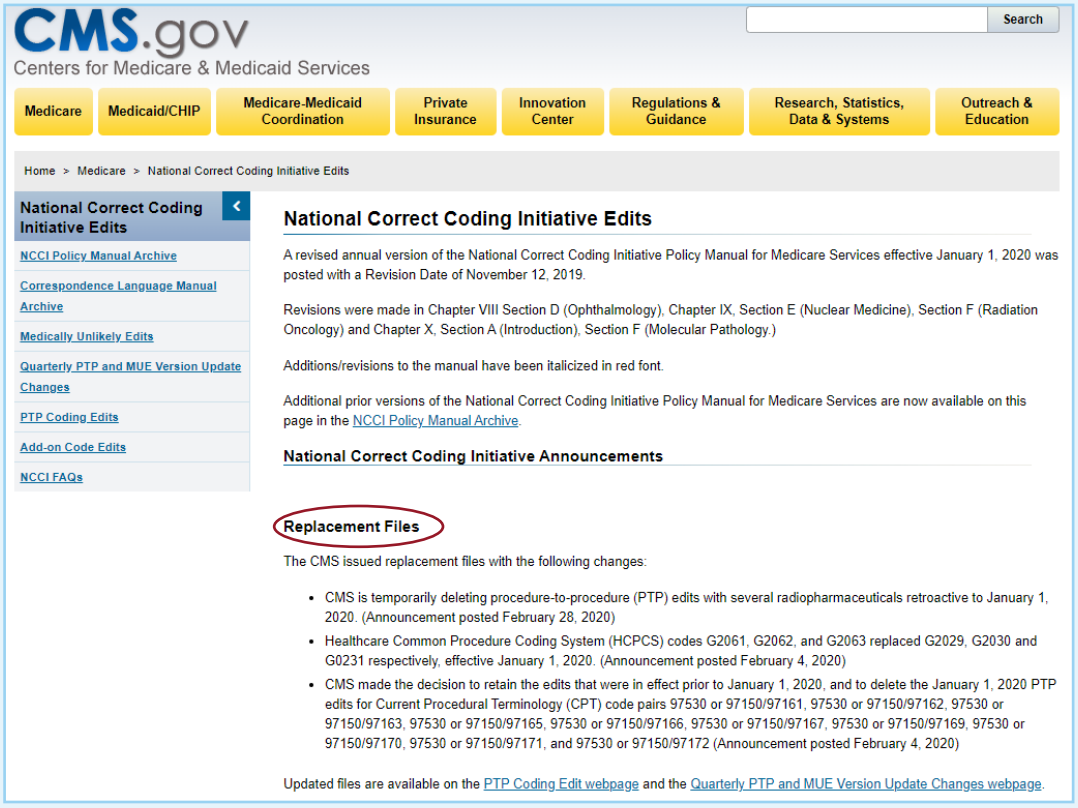


In late February 2020, CMS posted new CCI edit files on the NCCI edit page with an effective date of January 1, 2020, in an unconventional manner.

The new files omit a number of problematic edits previously reported by PARA – including:

- **97530 Therapeutic activities with a physical or occupational therapy evaluation**
- **92611 barium swallow study with 74230 videoradiography (now permits a modifier)**
- **Nuclear medicine codes with common radiopharmaceutical codes, e.g., 78306 with A9503**

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd



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Home > Medicare > National Correct Coding Initiative Edits

National Correct Coding Initiative Edits
- NCCI Policy Manual Archive
- Correspondence Language Manual Archive
- Medically Unlikely Edits
- Quarterly PTP and MUE Version Update Changes
- PTP Coding Edits
- Add-on Code Edits
- NCCI FAQs

National Correct Coding Initiative Edits

A revised annual version of the National Correct Coding Initiative Policy Manual for Medicare Services effective January 1, 2020 was posted with a Revision Date of November 12, 2019.

Revisions were made in Chapter VIII Section D (Ophthalmology), Chapter IX, Section E (Nuclear Medicine), Section F (Radiation Oncology) and Chapter X, Section A (Introduction), Section F (Molecular Pathology.)

Additions/revisions to the manual have been italicized in red font.

Additional prior versions of the National Correct Coding Initiative Policy Manual for Medicare Services are now available on this page in the NCCI Policy Manual Archive.

National Correct Coding Initiative Announcements

Replacement Files

The CMS issued replacement files with the following changes:

- CMS is temporarily deleting procedure-to-procedure (PTP) edits with several radiopharmaceuticals retroactive to January 1, 2020. (Announcement posted February 28, 2020)
- Healthcare Common Procedure Coding System (HCPCS) codes G2061, G2062, and G2063 replaced G2029, G2030 and G0231 respectively, effective January 1, 2020. (Announcement posted February 4, 2020)
- CMS made the decision to retain the edits that were in effect prior to January 1, 2020, and to delete the January 1, 2020 PTP edits for Current Procedural Terminology (CPT) code pairs 97530 or 97150/97161, 97530 or 97150/97162, 97530 or 97150/97163, 97530 or 97150/97165, 97530 or 97150/97166, 97530 or 97150/97167, 97530 or 97150/97169, 97530 or 97150/97170, 97530 or 97150/97171, and 97530 or 97150/97172 (Announcement posted February 4, 2020)

Updated files are available on the PTP Coding Edit webpage and the Quarterly PTP and MUE Version Update Changes webpage.

REVISED CCI EDIT FILES POSTED

In the past, Medicare acknowledged changes to previously published edits in its listing in the next quarter's "CCI Edit Changes" file. However, in this case, the deleted edits are not mentioned in the "changes" file, apparently because the new January 1, 2020 files make it appear as though the edits never existed.

The MACs, however, have not yet matched the claim edit files to permit processing the code pairs that had previously been excluded from being reported together.

The NCCI Edit Contractor, Capitol Bridge, LLC, suggests that

> "Providers may choose to delay submission of claims for deleted edits until after the implementation of the replacement edit file with retroactive date of January 1, 2020. Providers may also choose to appeal claims denied due to the PTP edits to the appropriate MAC including supporting documentation or resubmit claims denied due to the PTP edits after the implementation of the replacement edit file with January 1, 2020 retroactive date, as permitted by the MAC."

The complete text of an email sent by the NCCI edit contractor, Capitol Bridge, LLC, in reply to a **PARA** client who had inquired about the problematic new edits is provided below:

> "Thank you for your inquiry regarding the National Correct Coding Initiative (NCCI) program. The Centers for Medicare & Medicaid Services (CMS) owns the NCCI program and is responsible for all decisions regarding its contents.
>
> "In your correspondence, you inquired about the recent implementation of certain Procedure-to-Procedure (PTP) edits related to Nuclear Medicine and Diagnostic Radiology."After reviewing this issue more closely, CMS has made the decision to delete the following January 1, 2020 PTP edits:

Column 1	Column 2
78300	A9503
78300	A9561
78305	A9503
78305	A9561
78306	A9503
78306	A9542

Column 1	Column 2
78306	A9561
78315	A9503
78315	A9561
78315	A9528
78803	A9582

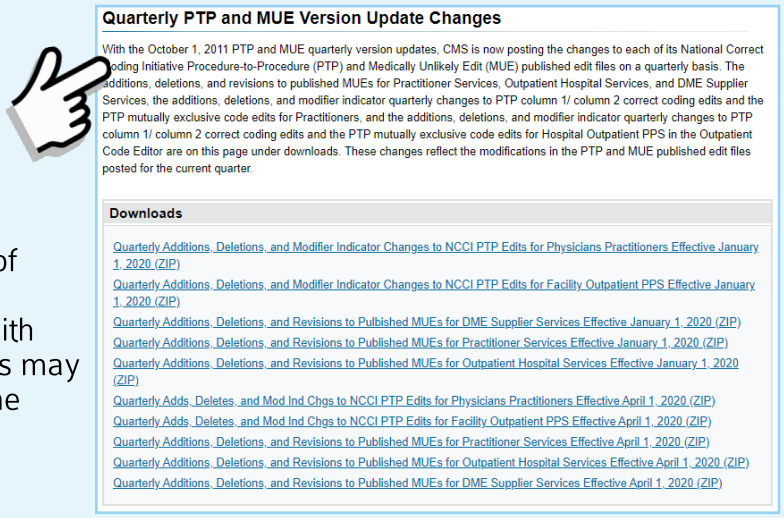
REVISED CCI EDIT FILES POSTED

"CMS will change the Practitioner (PRA) and Outpatient Hospital (OPH) Modifier indicator for the following January 1, 2020 PTP edit:

Column 1	Column 2	PRA Modifier Indicator	OPH Modifier Indicator
92611	74230	1	1

"Both of these changes will be retroactive to January 1, 2020 and will be implemented as soon as technically possible in a future edit update. The update will be available at the following websites:

"Medicare:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html



"Medicaid:

https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

"Providers may choose to delay submission of claims for deleted edits until after the implementation of the replacement edit file with retroactive date of January 1, 2020. Providers may also choose to appeal claims denied due to the PTP edits to the appropriate MAC including supporting documentation or resubmit claims denied due to the PTP edits after the implementation of the replacement edit file with January 1, 2020 retroactive date, as permitted by the MAC.

