# PARA WEEKLY eMAGAZINE

*Improving The Business of HealthCare Since 1985*

*March 13, 2019*

PRICING • CODING • REIMBURSEMENT • COMPLIANCE

## IN THIS ISSUE



## PARA



## NEWS FOR HEALTHCARE DECISION MAKERS

**1**

The number of new or revised Med Learn (MLN Matters) articles released this week. All new and previous Med Learn articles can be viewed under the type "Med Learn", in the **Advisor** tab of the **PARA Data Editor.** *Click here*

**7**

The number of new or revised Transmittals released this week. All new and previous Transmittals can be viewed under the type "Transmittals" in the **Advisor** tab of the **PARA Data Editor.** *Click here.*

**LABORATORY PRIVATE PAYORS**

***CMS Expands Reporting*** ***Page 10***

## FAST LINKS

# INFUSION OF CONTRAST

**Q.** Our facility is starting to see denials for the infusion/injections codes 96365, 96372 due to being a component of an imaging service such as 71275. I have discussed this with our radiology manager and they use the same access site as the ER to administer contrast, so we can't really apply a modifier for a distinct or separate service, can we?

If we can't apply a modifier, can you advise how to handle these situations as we won't start another access line unless necessary for imaging services?

**A.** **Answer:** It is inappropriate to report an IV therapy code for an imaging procedure which includes the phrase "with contrast" in the description.

Here's a link and an excerpt from the Medicare National Correct Coding Manual for 2019:

https://apps.para-hcfs.com/para/documents/CHAP9-CPTcodes70000-79999_draft%20103117.pdf

D. Interventional/Invasive Diagnostic Imaging

1. If a radiologic procedure requires that contrast be administered orally (e.g., upper GI series) or rectally (e.g., barium enema), the administration is integral to the radiologic procedure, and the administration service is not separately reportable. If a radiologic procedure requires that contrast material be administered parenterally (e.g., IVP, CT, MRI), the vascular access (e.g., CPT® codes 36000, 36406, 36410) and contrast administration (e.g., CPT® codes 96360-96376) are integral to the procedure and are not separately reportable.

CHAP9-CPTcodes70000-79999_final10312017.doc
Revision Date: 1/1/2018

CHAPTER IX
RADIOLOGY SERVICES
CPT CODES 70000 - 79999
FOR
*NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL*
*FOR MEDICARE SERVICES*

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As you can see in the screenshot below, the CCI Edit check in the **PARA Data Editor** indicates that a modifier would be required to bill an IV therapy administration code with 71275; in the case you describe, no modifier would be appropriate because the administration of contrast is "integral to" the imaging procedure:

**CCI Edits OPPS (v25.0, Jan-Mar 2019)**

Codes and/or Descriptions: **96365,96372,71275**

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

| PRIME CPT | SECOND CPT | Edit Type | GB Modifier Indicator |
|---|---|---|---|
| 71275 - COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST (NONCORONARY), WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING (Column 1) | 96365 - INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); INITIAL, UP TO 1 HOUR (Column 2) | Column 1/Column 2 Correct Coding | 1 - Code pair requires modifier to bill |
| 71275 - COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST (NONCORONARY), WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING (Column 1) | 96372 - THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); SUBCUTANEOUS OR INTRAMUSCULAR (Column 2) | Column 1/Column 2 Correct Coding | 1 - Code pair requires modifier to bill |
| 96365 - INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); INITIAL, UP TO 1 HOUR (Column 1) | 96372 - THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); SUBCUTANEOUS OR INTRAMUSCULAR (Column 2) | Column 1/Column 2 Correct Coding | 1 - Code pair requires modifier to bill |

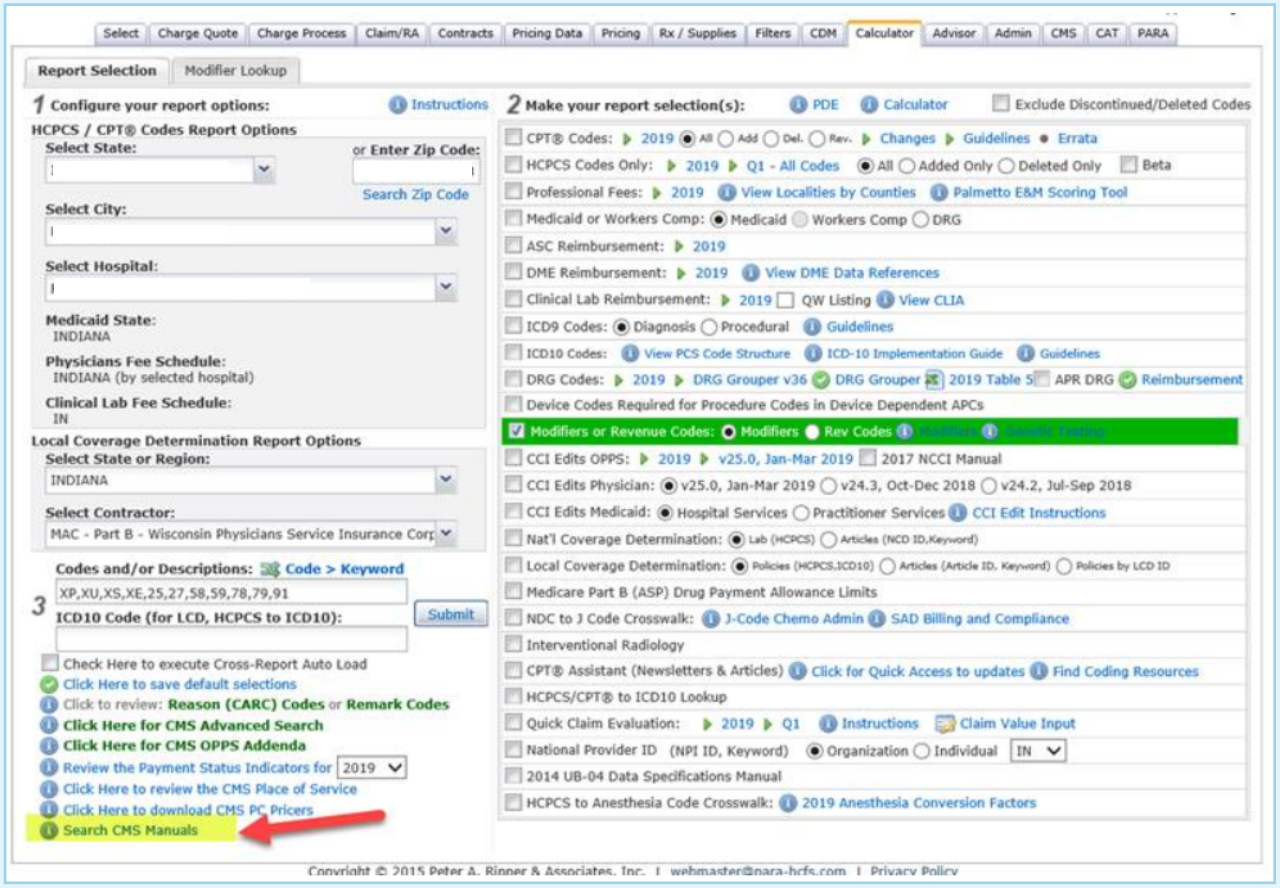
# CCI EDITS

**Q.** We have an Anthem BCBS claim that will not pass through our claim scrubber. It is stating the following: HCPCS 97530 may not be used with 97140 on Charge Line 2 without 25,27,58,59,78,79,91 or anatomical Mod due to CCI. Can you please let us know what modifier should be used on this therapy claim.

**A.** **Answer:** To determine the appropriate modifier, we need to see the claim in its entirety and the documentation. If these were the only two lines on the claim, modifier XU (unusual, non-overlapping service) would be appended to 97530 if the documentation clearly indicates separate time spent on each service.

CCI edits can be checked on the **PARA Data Editor Calculator** tab:

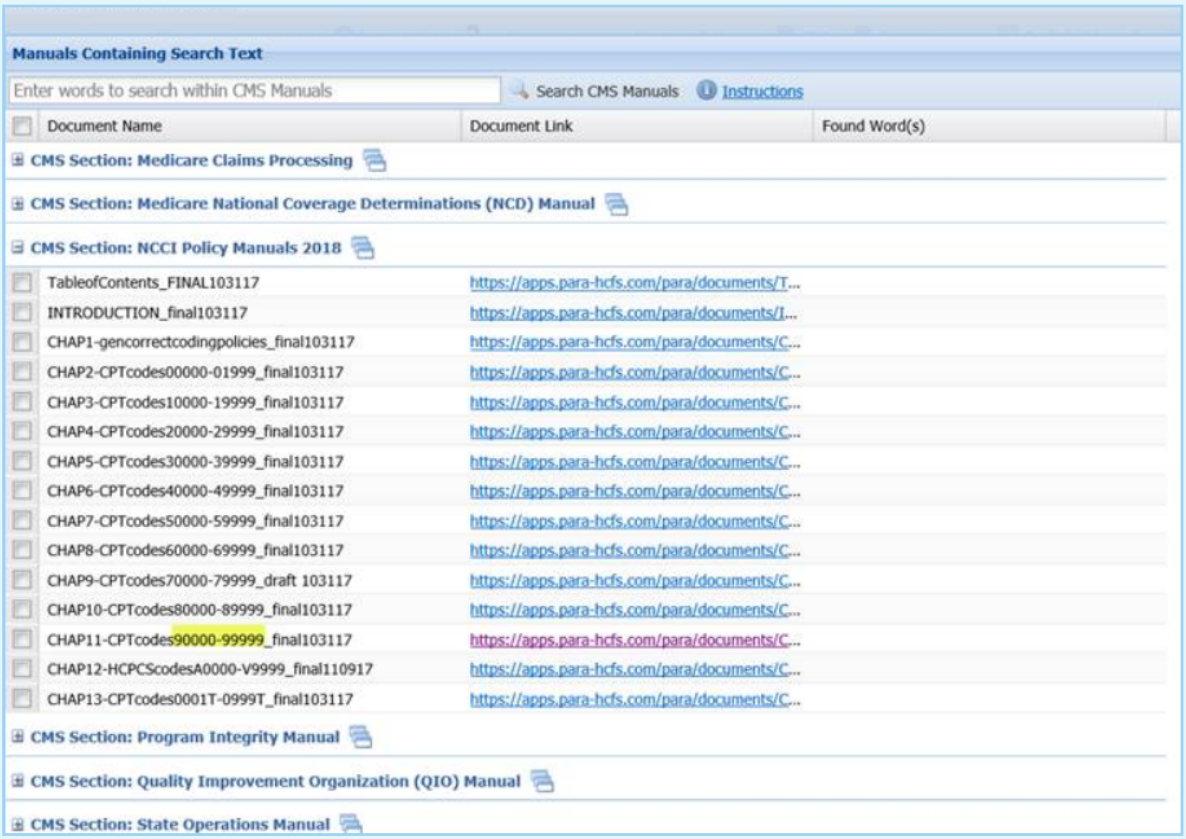

To facilitate a greater understanding of CCI edits, Medicare's NCCI Edit Manual is also available on the **PARA Data Editor** – click on the "CMS Manuals" link at the bottom left corner of the **Calculator** tab:



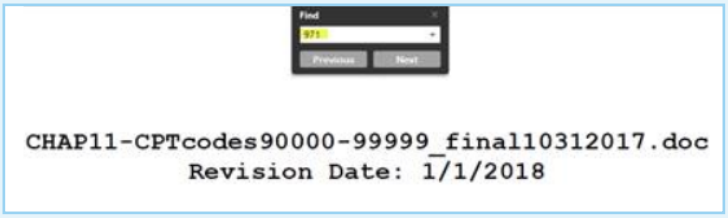
# CCI EDITS

Links to the chapters of the NCCI manual open up in an accordion – select the code range that is the topic of the question, in this case Chapter 11:

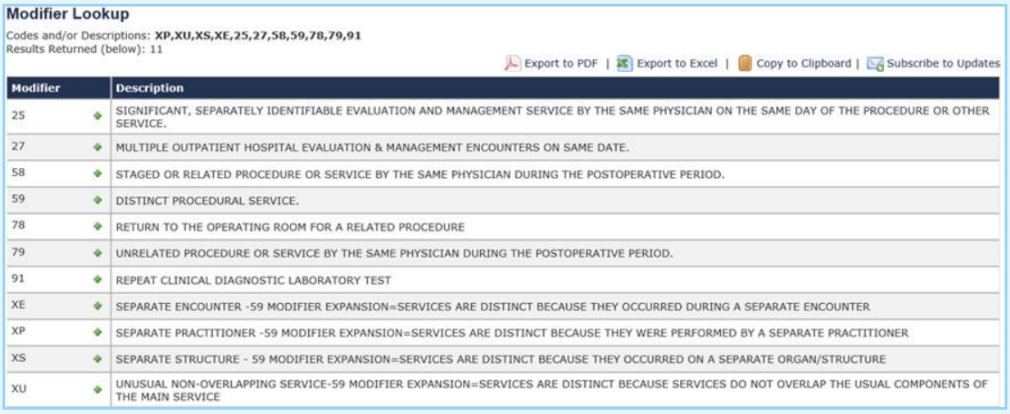
When the link opens, use the "Find" feature to look for a code; it is better to search for the first three or four digits because many references in the manual refer to code ranges rather than each specific code. While not all edits are individually addressed, sometime the manual will provide exactly the information needed:




Using the "Find" feature on 971, the user will shortly locate the following paragraph under Physical Medicine:




"5. The NCCI PTP edit with column one CPT® code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column two CPT® code 97530 (Therapeutic activities, direct patient contact, each 15 minutes) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 97530 of this NCCI PTP edit is appropriate only if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval." Here are the definitions of the modifiers that were in your question, plus the X{EPSU} modifiers, which are subsets of modifier 59.




| Modifier | Description |
|---|---|
| 25 | SIGNIFICANT, SEPARATELY IDENTIFIABLE EVALUATION AND MANAGEMENT SERVICE BY THE SAME PHYSICIAN ON THE SAME DAY OF THE PROCEDURE OR OTHER SERVICE. |
| 27 | MULTIPLE OUTPATIENT HOSPITAL EVALUATION & MANAGEMENT ENCOUNTERS ON SAME DATE. |
| 58 | STAGED OR RELATED PROCEDURE OR SERVICE BY THE SAME PHYSICIAN DURING THE POSTOPERATIVE PERIOD. |
| 59 | DISTINCT PROCEDURAL SERVICE. |
| 78 | RETURN TO THE OPERATING ROOM FOR A RELATED PROCEDURE |
| 79 | UNRELATED PROCEDURE OR SERVICE BY THE SAME PHYSICIAN DURING THE POSTOPERATIVE PERIOD. |
| 91 | REPEAT CLINICAL DIAGNOSTIC LABORATORY TEST |
| XE | SEPARATE ENCOUNTER -59 MODIFIER EXPANSION=SERVICES ARE DISTINCT BECAUSE THEY OCCURRED DURING A SEPARATE ENCOUNTER |
| XP | SEPARATE PRACTITIONER -59 MODIFIER EXPANSION=SERVICES ARE DISTINCT BECAUSE THEY WERE PERFORMED BY A SEPARATE PRACTITIONER |
| XS | SEPARATE STRUCTURE - 59 MODIFIER EXPANSION=SERVICES ARE DISTINCT BECAUSE THEY OCCURRED ON A SEPARATE ORGAN/STRUCTURE |
| XU | UNUSUAL NON-OVERLAPPING SERVICE-59 MODIFIER EXPANSION=SERVICES ARE DISTINCT BECAUSE SERVICES DO NOT OVERLAP THE USUAL COMPONENTS OF THE MAIN SERVICE |

# PATHOLOGY CODES

**Q.** We are needing assistance with a specimen that was sent to Ameripath for a Medicare beneficiary. Ameripath states we have to submit the bill to Medicare. The pathology came back, however when our HIM coders put in the diagnosis, there were no diagnoses that they could find that would pass medical necessity. The coders placed a GZ modifier on all pathology CPT® codes as there was also no ABN signed.

Can you please review to see if we have missed anything. As of right now there is $5,563.23 in pathology charges that will deny. The diagnoses used were Z01.812, B19.20, K74.60, R93.6, R53.83 and R50.9. The CPTs® charged from our lab department were the following for the pathology, 88185, 88184, 88237, 88262.

**A.** **Answer:** We agree that at least two of these HCPCS are not eligible for reimbursement with the diagnosis codes listed in your email. The codes reported were:

**2019 HCPCS Codes - ALL Quarter: Q1**

Codes and/or Descriptions: **88262,88237,88185,88184** for selected Provider:
Results returned(below): 4
AWI: **1**, DME: **IN**, Clinical Lab Fee Schedule: **IN**, Physician Fee Schedule:**INDIANA**

Export to PDF | Export to Excel | Physician Supervision Definitions

| Current Descriptor | Fee Schedule | | Initial APC | Payment | |
|---|---|---|---|---|---|
| 88184 - flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker<br>**Q2 - Paid or pkgd w status T** | GB (Physician Facility):<br>GB (Physician Non-Facility): | $61.88<br>$61.88 | 5673 - Level 3 Pathology | Weight:<br>Payment:<br>National Co-pay:<br>Minimum Co-pay: | 3.4498<br>$274.22<br>$0.00<br>$54.85 |
| 88185 - flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (list separately in addition to code for first marker)<br>**N - Payment is packaged into payment for other services.** | GB (Physician Facility):<br>GB (Physician Non-Facility): | $22.85<br>$22.85 | | | |
| 88237 - tissue culture for neoplastic disorders; bone marrow, blood cells<br>**Q4 - Paid or pkgd to most APCs** | (ClinLab): | $143.75 | | | |
| 88262 - chromosome analysis; count 15-20 cells, 2 karyotypes, with banding<br>**Q4 - Paid or pkgd to most APCs** | (ClinLab): | $138.49 | | | |

The diagnoses provided are as displayed below:

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

Report Selection | ICD10 Codes

**ICD10 Codes**

Codes and/or Descriptions: **Z01812,B1920,K7460,R936,R5383,R509**

Export to PDF | Export to Excel | Copy to Clipboard

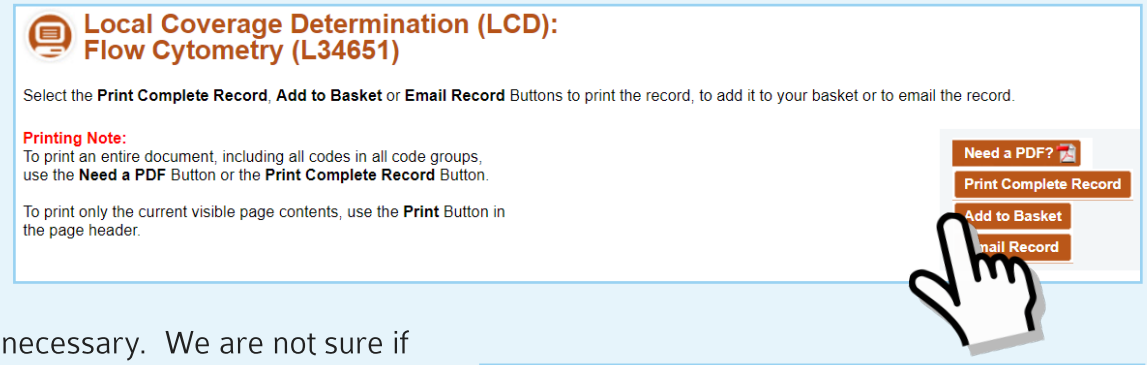
| ICD10 Code | Description | Type | ICD9 Code Map(s) |
|---|---|---|---|
| B1920 | Unspecified viral hepatitis C without hepatic coma | Diagnosis | ICD9s |
| K7460 | Unspecified cirrhosis of liver | Diagnosis | ICD9s |
| R509 | Fever, unspecified | Diagnosis | ICD9s |
| R5383 | Other fatigue | Diagnosis | ICD9s |
| R936 | Abnormal findings on diagnostic imaging of limbs | Diagnosis | ICD9s |
| Z01812 | Encounter for preprocedural laboratory examination | Diagnosis | ICD9s |