"CMS and the NCCI Program appreciate your time in making this inquiry.

"Sincerely,

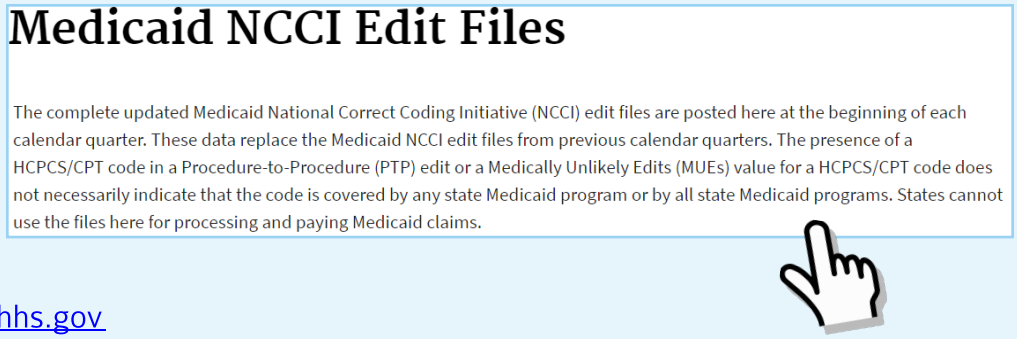
Capitol Bridge, LLC

National Correct Coding Initiative Contractor

Email:NCCIPTPMUE@cms.hhs.gov

P.O. Box 368

Pittsboro, IN 46167SBA Certified 8(a) Small Disadvantaged Business



OIG CRITICIZES LABORATORY TRAVEL ALLOWANCE PAYMENTS

In December of 2019, the Office of the Inspector General published a report critical of one MAC's performance in paying for travel allowances for phlebotomy services.

The report alleged that the MAC did not sufficiently monitor provider use of the reimbursement codes. As a result, providers nationwide can expect MACs to be more aggressive in auditing claims which report P9603 or P9604 in the future.

A link and an excerpt from the OIG report "NOVITAS SOLUTIONS, INC. NEEDS ENHANCED GUIDANCE AND PROVIDER EDUCATION RELATED TO PHLEBOTOMY TRAVEL ALLOWANCE" is provided:

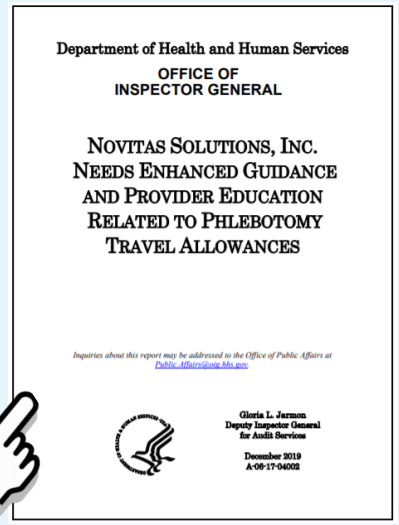
https://oig.hhs.gov/oas/reports/region6/61704002.pdf

NO DOCUMENTATION TO SUPPORT SPECIMEN COLLECTION

Payments to Medicare providers should not be made unless the provider has furnished information necessary to the MAC to determine the amount owed to the provider.

The Manual states that the travel allowance should be prorated by dividing the mileage by the total number of patients from whom specimen draws or pickups were made in the same trip.

Each January, CMS publishes the national rate of payment for laboratory specimen collection services. The per-mile rate for P9603 is based on the IRS standard mileage rate for business plus an allowance to cover technician labor expense. However, Medicare Administrative Contractors may pay more than the minimum rate if local conditions warrant it.



Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

NOVITAS SOLUTIONS, INC.
NEEDS ENHANCED GUIDANCE
AND PROVIDER EDUCATION
RELATED TO PHLEBOTOMY
TRAVEL ALLOWANCES

Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

December 2019
A-06-17-04002

HCPCS/CPT®	OPPS Status Indicator	Medicare 2020 Fee Schedule
P9603 - TRAVEL ALLOWANCE ONE WAY IN CONNECTION WITH MEDICALLY NECESSARY LABORATORY SPECIMEN COLLECTION DRAWN FROM HOME BOUND OR NURSING HOME BOUND PATIENT; PRORATED MILES ACTUALLY TRAVELLED	A	1.03
P9604 - TRAVEL ALLOWANCE ONE WAY IN CONNECTION WITH MEDICALLY NECESSARY LABORATORY SPECIMEN COLLECTION DRAWN FROM HOME BOUND OR NURSING HOME BOUND PATIENT; PRORATED TRIP CHARGE	A	10.30

OIG CRITICIZES LABORATORY TRAVEL ALLOWANCE PAYMENTS

MACs have the option of establishing a higher per mile rate in excess of the minimum set forth by CMS each year if local conditions warrant it. Medicare may review and update the minimum mileage rate throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed.

The CMS transmittal announcing 2020 rates was released on January 17, 2020, with rates retroactive to January 1, 2020.

Here is a link:

https://www.cms.gov/files/document/mm11641.pdf

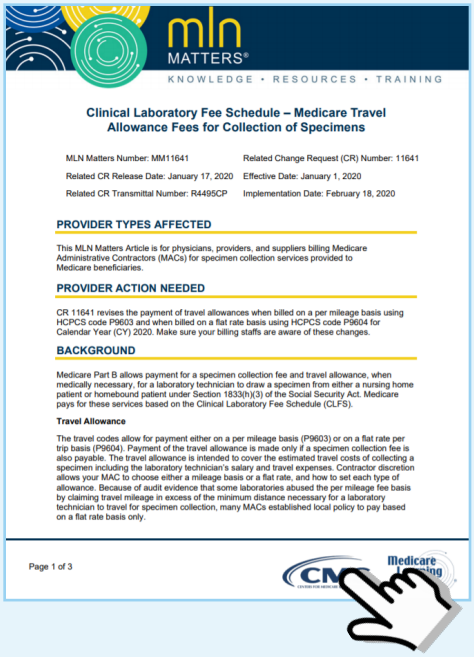
Each MAC may, at its discretion, choose to pay either a mileage basis or a flat rate per trip. Many MACs have established local policy to pay only on a flat-rate basis, because audits have shown that some laboratories abused the per mileage fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection,.

Per Mile Travel Allowance (P9603), The per mile travel allowance (P9603) is to be used in situations where the average trip to the patients' homes is longer than **20 miles** round trip and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the Federal mileage rate of **$0.575** per mile plus an additional **$0.45** per mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum **$1.03 per mile (actual total of $1.025 rounded up to reflect systems capabilities)**, if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the CLFS, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per Flat-Rate Trip Basis Travel Allowance (P9604) travel allowance is $10.30.

Note: Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims that you bring to their attention.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Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

MLN Matters Number: MM11641 Related Change Request (CR) Number: 11641
Related CR Release Date: January 17, 2020 Effective Date: January 1, 2020
Related CR Transmittal Number: R4495CP Implementation Date: February 18, 2020

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 11641 revises the payment of travel allowances when billed on a per mileage basis using HCPCS code P9603 and when billed on a flat rate basis using HCPCS code P9604 for Calendar Year (CY) 2020. Make sure your billing staffs are aware of these changes.

BACKGROUND

Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Medicare pays for these services based on the Clinical Laboratory Fee Schedule (CLFS).

Travel Allowance

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Contractor discretion allows your MAC to choose either a mileage basis or a flat rate, and how to set each type of allowance. Because of audit evidence that some laboratories abused the per mileage fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection, many MACs established local policy to pay based on a flat rate basis only.