# PATHOLOGY CODES

These diagnoses do not meet the Local Coverage Determination criteria for medical necessity for 88184 and 88185; the LCD is available at the following link:

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34651&ver=29&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=Indiana&CptHcpcsCode=88184&bc=gAAAACAAAAAA&

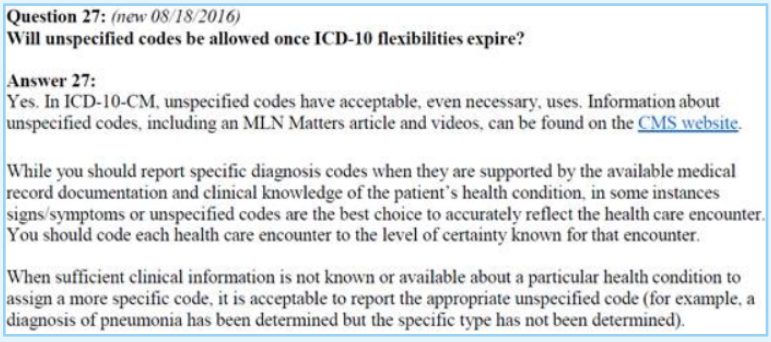
In regard to the other two codes -- while we did not find an LCD or an National Coverage Determination (NCD) for 88237 or 88262, the diagnosis code for pre-procedural lab testing is not considered medically necessary. We are not sure if these were flagged in your system as not medically necessary, but I would not have appended the GZ modifier on 88237 or 88262, since it is possible that the other diagnosis codes may have covered the testing.




If a provider appends the GZ modifier to a line, Medicare will automatically adjudicate the charge to provider liability, it will not check it for medical necessity in case the provider was incorrect in assuming that it was non-covered. It's an automatic provider write-off.

Finally the use of "unspecified" or "Other" codes should be avoided if information to support a more specific code is reasonably available.

https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf

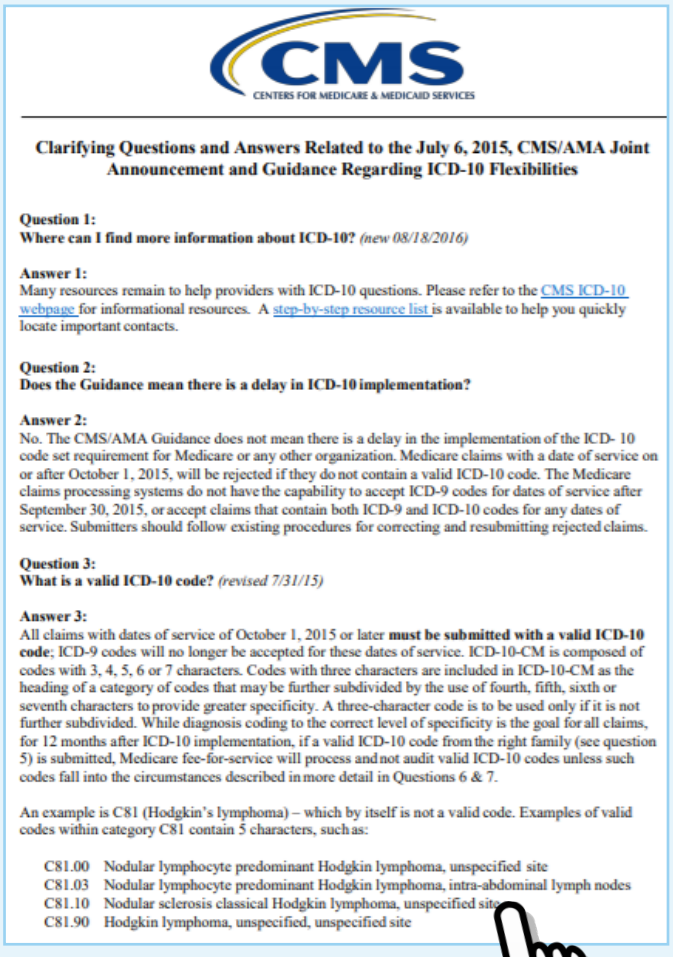


**Question 27:** *(new 08/18/2016)*
**Will unspecified codes be allowed once ICD-10 flexibilities expire?**

**Answer 27:**
Yes. In ICD-10-CM, unspecified codes have acceptable, even necessary, uses. Information about unspecified codes, including an MLN Matters article and videos, can be found on the CMS website.

While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined).



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

**Clarifying Questions and Answers Related to the July 6, 2015, CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities**

**Question 1:**
**Where can I find more information about ICD-10?** *(new 08/18/2016)*

**Answer 1:**
Many resources remain to help providers with ICD-10 questions. Please refer to the CMS ICD-10 webpage for informational resources. A step-by-step resource list is available to help you quickly locate important contacts.

**Question 2:**
**Does the Guidance mean there is a delay in ICD-10 implementation?**

**Answer 2:**
No. The CMS/AMA Guidance does not mean there is a delay in the implementation of the ICD- 10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015, or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

**Question 3:**
**What is a valid ICD-10 code?** *(revised 7/31/15)*

**Answer 3:**
All claims with dates of service of October 1, 2015 or later **must be submitted with a valid ICD-10 code**; ICD-9 codes will no longer be accepted for these dates of service. ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, if a valid ICD-10 code from the right family (see question 5) is submitted, Medicare fee-for-service will process and not audit valid ICD-10 codes unless such codes fall into the circumstances described in more detail in Questions 6 & 7.

An example is C81 (Hodgkin's lymphoma) – which by itself is not a valid code. Examples of valid codes within category C81 contain 5 characters, such as:

C81.00 Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
C81.03 Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes
C81.10 Nodular sclerosis classical Hodgkin lymphoma, unspecified site
C81.90 Hodgkin lymphoma, unspecified, unspecified site

# 340B MODIFIERS

**Q.** I have a question regarding the new modifiers created for 340B Drugs. With us being a critical access hospital do we still use these?

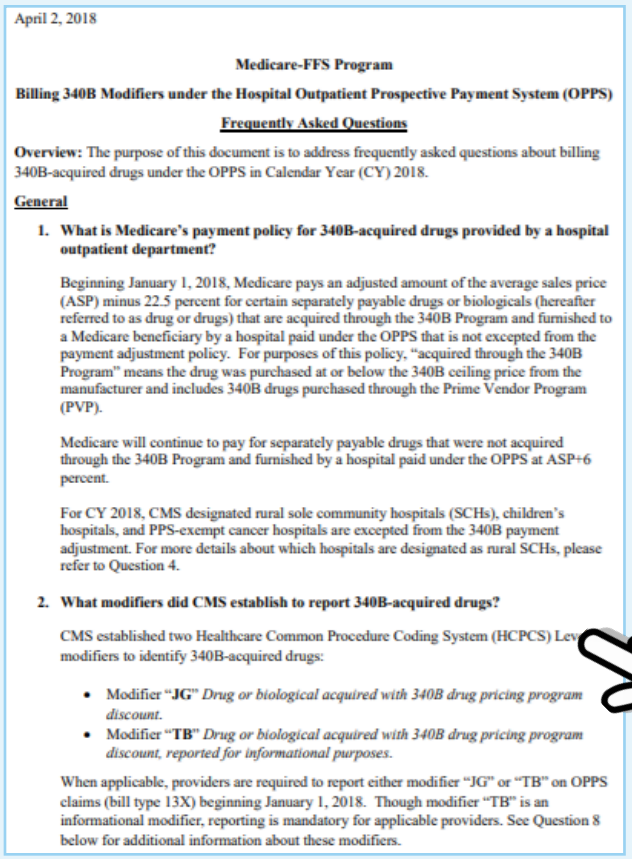
**A.** **Answer:** It is optional for a CAH to report the 340B modifiers. I have attached a Medicare FAQ on this topic.

April 2, 2018

**3. Are Critical Access Hospitals (CAHs) subject to the 340B payment policy? Should CAHs report the informational modifier "TB"? What about hospitals located in Maryland that are paid under a cost containment waiver?**

No, CAHs are not subject to the 340B payment policy because CAHs are not paid under the OPPS. Neither modifier "JG" nor modifier "TB" is required to be reported by CAHs. However, CAHs have the option of reporting informational modifier TB on a voluntary basis for drugs that were acquired under the 340B Program.

Likewise, hospitals paid under the Maryland waiver are excluded from the OPPS and are not subject to the payment policy change. These hospitals, as well as any other hospitals that are excluded from the OPPS, are similarly not required to report the JG modifier, but have the option to report the TB modifier on a voluntary basis.



April 2, 2018

**Medicare-FFS Program**

**Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS)**

**Frequently Asked Questions**

**Overview:** The purpose of this document is to address frequently asked questions about billing 340B-acquired drugs under the OPPS in Calendar Year (CY) 2018.

**General**

1. **What is Medicare's payment policy for 340B-acquired drugs provided by a hospital outpatient department?**

   Beginning January 1, 2018, Medicare pays an adjusted amount of the average sales price (ASP) minus 22.5 percent for certain separately payable drugs or biologicals (hereafter referred to as drug or drugs) that are acquired through the 340B Program and furnished to a Medicare beneficiary by a hospital paid under the OPPS that is not excepted from the payment adjustment policy. For purposes of this policy, "acquired through the 340B Program" means the drug was purchased at or below the 340B ceiling price from the manufacturer and includes 340B drugs purchased through the Prime Vendor Program (PVP).

   Medicare will continue to pay for separately payable drugs that were not acquired through the 340B Program and furnished by a hospital paid under the OPPS at ASP+6 percent.

   For CY 2018, CMS designated rural sole community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment. For more details about which hospitals are designated as rural SCHs, please refer to Question 4.

2. **What modifiers did CMS establish to report 340B-acquired drugs?**

   CMS established two Healthcare Common Procedure Coding System (HCPCS) Lev modifiers to identify 340B-acquired drugs:

   - Modifier "**JG**" *Drug or biological acquired with 340B drug pricing program discount.*
   - Modifier "**TB**" *Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.*

   When applicable, providers are required to report either modifier "JG" or "TB" on OPPS claims (bill type 13X) beginning January 1, 2018. Though modifier "TB" is an informational modifier, reporting is mandatory for applicable providers. See Question 8 below for additional information about these modifiers.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf

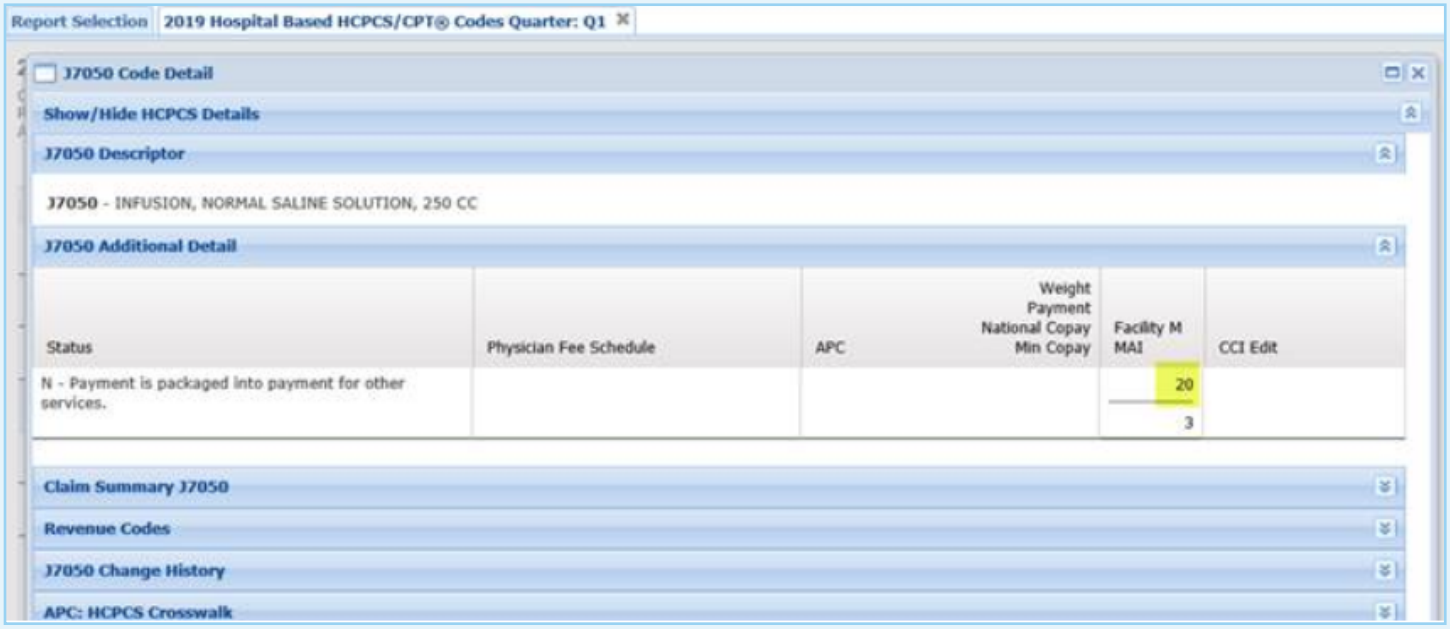
# J7050 QUESTION

**Q.** We are wondering if you could help us on Sodium Chloride flushes. We are seeing duplicate charges and want to know if this is accurate or what others are doing. Some background: the RN hangs an NS 100ml bag (medication backup) and then medication bag is also hung.