Page 1 of 3

Another MAC, WPS, published the following tips for documentation in support of travel allowances:

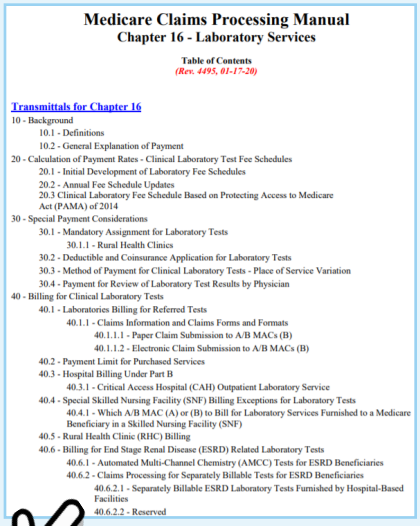
Laboratory Services

- Clear indication of patient name, date of birth, and date of service
- Lab results for date(s) of service billed
- Signed and dated physician order or progress/clinic/visit notes that clearly document the specific service(s) to be performed
- Documentation to support the medical necessity of ordered test(s)
- Medical diagnosis
- Signs and symptoms (rationale for lab performed)
- If travel allowance for specimen collection is billed:
  - Number of collections performed per trip (for both Medicare and non-Medicare patients) to compute the Medicare prorated fee
  - Documentation of miles actually traveled
  - Documentation supporting that patient is homebound or nursing home bound

OIG CRITICIZES LABORATORY TRAVEL ALLOWANCE PAYMENTS

The Medicare Claims Processing Manual offers the following guidance on claiming reimbursement for travel. Excerpts from Chapter 16 of the Manual are provided here:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf#



Medicare Claims Processing Manual
Chapter 16 - Laboratory Services

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(Rev. 4495, 01-17-20)

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60.2 - Travel Allowance

The Medicare Claims Processing Manual provides the following direction on calculating the mileage for lab specimen collection:

Per Mile Travel Allowance (P9603)

- The minimum "per mile travel allowance" is $0.99. The per mile travel allowance is to be used in situations where the average trip to patients' homes is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip, one way, in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually traveled (A/B MAC (B) allowance on per mile basis); or

- The per mile allowance was computed using the Federal mileage rate plus an additional 45 cents a mile to cover the technician's time and travel costs. A/B MACs (B) have the option of establishing a higher per mile rate in excess of the minimum ($0.99 a mile in CY 2016) if local conditions warrant it.

The minimum mileage rate will be reviewed and updated in conjunction with the clinical lab fee schedule as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

Example 1:

In CY 2016, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $59.40 (60 miles x $0.99 cents a mile), plus the specimen collection fee.

Example 2:

In CY 2016, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or $39.60 (40 x $0.99), plus the specimen collection fee.

Flat Rate (P9604)

The CMS will pay a minimum of $10.30 (based on CY 2019) one way flat rate travel allowance. The flat rate travel allowance is to be used in areas where average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. The laboratory does the pro-ration when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be paid for each patient encounter.

OIG CRITICIZES LABORATORY TRAVEL ALLOWANCE PAYMENTS

This rate is based on an assumption that a trip is an average of 15 minutes and up to 10 miles one way. It uses the Federal mileage rate and a laboratory technician's time of $17.66 an hour, including overhead. A/B MACs (B) have the option of establishing a flat rate in excess of the minimum of $9.90, if local conditions warrant it. The minimum national flat rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule, as necessitated by adjustments in the Federal travel allowance and salaries.

The claimant identifies round trip travel by use of the LR modifier.

Example 3:

A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x $9.90 for a total trip reimbursement of $19.80, plus the specimen collection fee.

Example 4:

A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $9.90 = $59.40). Each of the claims submitted would be for $11.88 ($59.40/5 = $11.88). Since one of the patients is non-Medicare, four claims would be submitted for $11.88 each, plus the specimen collection fee for each.

Example 5:

A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $9.90 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $9.90 = $19.80) and then divided by five (1/5 of $19.80 = $3.96). Since one of the patients is non-Medicare, four claims would be submitted for $3.96 each, plus the specimen collection fee.

If an A/B MAC (B) determines that it results in equitable payment, the A/B MAC (B) may extend the former payment allowances for additional travel (such as to a distant rural nursing home) to all circumstances where travel is required. This might be appropriate, for example, if the A/B MAC (B)'s former payment allowance was on a per mile basis. Otherwise, it should establish an appropriate allowance and inform the suppliers in its service area. If an A/B MAC (B) decides to establish a new allowance, one method is to consider developing a travel allowance consisting of:

- • The current Federal mileage allowance for operating personal automobiles, plus a personnel allowance per mile to cover personnel costs based upon an estimate of average hourly wages and average driving speed

A/B MACs (B) must prorate travel allowance amounts claimed by suppliers by the number of patients (including Medicare and non-Medicare patients) from whom specimens were drawn on a given trip.

The A/B MAC (B) may determine that payment in addition to the routine travel allowance determined under this section is appropriate if:

- The patient from whom the specimen must be collected is in a nursing home or is homebound; and
- The clinical laboratory tests are needed on an emergency basis outside the general business hours of the laboratory making the collection
- Subsequent updated travel allowance amounts will be issued by CMS via Recurring Update Notification (RUN) on an annual basis.

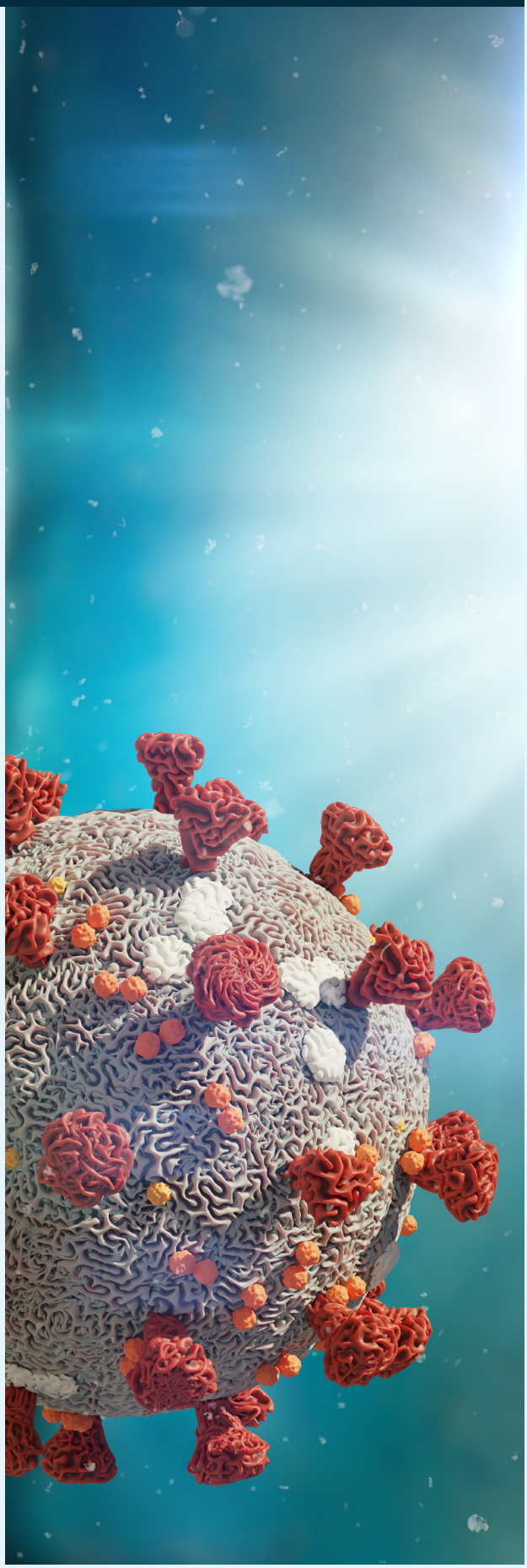
CORONAVIRUS UPDATE 2-28-2020

Coronaviruses are classified as a large family of viruses that cause infection in the sinuses, nose and upper throat. Some coronaviruses cause illness in people and others circulate among animals, including camels, cats and bats.

The 2019 Novel Coronavirus is a new form of coronavirus first identified in Wuhan, Hubei Province, China. This virus has been officially named “SARS-CoV2” which is a betacoronavirus.The disease it causes is now referred to as COVID-19 (previously referred to as 2019-nCoV).

The COVID-19 outbreak has been detected in 50 locations internationally, including multiple confirmed cases in the United States.The Centers for Disease Control (CDC) confirmed that the disease has caused illness including illness resulting in death and sustained person to person spread.Individual risk is dependent on exposure.

Symptoms of the COVID-19 can include fever, cough and shortness of breath.However, some patients with confirmed COVID-19 have developed little to no symptoms depending on the incubation period.The CDC reported, “Symptoms may appear in as few as 2 days or as long as 14 after exposure “. The CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens.