We make the medication ourselves, which also comes in a bag. We are reporting J7050 because it's under the 250 ml one for each bag. Is that accurate? We are seeing duplicate denials for these charges. One suggestion was to remove one charge completely. Our other thought it to have it rolled into the other charge or into the med itself, but we are unsure which is the proper resolution. Can you help us?

**A.** **Answer:** Without seeing the remark codes on the denial, we are unable to speculate what the problem might be.

That being said, J7050 has an Medically Unlikely Edit quantity of 20 units, which would indicate that it is perfectly acceptable to bill Medicare up to 20 units on an outpatient claim.

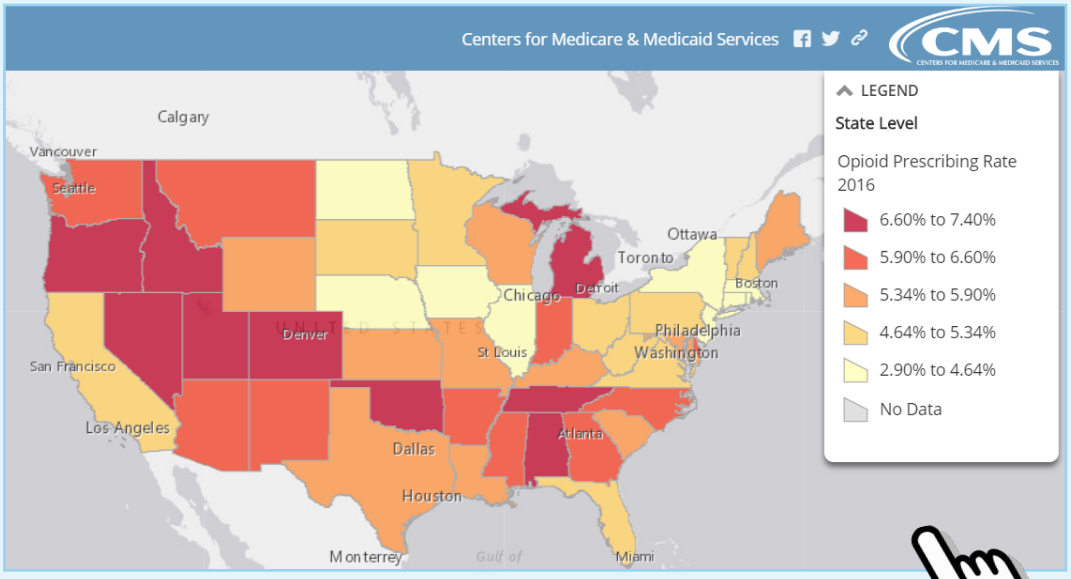



Some payers deny "piggyback" IV fluid charges. While we don't agree with this policy, it might be the factor at work here. You may want to check the reimbursement policies of the payer, and/or the hospital's contract with that payer, if one exists.

# CMS RELEASES NEW OPIOID PRESCRIBING MAPPING TOOL

***On February 22, CMS released an expanded version of the Opioid Prescribing Mapping Tool, ensuring that you have the most complete and current data to effectively address the opioid epidemic across the country.***

This update further demonstrates the agency's commitment to opioid data transparency and using data to better inform local prevention and treatment efforts, particularly in rural communities hard hit by the opioid crisis. For the first time, the tool includes data for opioid prescribing in the Medicaid program. Additionally, users can now make geographic comparisons of Medicare Part D opioid prescribing rates over time for urban and rural communities.




The Medicare Part D opioid prescribing mapping tool is an interactive tool that shows geographic comparisons at the state, county, and ZIP code levels of de-identified Medicare Part D opioid prescriptions filled within the United States. The mapping tool presents Medicare Part D opioid prescribing rates for 2016 as well as the change in opioid prescribing rates from 2013 to 2016.

The mapping tool allows the user to see both the number and percentage of opioid claims at the local level in order to better understand how this critical issue impacts communities nationwide. By openly sharing data in a secure, broad, and interactive way, CMS and the U.S. Department of Health and Human Services (HHS) believe that this level of transparency will inform community awareness among providers and local public health officials.

The data reflect Medicare Part D prescription drug claims prescribed by health care providers. Approximately 70% of Medicare beneficiaries have Medicare prescription drug coverage either from a Part D plan or a Medicare Advantage Plan offering Medicare prescription drug coverage. In 2016, Medicare Part D spending was $146 billion; U.S. retail prescription drug spending was about $329 billion. The mapping tool does not contain beneficiary information nor does the information presented in this tool indicate the quality or appropriateness of care provided by individual physicians or in a given geographic region.

The map will automatically adjust between state, county, and zip code levels as users zoom in or out.

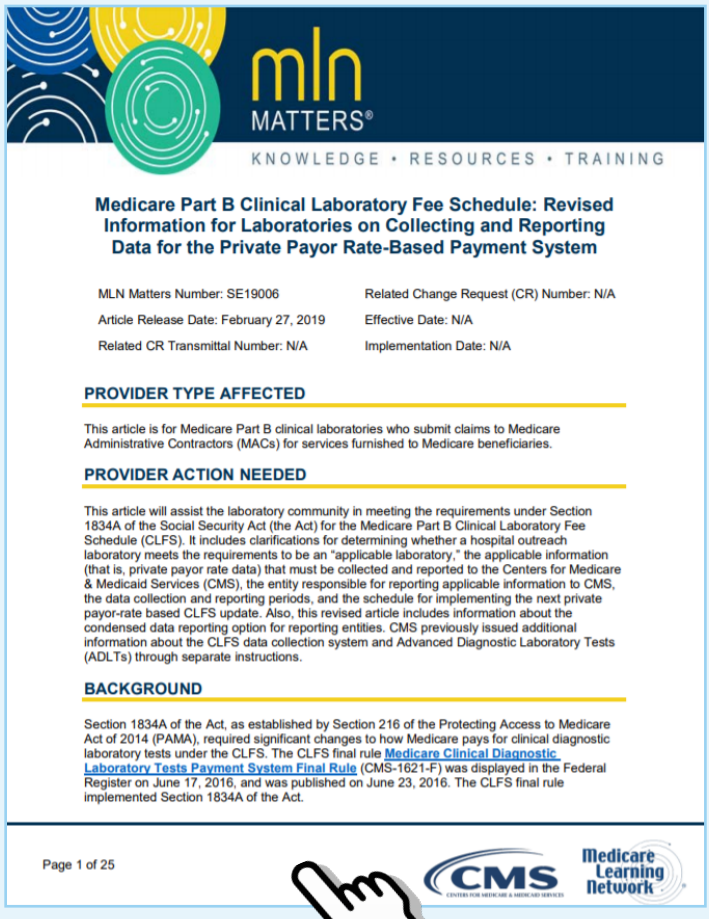
# CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

**Medicare requires "applicable laboratories" to report private payor remittance data for the purpose of developing its payment rates under the Clinical Laboratory Fee Schedule (CLFS.)**

**This year, the definition of "applicable laboratories" was expanded to include certain physician groups and hospitals. A number of PARA clients have requested information on whether they will be required to report.**

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

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



mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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

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

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

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

**PROVIDER TYPE AFFECTED**

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

**PROVIDER ACTION NEEDED**

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

**BACKGROUND**

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

Page 1 of 25

CMS Medicare Learning Network

For purposes of determining applicable laboratory status under the CLFS, a hospital outreach laboratory is a hospital-based laboratory that furnishes laboratory tests to patients other than admitted inpatients or registered outpatients of the hospital. A hospital outreach laboratory bills for Medicare Part B services it furnishes to non-hospital patients using the Form CMS-1450 14x Type of Bill (TOB).

### I. Determination of Applicable Laboratory Status Based on the NPI

This section includes information on how independent laboratories and physician office laboratories that bill Medicare Part B under their own NPI and hospital outreach laboratories that bill Medicare Part B under their own NPI (separate from the hospital's NPI) determine whether they are an applicable laboratory. As discussed later in this article, hospital outreach laboratories that bill Medicare Part B using the hospital's NPI must determine applicable laboratory status based on its revenues attributed to the Form CMS-1450 14x TOB.

There are four steps in determining whether a laboratory meets the requirements to be an applicable laboratory based on the laboratory's own billing NPI:

## CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

1. Is the laboratory certified under CLIA?
2. Does the CLIA- certified laboratory bill Medicare Part B under its own NPI?
3. Does the laboratory meet the majority of Medicare revenues threshold?
4. (4) Does the laboratory meet the low expenditure threshold?

The first step hospitals should take is to identify if it reports a separate NPI on the 141 (non-patient services) bill type. If the lab bills under the same NPI as the hospital, the laboratory is not required to report private payor reimbursement rates. If the lab uses a separate NPI, additional financial analysis is required to determine whether the organization is required to report.

**Background:** Under the Protecting Access to Medicare Act (PAMA) of 2014, Medicare is required to base payment for clinical lab services on a basis equivalent to the amounts that large insurers pay for private payor patients. Medicare is required by law to develop rates in the CLFS to be equal to the weighted median of private payor rates determined for the test.

To meet this obligation, CMS required large independent laboratories to submit the necessary private payor payment rate data. "Applicable laboratories" are required to collect private payor payment rates during a specified period and report the data to CMS during a specified window.

Prior to 2019, hospital laboratories and physician practices were not required to report data. However, in the 2019 Clinical Fee Schedule Final Rule, Medicare expanded the definition of "applicable laboratory" to include "hospital outreach laboratories" which bill for services on a UB04 14X bill type (non-patient services.) The original CMS language defining "applicable laboratories" included hospital laboratories which:

- Are independently enrolled in Medicare with a separate NPI
- Submit claims to Medicare for lab services on either the CMS1500/837p, or UB04/837i bill type 14X (non-patient services)
- Are reimbursed under the CLFS or the Medicare Physician Fee Schedule for at least 50 percent of its revenues
- Received total revenues under the CLFS of at least $12,500 during a data collection period

Effective January 1, 2019, the regulatory definition of an applicable laboratory is summarized below. An applicable laboratory means an entity that:

- Is a laboratory as defined under the Clinical Laboratory Improvement Amendments (CLIA) regulatory definition of a laboratory (42 CFR Section 493.2);
- The laboratory bills Medicare under its own National Provider Identifier (NPI) or a. For hospital outreach laboratories: Bills Medicare Part B on the Form CMS-1450 under TOB 14x
- The laboratory must meet a "majority of Medicare revenues," threshold, where it receives more than 50 percent of its total Medicare revenues from one combination of the CLFS or the PFS in a data collection period. For purposes of determining whether a laboratory meets the "majority of Medicare revenues" threshold, total Medicare revenues includes: fee-for-service payments under Medicare Parts A and B, prescription drug payments under Medicare Part D, and any associated Medicare beneficiary deductible or coinsurance. Effective January 1, 2019, total Medicare revenues no longer includes Medicare Advantage payments under Medicare Part C.

## CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

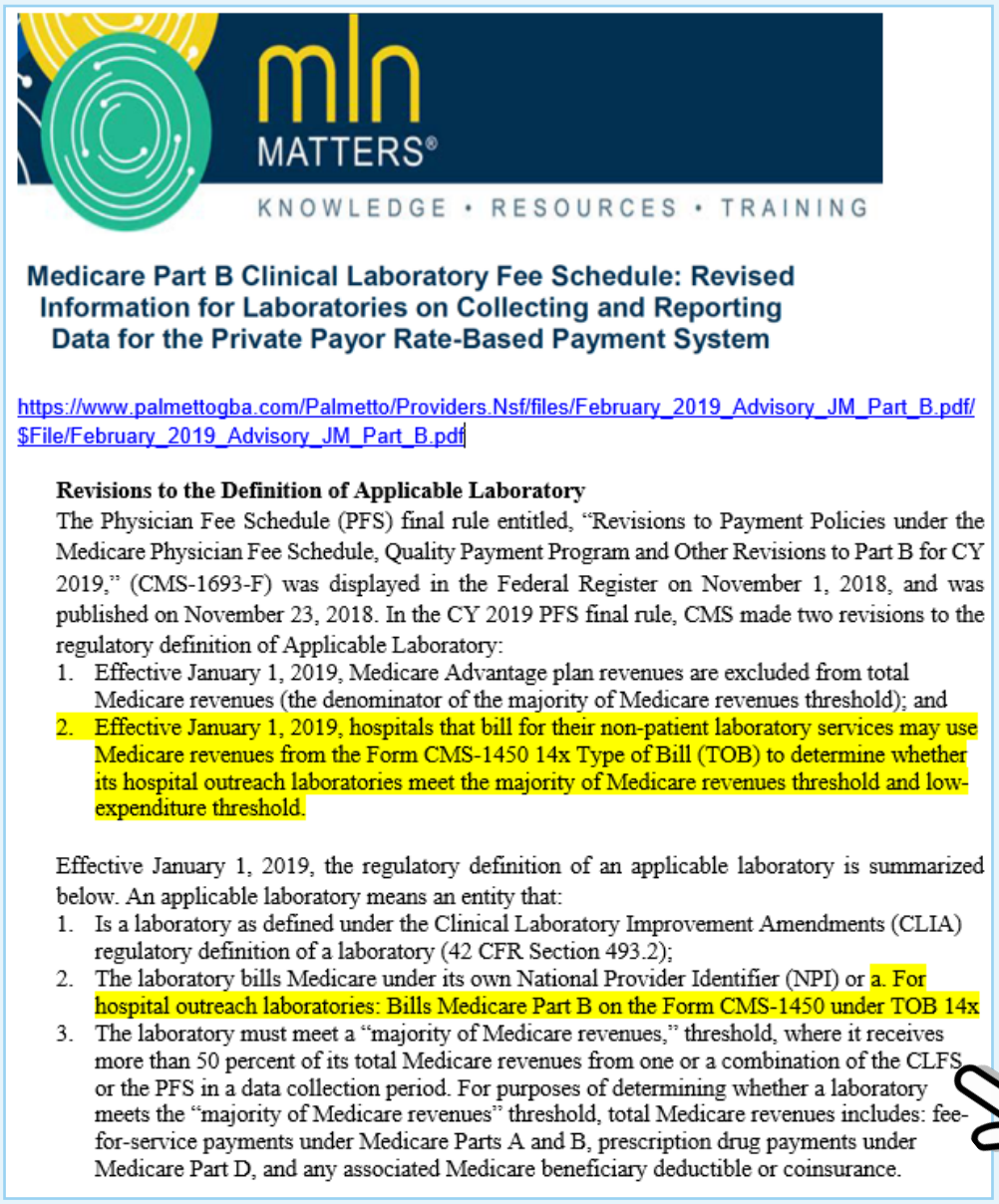
- The laboratory must meet a "low expenditure" threshold, where it receives at least $12,500 of its Medicare revenues from the CLFS in a data collection period.