Coding COVID-19

As new clinical information becomes available, detail in coding selection may be revised.The ICD-10-CM codes provided in this reference are intended to provide information on the coding of encounters related to coronavirus. All coding selections should be supported by documentation.

CORONAVIRUS UPDATE 2-28-2020

Confirmed Cases

When a one of the following conditions is confirmed as due to the COVID-19, both the respiratory condition and ICD-10CM code B97.29 should be coded. Refer to the **PARA Data Editor** code selection below:

- **Pneumonia** confirmed as due to the COVID-19, assign codes J12.89; Other viral pneumonia, and B97.29; Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J1289	Other viral pneumonia
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Acute bronchitis** confirmed as due to COVID-19, assign codes J20.8, Acute bronchitis due to other specified organisms, and B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J208	Acute bronchitis due to other specified organisms
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Bronchitis Not Otherwise Specified (NOS)** due to the COVID-19, assign codes J40, Bronchitis, not specified as acute or chronic; and B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J40	Bronchitis, not specified as acute or chronic
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Acute respiratory infection, NOS or Lower respiratory infection NOS**, assign ICD-10 CM codes code J22, Unspecified acute lower respiratory infection, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J22	Unspecified acute lower respiratory infection
B9729	Other coronavirus as the cause of diseases classified elsewhere

CORONAVIRUS UPDATE 2-28-2020

- **Respiratory infection, NOS**, assign ICD-10 CM code J98.8, Other specified respiratory disorders, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J988	Other specified respiratory disorders
B9729	Other coronavirus as the cause of diseases classified elsewhere

- **Acute respiratory distress syndrome (ARDS)**, assign ICD-10 CM codesJ80, Acute respiratory distress syndrome, and B97.29, Other coronavirus as the cause of diseases classified elsewhere

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
J80	Acute respiratory distress syndrome
B9729	Other coronavirus as the cause of diseases classified elsewhere

Concern for or Exposure to COVID-19

In some cases, the patient may be evaluated for exposure or possible exposure to the COVID-19, however, after evaluation the condition may be ruled out.In those cases, it would not be appropriate to report a code for the actual virus. Please refer to the **PARA Data Editor** code descriptions for exposure without symptoms.

- **Actual Exposure to COVID-19** without symptoms, assign ICD-10 CM code Z20.828, contact with and (suspected) exposure to other viral communicable diseases

- **Concern of possible exposure** without symptoms, assign ICD-10 CM code Z03.818, Encounter of observation for suspected exposure of other biological agents ruled out

PARA - Healthcare Financial Services
ICD10 Codes

ICD10 Code	Description
Z20828	Contact with and (suspected) exposure to other viral communicable diseases
Z03818	Encounter for observation for suspected exposure to other biological agents ruled out

When signs and symptoms are documented, the coder should report that symptom rather than a code for exposure or possible exposure.

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

PARA - Healthcare Financial Services
ICD10 Codes

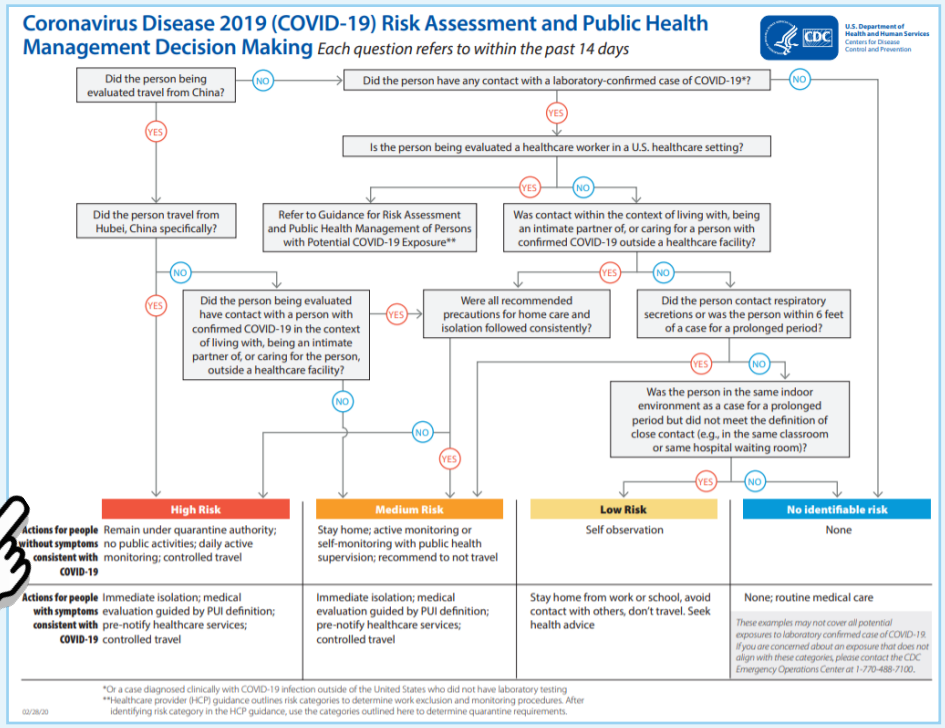
ICD10 Code	Description
R05	Cough
R0602	Shortness of breath
R509	Fever, unspecified

CORONAVIRUS UPDATE 2-28-2020

Risk Assessment

Please refer to the Risk Assessment reference from the CDC.The CDC continues to monitor and provide updates of the virus.

https://www.cdc.gov/coronavirus/2019-ncov/downloads/public-health-management-decision-making.pdf



The CDC reported that the COVID-19 is likely spread person to person via respiratory droplets when the infected person coughs or sneezes.There is much more to learn about the transmissibility, severity, and other features associated with COVID-19 and investigations are ongoing.

https://www.cdc.gov/coronavirus/2019-ncov/index.html

The best way to prevent infection is to avoid being exposed to this virus. However, as a reminder, CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:

- Wash your hands often with soap and water for at least 20 seconds
- Use an alcohol-basedhand sanitizer that contains at least 60% alcohol if soap and water are not available
- Avoid touching your eyes, nose, and mouth with unwashed hands
- Avoid close contact with people who are sick
- Stay home when you are sick
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash
- Clean and disinfect frequently touched objects and surfaces

4 NON-TRADITIONAL APPROACHES TO MITIGATING WRITE-OFFS AND IMPROVING HOSPITAL COLLECTIONS

Multiple factors continue to fuel a dramatic increase in hospital bad debt nationwide, squeezing already-thin hospital margins and undermining financial stability. Yet even as the problem grows worse, many facilities admit they don't have systems in place to recover bad debt. And among those that do, the vast majority don't expect to collect more than 20 cents on the dollar.

As value-based care turns up the pressure on revenues, few organizations can afford to carry a growing burden of bad debt. Without tools to identify and reduce the causes of bad debt and maximize the collection of aging claims when they do occur, hospitals put their financial future at risk.

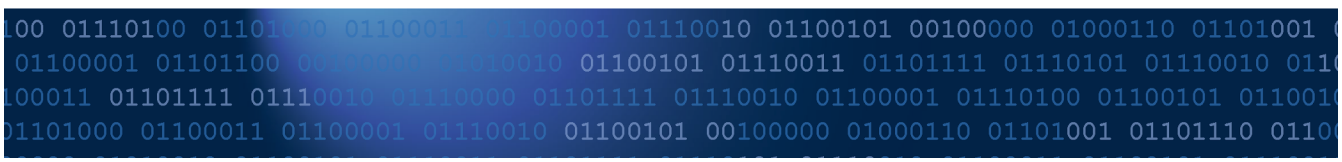
Fortunately, new technologies are supporting highly effective, non-traditional methods for eliminating bad debt at its inception and generating much higher collection rates on even the oldest unpaid claims. Healthcare Financial Resources Inc. (HFRI) is an industry leader in implementing these breakthrough solutions. For clients, HFRI can transform unpaid bills that otherwise would've been written down to zero into a substantial and sustainable revenue stream.

WRITE-OFFS SNOWBALL

Bad debt represents claims for service—both to insurance companies and patients—that are not expected to be paid and ultimately must be written off the balance sheet. For hospitals, it is an enormous and growing challenge. From 2011 and 2017, write-offs for the average, 350-bed hospital soared by 79%, from $3.9 million per facility to $7 million.[1]

In a 2018 survey of hospital C-suite executives and finance leaders, approximately two-thirds of respondents said their organization's bad debt was $10 million or less, while another one-third reported bad debt exceeding $10 million.[2] Of that group, 20% had bad debt of between $10 million and $30 million, 10% had between $30 million and $50 million, and 6% had bad debt in excess of $50 million.[3] According to Moody's Investors Service, nonprofit hospitals' median bad debt as a percentage of net revenues rose to 4.6% in 2018 from 4.3% in 2017.[4]

Hospitals say the epidemic of unpaid bills to a great extent reflects the rise of high-deductible health insurance plans, which increased in volume from just 4% of the overall insured population in 2006 to 29% in 2018.[5]

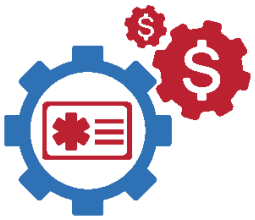


In a 2018 survey by Sage Growth Partners, 59% of responding healthcare executives (and 68% of executives with small, 50-beds-or-less hospitals) said high patient co-pays, greater deductibles and other health insurance reforms collectively represented the largest drivers of bad debt.[6]

There's no question high-deductible plans are increasing the financial strain for patients, whose average out-of-pocket costs jumped 11% in 2017 to $1,813 by year-end.[7] A 2017 poll underscored the anxiety many consumers experience when it comes to healthcare expenses: Less than a quarter of Americans said they could cover an unexpected medical bill of $2,000 or more, and almost two-thirds said they believed a large medical bill they were unable to afford was worse or equal to a serious illness.[8]

Along with high-deductible plans, other factors contributing to bad debt include ineffective revenue cycle management processes, industry-wide revenue cycle management complexities and regulations, changes in reimbursement models and high poverty rates, according to hospital leaders.[9]

Legislative initiatives designed to reduce surprise medical billing also have the potential to exacerbate the bad debt problem, Moody's Investors Service reports. While these laws would benefit consumers, they would also increase hospitals' billing and collection responsibilities.[10]



A SHIFTING PLAYING FIELD

Other industry changes threaten to compound, directly or indirectly, the burden bad debt imposes on hospitals. For example, before 2012, the Centers for Medicare and Medicaid Services (CMS) reimbursed Medicare providers for between 70-100% of beneficiary bad debt, depending on the provider type.

However, the Middle-Class Tax Relief and Job Creation Act of 2012 stipulated a three-year, phase-down of Medicare bad debt reimbursement to a maximum of 65%, starting in 2013. A recent study pegged the cumulative impact of this reduction on hospitals at about $5.7 billion in foregone Medicare revenue over the period extending from 2013 to 2029.

Separately, a new accounting standard that took effect in December 2018 significantly altered the definition of bad debt. Previously, most hospitals reported bad debt as the difference between what they billed patients and what the patients actually ended up paying. But under the new standard, hospitals can only report bad debt when an adverse personal event like bankruptcy or loss of employment prevents the patient from paying what the hospital expected to receive.[11]

The change, imposed by the Financial Accounting Oversight Board, may impact how some hospitals report their community benefits which, in turn, could jeopardize their tax-exempt status.[12] In addition, monitoring actual levels of bad debt may become more problematic for hospitals, since the standard narrows its definition and no longer requires the disclosure of bad debt on financial statements.[13]

INADEQUATE TOOLS

> "90% OF HOSPITALS DON'T EXPECT TO RECOVER MORE THAN 20% OF THEIR BAD DEBT."

Given the magnitude of the bad debt problem, one might assume hospitals are pursing all available means to improve collections and mitigate write-offs. However, the complexity of the revenue cycle, coupled with the labor-intensive nature of reworking denied and unpaid claims, makes the task of cleaning up bad debt much easier said than done.

The surprising reality is that fully one-fifth of hospitals, or 21%, do not have an in-house process or third-party vendor for bad debt recovery, according to a 2018 survey by Sage Growth Partners.[14] And of those that do, more than 90% don't expect to recover more than 20% of their bad debt, the survey found.[15]

Healthcare AR follow-up traditionally has been highly dependent on manual intervention. Because the reasons for denying or delaying claims can vary greatly between insurance companies, trained personnel must analyze each unresolved payment and associated payer rules to determine the underlying cause and what, if any, action can be taken.

This process can be extremely time-consuming and usually involves multiple conversations with the insurance company representative. As payer contracts and reimbursement requirements have become more complex and the volume of insurance company denials has increased, the ability of staff to keep pace has diminished.

Recent analysis found that hospital claims totaling $262 billion were denied in 2016; an amount representing about 9% of all healthcare transactions.[16] The cost of remediating denials through appeal, meanwhile, averaged $118 per claim, or $8.6 billion for U.S. hospitals overall.[17] Yet only about 65% of payer rejections are reworked and resubmitted.[18]

4 NON-CONVENTIONAL APPROACHES TO BAD DEBT REDUCTION

HFRI has focused exclusively on the challenges associated with hospital payment delay, denial resolution and bad debt for nearly 20 years. From this effort, we've perfected a system that relies on pricing transparency to quantify the patient's financial responsibility, along with robotic process automation, intelligent automation and staff specialization to streamline and accelerate the resolution process. Our process relies on four, non-conventional approaches:

1. **Zeroing in on denial management**

   Through the years, we've identified the top reasons, or root causes, for denied or delayed claims. Understanding specific denial types and the departments where they're likely to occur allows organizations to establish proactive systems that help prevent the denials from happening in the first place. Additionally, organizations can develop new training in these areas to help lower the denial rate and increase revenue. Finally, the ability to pinpoint denial types, causes and patterns enables prompt follow-up with insurance companies to ensure payments are made in accordance with the terms of an existing contract.

The top seven reasons for denials, based on our extensive experience with clients, include:

- **Utilization:** This category includes the clinical areas of medical necessity, pre-authorization, DRG downgrades and experimental treatments.
- **Coverage:** Unresolved claims due to coverage issues involve real or perceived errors or omissions surrounding health plan coverage limits.
- **Contractual:** Payment delays and rejections stemming from contractual issues can involve a wide range of issues, from payer underpayments for specific services like surgery, ED, lab and radiology, therapies and observation to misinterpretations regarding per diems, bundled payments for multiple procedures and carve-outs.
- **Coding and Billing:** Coding and billing issues can involve Reason Code 97 rejections triggered by the failure of hospital coders to properly include National Correct Coding Initiative (NCCI) edits, as well as demographic errors.
- **Submission/Re-billing:** Denials triggered by submission problems include failure to include the primary EOB, crossovers between supplemental and primary insurance and missing medical records are common rejection reasons.
- **Cash Posting:** This category frequently involves problems determining the appropriate allocation of unapplied cash.
- **Process Delays:** Process issues usually involve payers taking an excessive amount of time to process a claim for reasons unrelated to the claim itself.

For more detailed information, read The 7 Most Common Root Causes for Denials and Delayed Account Resolution

2. **Price transparency capabilities**

Overcoming denials and bad debt starts with improved price transparency. Our comprehensive process allows hospitals to create rational and sustainable pricing models built around accurate cost, reimbursement and peer pricing data.

Not only does this enable the hospital to develop market-based pricing strategies that optimize margins while remaining competitive with local and regional peer organizations, the information can be cross-referenced against a patient's deductible and co-pay limits to determine what that individual will owe. This, in turn, can be shared with patients in an easy-to-understand format to accurately convey their financial responsibilities before services are rendered.

Creating detailed patient cost visibility allows hospitals to either receive payment upfront or work with the patient to develop a viable payment plan. In either case, the likelihood of patient bad debt is significantly diminished.

3. New technological tools

HFRI's robotic process automation (RPA) helps alleviate the workload associated with denial remediation and bad debt mitigation by replicating simple, manual human activities, while intelligent automation takes this a step further by incorporating machine learning and decision-making logic into the process.

HFRI's hybrid technological/expert specialization approach is unlike any other bad debt service or solution on the market. This process reduces the human touches necessary to identify the root causes of payment delays, underpayments and denials.

It also provides detailed information which allows HFRI remediation specialists to work far more efficiently and effectively to resolve unpaid claims. Just as important, intelligent automation is able to remedy the simplest denials or delays with no human intervention whatsoever.

This process can also quickly identify patient responsibility, allowing hospitals to generate invoices quicker. The sooner a patient understands their financial responsibility, the better chance you'll have of recovering that money. Together, these breakthrough technological capabilities accelerate claims resolution, reduce write-offs and improve hospital cash flow.

For more information on HFRI's intelligent automation process, read 6 Steps for Deploying Intelligent Automation Solutions in Denial Management

4. Pre write-off AR management

As part of its overall bad debt mitigation solution, HFRI harnesses its technology to address hospitals' oldest outstanding claims. The goal is to increase reimbursements by ensuring that even AR that is 300 days or older continues to be pursued to resolution.

This approach represents a significant shift in the industry. According to a recent study, 20% of responding chief financial officers said their hospital or health system currently writes off claims at 120 days, while 92% said they write off claims from between 120 to over 300 days.[19]

HFRI's pre write-off processes can be incorporated as one element in a comprehensive AR management strategy designed to optimize collections at each stage of the claim's lifecycle. A health system on the West Coast, for example, uses internal staff to work commercial accounts up to 60 days from the billing date, then shifts to a primary AR vendor to handle claims that are aged 60 to 120 days. HFRI is assigned claims of 180 days or greater and has collected over $50 million in revenue from these highly-aged claims since 2012.

By pursuing super-aging claims, even those with small dollar value, HFRI can help health systems increase cashflow and improve margins. Resolving denials that previously have been worked unsuccessfully by internal billing staff or primary vendors generates new collections from claims that otherwise would have been written off.

For more detailed information on HFRI's pre write-off solution, read 4 Steps to Reducing Aged AR Denial Write-Offs and Increasing Cash Collections

Download the PDF version by clicking the image above.

DEMONSTRATED SUCCESS

For most hospitals, HFRI's comprehensive AR management solution typically increases cash collections by 30% versus a non-automated approach, and some clients have seen collections jump by as much as 100%. In addition, the lifecycle for resolving a claim is generally reduced by 25% or more. And thanks to ongoing process improvement guidance provided by HFRI, the volume of denials, delays and underpayments is usually reduced by 20-25%.

For years, many hospitals viewed bad debt as an unfortunate but unavoidable cost of doing business. But as unpaid claims pile up, bad debt has emerged as a grave threat to hospitals' financial sustainability. If your organization is ready to finally tackle this chronic problem in a systematic and effective manner, contact HFRI to learn more about how we can help you collect every dollar you're entitled to.

[1] Kelly Gooch, "4 ways hospitals can lower claim denial rates," Becker's Hospital CFO Report, Jan. 5, 2018
[2] Jacqueline LaPointe, "21% of Orgs Do Not Have a Hospital Bad Debt Recovery Process," RevCycle Intelligence, June 20, 2018
[3] Ibid.
[4] Kelly Gooch, "Nonprofit hospitals' bad debt is rising again, Moody's says," Becker's Hospital CFO Report, Nov. 22, 2019
[5] Ibid.
[6] Jacqueline LaPointe, "21% of Orgs Do Not Have a Hospital Bad Debt Recovery Process," RevCycle Intelligence, June 20, 2018
[7] Ibid.
[8] "Ipsos/Amino Poll: 63% of Americans Think a Large Medical Bill That They Can't Afford is Worse Than or Equal to a Serious Illness," Amino, March 21, 2017
[9] Ibid.
[10] Tina Reed, "Moody's: Higher deductibles, surprise billing legislation will increase hospitals' bad debt," Fierce Healthcare, Nov. 25, 2019
[11] "The definition of `bad debt' just changed. Here's what you need to know," Advisory Board, March 23, 2018
[12] Ibid.
[13] Tina Reed, "Moody's: Higher deductibles, surprise billing legislation will increase hospitals' bad debt," Fierce Healthcare, Nov. 25, 2019
[14] Jacqueline LaPointe, "21% of Orgs Do Not Have a Hospital Bad Debt Recovery Process," RevCycle Intelligence, June 20, 2018
[15] Ibid.
[16] Philip Betbeze, "Claims Appeals Cost Hospitals Up to $8.6B Annually," HealthLeaders, June 26, 2017
[17] Ibid.
[18] Chris Wyatt, "Optimizing the Revenue Cycle Requires a Financially Integrated Network," HFMA, July 7, 2015
[19] Philip Betbeze, "Claims Appeals Cost Hospitals Up to $8.6B Annually," HealthLeaders, June 26, 2017

HEALTHCARE FINANCIAL RESOURCES

Healthcare Financial Resources (HFRI) transforms accounts receivable follow-up by harnessing intelligent automation to help hospitals and health systems accelerate cash flow and improve operating margins by resolving insurance claims quickly and effectively.

For more information, visit: www.hfri.net
2500 Westfield Dr. Suite 2-300 | Elgin, IL 60124 | 888.971.9309

Resolution | Recovery | Management

HFRI is altering the hospital AR landscape by delivering unparalleled speed, scalability and accuracy to the insurance AR management process. Through our proprietary, intelligent automation and powerful process engineering, we're able to resolve all claims, regardless of size or age. That means you're able to recover collections from insurance claims that otherwise would have been written off.

Our AR management services are easily integrated into your hospital's existing workflow to seamlessly function as an extension to your existing billing office. **HFRI** specialists collaborate with your team not only to assist with your denial management initiatives but to identify root causes that will help prevent denials from occurring in the first place.

Specialized Services to Improve AR Performance

HEALTHCARE FINANCIAL RESOURCES

HFRI's scalable, client-specific solutions allow hospitals to systematically address problem claims across the full AR spectrum, from government and commercial payers to managed care, worker's compensation and personal injury claims.

Our capabilities include:

- Primary AR recovery and resolution
  We pursue aging, small-balance claims identified by your staff as problematic. If a claim has previously been worked internally, referring it to **HFRI's** dedicated, specialized teams can help ensure quicker cash conversion and a reduction of bad debt reserves.

- Pre write-off AR recovery and resolution
  In addition to primary AR recovery and management services, **HFRI** also offers pre write-off (often known as secondary) insurance AR recovery to help you collect highly-aged claims and minimize write-offs.

- Legacy system conversions
  Transitioning to a new system can slow down the claims process and create problems for hospital personnel who must work between two billing platforms. **HFRI** can provide interim solutions to help you accelerate pre-conversion cash and assist with post-conversion AR resolution. AR recovery projects: **HFRI** is available to assist you on a temporary project basis to address AR backlogs that can't be worked by your existing staff.

NEW YEAR'S RESOLUTION #1: GET PDE FIT

In an effort to streamline the **PARA Data Editor (PDE)** training process, **PARA** will begin hosting weekly Overviews of the **PDE**. These sessions will be open to any client or user who wishes to join, and will consist of a high-level review of the functionality available within the **PDE**. If you are new to the **PDE**, or would like a refresher on its capabilities, please join us at whichever session is most convenient for you.

Beginning January 8, 2020 Overview sessions will be held:

Wednesdays at 11:00 am Pacific time
(12:00 pm Mountain, 1:00 pm Central, 2:00 pm Eastern)

Fridays 8:00 am Pacific time
(9:00 am Mountain, 10:00 am Central, 11:00 am Eastern)

Please note, focused training for your staff on the modules of the **PDE** that you choose to utilize will still be available.

If you are interested in attending one of the sessions, please email Mary McDonnell, Director of PDE Training and Development at mmcdonnell@para-hcfs.com. An invitation to the session of your choice will be emailed to you. If you have any questions, please email us at the address above or call (800) 999-3332 ext. 216.

KEY OPPORTUNITIES FOR HOSPITALS TO BOOST MARGINS

About 60 million Americans live in rural areas and depend on local hospitals for care. In 2019, a record 18 rural hospitals closed, bringing the total closures since 2010 to 124, according to the Cecil G. Sheps Center for Health Services Research.

With almost 700 more rural hospitals at risk of shutting, the need for strategies to boost margins at these facilities has never been greater.

During a February 26, 2020 webinar sponsored by **Healthcare Financial Resources** and hosted by Becker's Hospital Review, three representatives from **HFRI** discussed ways hospital leaders can help their organizations achieve financial sustainability.

Participants included:

- Jon Giuliani, Vice President of Operations
- Randi Brantner, Vice President of Analytics
- Daniel Low, Director of Operations

Factors contributing to rural hospital closures include increasing costs and declining revenues, complex patient populations and difficulties attracting and retaining providers. Solving these issues can not only help these hospitals stay open, but really thrive in their communities, according to Mr. Giuliani.

"The best way to ensure we can offer the highest quality of care to as many people as possible is to ensure our providers are healthy financially," Mr. Giuliani said. "Those margins help drive growth, research and continuous improvement in care."

Preparing for price transparency

To achieve thicker margins, today's hospital leaders must help their organizations meet the demands of changing regulatory requirements and rising consumerism within the industry.

In 2015, CMS began introducing price transparency guidelines, requiring hospitals to provide a standard list of charges upon patient request. Beginning in 2021, CMS' final rule will require hospitals to publish standard charges online in a machine-readable file and to disclose negotiated payer rates.

"We foresee a continued legal battle but are proactively looking to prepare our hospitals for a consumer-centric approach to pricing transparency," Ms. Brantner said. "We recommend an intuitive user-friendly solution that incorporates the complete list of charges, the base CDM price and a list of common procedures in a consumer-friendly language."

HFRI also suggests initiating the functionality to allow patients to enter copay and deductible information for a more complete estimate. By inputting the patient's insurance details and accessing the facility's historical data, hospitals can gauge a truer estimate of services and patient obligation, according to Ms. Brantner.

"We've found that this strategy improves collections, reduces bad debt and is great customer service that improves the customer experience," Ms. Brantner said.

KEY OPPORTUNITIES FOR HOSPITALS TO BOOST MARGINS

Designing pricing strategies

Before hospitals publish their charges — which are intended to represent the statistical basis of costs for hospitals—a prudent pricing strategy should be implemented. Thus, **HFRI** recommends hospitals price a chargemaster in line with Medicare fee schedules, costs or comparative peer-pricing data.

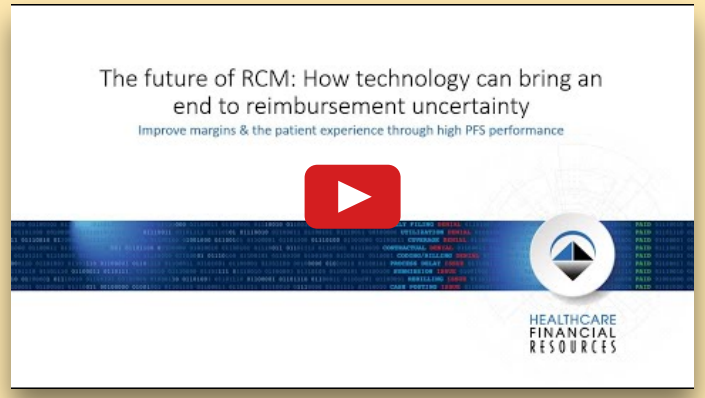
All hospitals are reimbursed differently, depending on their outpatient prospective payment system, critical access status or other third party payer contracts, but most charges are typically divided into five basic revenue streams: room rates/observations, emergency room/clinic visits, diagnostic and therapeutic services, operating room services and drugs and supplies.

"Cost-based mark-ups are recommended for drugs/supplies so that full transparency can be achieved," Ms. Brantner said. "We also recommend identifying [diagnostic and therapeutic] items with negative patient satisfaction and pricing those items competitively for outpatients against other data sources, such as a freestanding facility or actual clinic data."

Before new price transparency regulations take effect, it's important for hospitals to establish rational pricing strategies that can stand up to the test of consumerism. Implementing effective pricing methods improve hospitals' contract management capabilities—as they have prices that are relative to the peer market—and enable them to better articulate pricing strategies to payers.

Opportunities to boost hospital efficiencies

Identifying payer issues upfront can help hospitals improve back-end efficiency and reduce cash loss. Additionally, improved efficiency and well-organized teams will ultimately lead to an improved patient experience.



"A well-tuned insurance accounts receivable team will help ensure patients' claims are paid appropriately and that patients are billed correctly and timely," Mr. Low said. "Identifying [payer] issues and building payer relationships is also critical to reducing current and future rejections."

Challenges with new EHR systems have been well-documented, with one survey finding 65 percent of respondents who implemented new software experiencing financial losses in their practice. To ensure EHR systems don't negatively impact efficiency, productivity and cost, complete and proper implementation should be top of mind for hospitals.

During new implementations, facilities often see days in accounts receivable and denials increase while cash flow decreases, which can be a year or more until stabilization, according to Mr. Low.

"Building, reporting and assessing the data with the EHR system is a challenging and always evolving task," Mr. Low said. "Communication between the clearinghouse and EHR should be a main focus to ensure staff have the ability to stop account issues prior to billing."

Conclusion

Preparing for price transparency and developing effective pricing strategies for hospital charges is paramount for all healthcare facilities this year. Meeting this challenge will be especially important for rural hospitals and other organizations facing fiscal challenges. Healthcare leaders should look to arm their teams with the appropriate tools and processes for improving revenue cycle efficiency and reimbursement.

To learn more about Healthcare Financial Resources click here, and view the full webinar here or the icon above.

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, March 5, 2020

News

·DMEPOS Suppliers: HCPCS Codes Affected by Further Consolidated Appropriations Act

·Medicare Promoting Interoperability Program: CAH Reconsideration Forms due March 6

·Medicare Promoting Interoperability Program: Submit Proposals for New Measures by July 1

·PEPPERs for Short-term Acute Care Hospitals

·2018 Geographic Variation Public Use File

·Help Your Patients Make Informed Food Choices

Compliance

·Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

·Average Sales Price Files: April 2020

Events

·Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12

·Open Payments: Your Role in Health Care Transparency Call — March 19

·Anesthesia Modifiers: Comparative Billing Report Webinar — March 19

·Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2

·LTCH and IRF Quality Reporting Programs: SPADEs In-Depth Training Event — June 9-10

MLN Matters® Articles

·Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements

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

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

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.**

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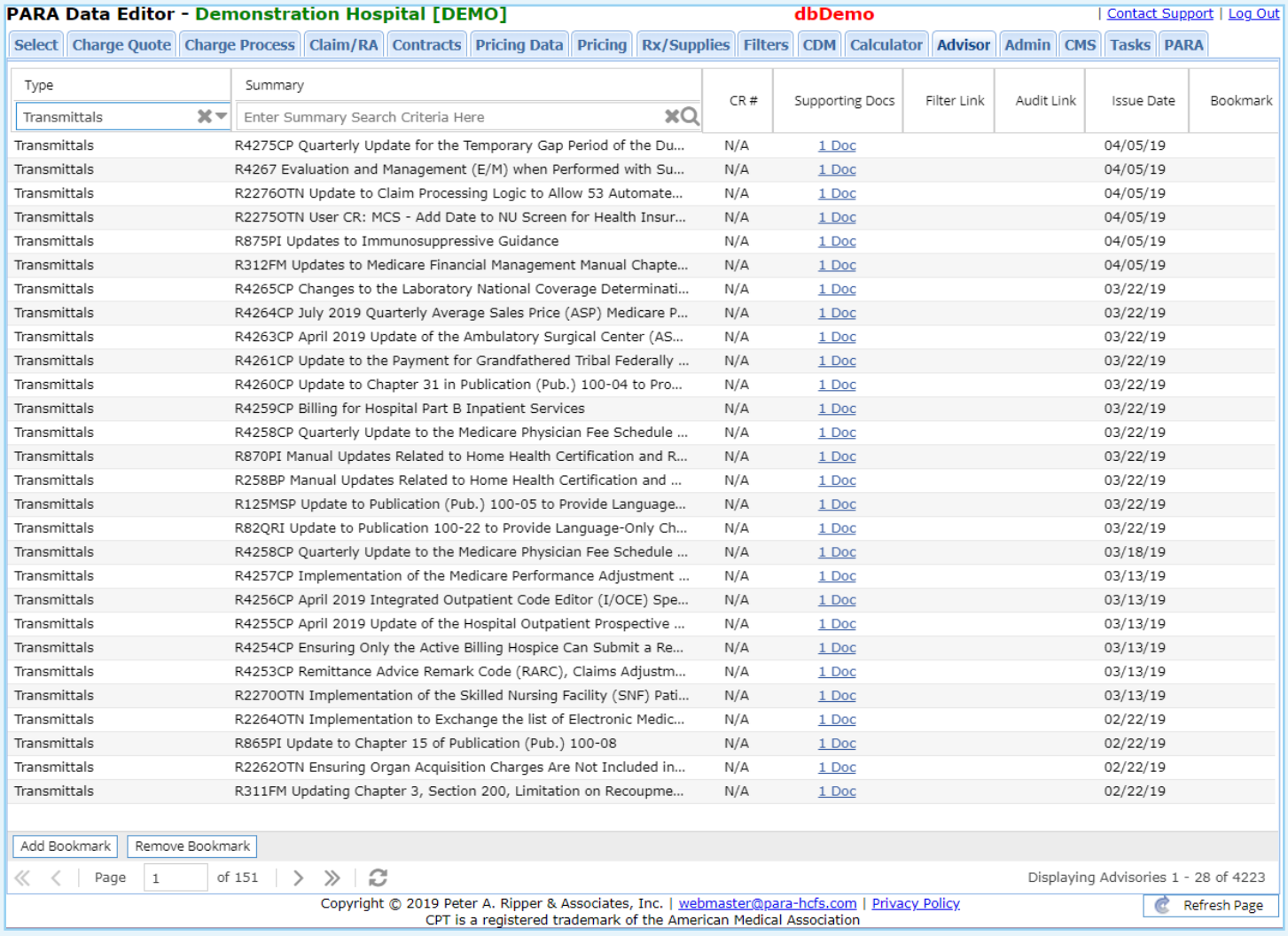

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Transmittals	R4275CP Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			04/05/19	
Transmittals	R4267 Evaluation and Management (E/M) when Performed with Su...	N/A	1 Doc			04/05/19	
Transmittals	R2276OTN Update to Claim Processing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

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The link to this MedLearn MM11680

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April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1

MLN Matters Number: MM11680 | Related Change Request (CR) Number: 11680

Related CR Release Date: March 6, 2020 | Effective Date: April 1, 2020

Related CR Transmittal Number: R4543CP | Implementation Date: April 6, 2020

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 11680 provides the Integrated OCE (I/OCE) instructions and specifications for the I/OCE that is being updated for April 1, 2020. Please make sure your billing staff is aware of this update.

BACKGROUND

CR 11680 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/COE is being updated for April 1, 2020. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated I/OCE.

This I/OCE will be used in the Outpatient Prospective Payment System (OPPS) and for non-OPPS claims for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the HH PPS or to a hospice beneficiary for the treatment of a non-terminal illness.

The I/OCE specifications will be posted on the Centers for Medicare & Medicaid Services website at http://www.cms.gov/OutpatientCodeEdit/.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendment (CLIA) Edits

MLN Matters Number: MM11640
Related Change Request (CR) Number: 11640
Related CR Release Date: March 6, 2020
Effective Date: April 1, 2020
Related CR Transmittal Number: R4542CP
Implementation Date: April 6, 2020

Note: On March 5, CMS released information about developing a second HCPCS billing code (U0002), which laboratories can use to bill for certain 2019-Novel Coronavirus (COVID-19) and SARS-Co-V-2 diagnostic tests to help increase testing and track new cases, in addition to a previous HCPCS billing code (U0001), which laboratories can use to test for SARS-Co-V-2. (See https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests.)

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 11640 informs the MACs about new HCPCS codes for 2020 that are subject to and excluded from Clinical Laboratory Improvement Amendment (CLIA) edits. Please make sure your billing staffs are aware of this update.

BACKGROUND

CLIA regulations require facilities to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for an HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

HCPCS codes that are considered a laboratory test under CLIA change annually.

The following HCPCS code was discontinued on June 30, 2019:

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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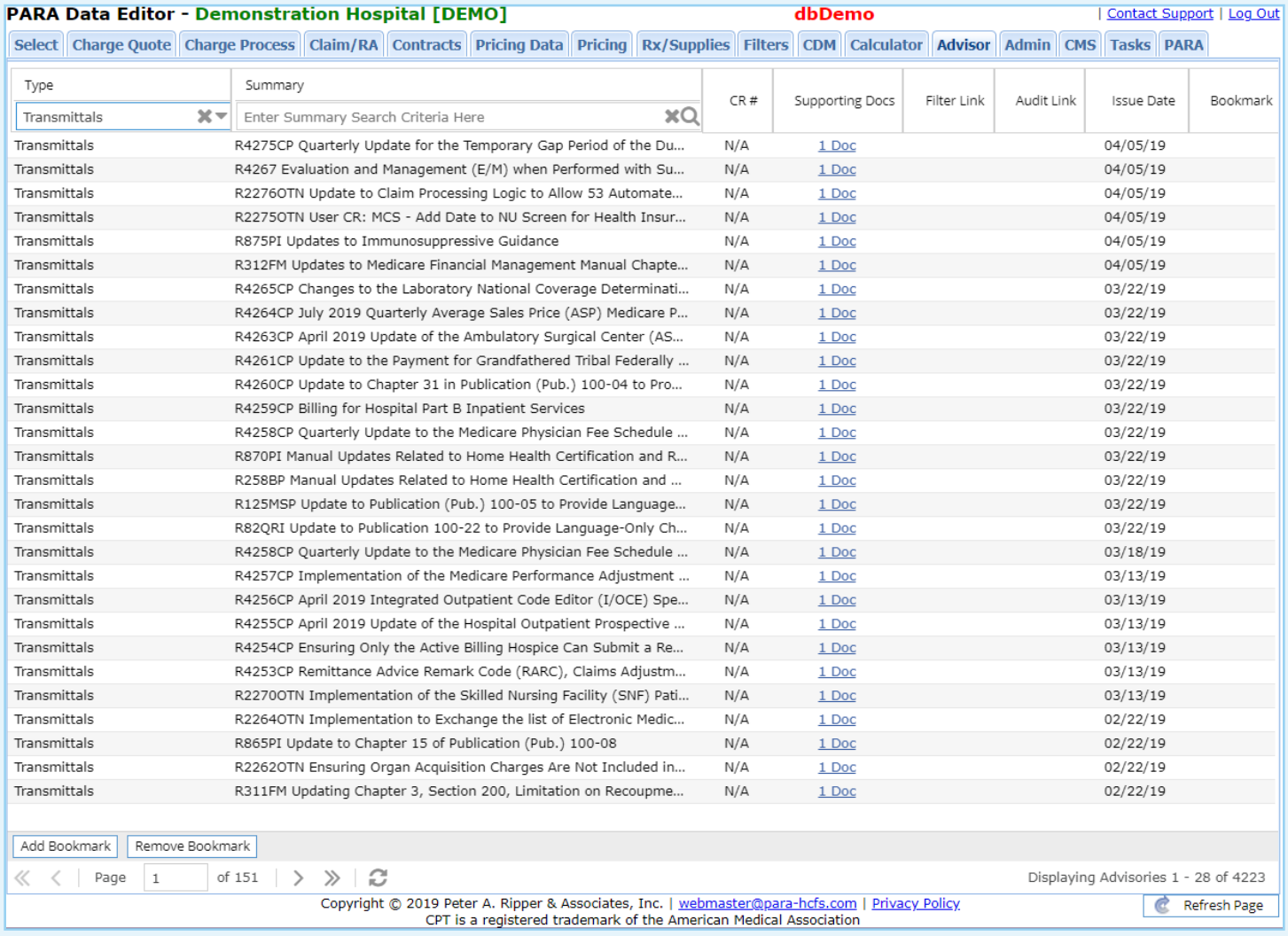
There were FIVE new or revised Transmittals released this week.

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** 5



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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	
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Transmittals	R4254CP Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
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Transmittals	R2270OTN Implementation of the Skilled Nursing Facility (SNF) Pati...	N/A	1 Doc			03/13/19	
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Transmittals	R865PI Update to Chapter 15 of Publication (Pub.) 100-08	N/A	1 Doc			02/22/19	
Transmittals	R2262OTN Ensuring Organ Acquisition Charges Are Not Included in...	N/A	1 Doc			02/22/19	
Transmittals	R311FM Updating Chapter 3, Section 200, Limitation on Recoupme...	N/A	1 Doc			02/22/19	

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The link to this Transmittal R944PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 944	**Date: March 06, 2020**
	Change Request 11541

SUBJECT: Section 4.26.2 in Chapter 4 of Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to re-insert a paragraph in section 4.26.2 in chapter 4 of Pub. 100-08 that was deleted in error. The paragraph permits a supplier to deliver a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) item to the patient's home approximately two (2) days prior to the patient's anticipated discharge.

EFFECTIVE DATE: April 06, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 06, 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	4/4.26/4.26.2/Exceptions

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 R4543CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4543	**Date: March 06, 2020**
	Change Request 11680

SUBJECT: April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1

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

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

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

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

Recurring Update Notification

The link to this Transmittal R4544CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4544	**Date: March 06, 2020**
	Change Request 11691

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

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

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

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

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

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R4542CPI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4542	**Date: March 06, 2020**
	Change Request 11640

SUBJECT: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

I. SUMMARY OF CHANGES: This Change Request (CR) informs contractors about the new HCPCS codes for 2020 that are subject to and excluded from CLIA edits. This Recurring Update Notification applies to Chapter 16, section 70.9.

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

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

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

III. FUNDING:

For Medicare Administrative Contractors (MACs):
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R4541CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4541	**Date: March 6, 2020**
	Change Request 11681

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

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

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

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

Recurring Update Notification

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