Consequently, hospitals conducting significant "outreach" laboratory service should verify whether the 141 bill type uses the same NPI as the main facility. If the lab uses a separate NPI, the hospital must evaluate whether it meets the other tests for required reporting. Reporting is due in 2020, and significant penalties apply if reporting is not submitted promptly and accurately.

While Medicare did not intend to include hospitals in the data collection requirement, the expansion to include hospitals with significant lab business responds to criticism that the data used to calculate the current CLFS rates was obtained from too narrow a provider base.

Links and excerpts to Medicare announcements on this topic are provided below:

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



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

https://www.palmettogba.com/Palmetto/Providers.Nsf/files/February_2019_Advisory_JM_Part_B.pdf/$File/February_2019_Advisory_JM_Part_B.pdf

**Revisions to the Definition of Applicable Laboratory**

The Physician Fee Schedule (PFS) final rule entitled, "Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019," (CMS-1693-F) was displayed in the Federal Register on November 1, 2018, and was published on November 23, 2018. In the CY 2019 PFS final rule, CMS made two revisions to the regulatory definition of Applicable Laboratory:

1. Effective January 1, 2019, Medicare Advantage plan revenues are excluded from total Medicare revenues (the denominator of the majority of Medicare revenues threshold); and
2. Effective January 1, 2019, hospitals that bill for their non-patient laboratory services may use Medicare revenues from the Form CMS-1450 14x Type of Bill (TOB) to determine whether its hospital outreach laboratories meet the majority of Medicare revenues threshold and low-expenditure threshold.

Effective January 1, 2019, the regulatory definition of an applicable laboratory is summarized below. An applicable laboratory means an entity that:

1. Is a laboratory as defined under the Clinical Laboratory Improvement Amendments (CLIA) regulatory definition of a laboratory (42 CFR Section 493.2);
2. The laboratory bills Medicare under its own National Provider Identifier (NPI) or a. For hospital outreach laboratories: Bills Medicare Part B on the Form CMS-1450 under TOB 14x
3. The laboratory must meet a "majority of Medicare revenues," threshold, where it receives more than 50 percent of its total Medicare revenues from one or a combination of the CLFS or the PFS in a data collection period. For purposes of determining whether a laboratory meets the "majority of Medicare revenues" threshold, total Medicare revenues includes: fee-for-service payments under Medicare Parts A and B, prescription drug payments under Medicare Part D, and any associated Medicare beneficiary deductible or coinsurance.

# CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

> ***Effective January 1, 2019, total Medicare revenues no longer includes Medicare Advantage payments under Medicare Part C.***
>
> 4. The laboratory must meet a "low expenditure" threshold, where it receives at least $12,500 of its Medicare revenues from the CLFS in a data collection period.

A link and an excerpt from the Medicare website summarizes the changed requirement:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html

The Clinical Laboratory Fee Schedule (CLFS) final rule entitled "Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System" (CMS-1621-F) was published in the Federal Register on June 23, 2016. The final CLFS rule implements section 216 of the Protecting Access to Medicare Act (PAMA) of 2014.

Under the final rule, laboratories, including physician office laboratories, are required to report private payor rate and volume data if they:

- have more than $12,500 in Medicare revenues from laboratory services on the CLFS and
- they receive more than 50 percent of their Medicare revenues from laboratory and physician services during a data collection period

Laboratories will collect private payor data from January 1, 2019 through June 30, 2019 and report it to CMS by March 31, 2020.

We will post the new Medicare CLFS rates (based on weighted median private payor rates) in November 2020 that will be effective on January 1, 2021

# CY2020 SNF PROVIDERS: WHAT IS THE PDPM?

**WHAT**

**is the Long-Term Care /Skilled Nursing Facility Patient-Driven Payment Model, or PDPM?**

The PDPM is the CMS designated next iteration of payment reform following the Resident Classification System Version 1 (RCS-1) advance notice of rule-making that was released in CY2017. This new payment reform is set to replace the RUGs IV system of reimbursement. PDPM follows suit from RCS-1 in moving away from a "therapy minutes driven reimbursement system" to a system that is more focused on the "clinical characteristics of the resident".

Good news to providers, under the PDPM reimbursement will be decided on fewer Minimum Data Set (MDS) assessments. With this being said, there are an expected reduction in scheduled PPS assessments from five to one required assessment and only two unscheduled assessments (the IPA and the Discharge PPS assessments). Just with this reduction in administrative tasks Medicare is expecting to save over $2 billion dollars over a 10 - year period.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

# CY2020 SNF PROVIDERS: WHAT IS THE PDPM?

This payment model is expected to be implemented beginning October 01, 2019.

**Overview of Case-Mix Categories:**

Within the new PDPM, resident characteristics will determine the clinical category for care.

1. Acute infection
2. Acute neurological
3. Cancer
4. Cardiovascular and coagulations
5. Major-joint replacement or spinal surgery
6. Medical management
7. Non-orthopedic surgery
8. Non-surgical orthopedic/musculoskeletal
9. Orthopedic surgery
10. Pulmonary

These are further grouped into four categories for Occupational Therapy (OT) and Physical Therapy (PT) calculations:

1. Major joint replacement or spinal surgery
2. Other orthopedic
3. Non-orthopedic and acute neurologic
4. Medical Management

PDPM uses five case-mix components and a non-case-mix component to determine the rate of reimbursement for the residents stay, which differs from the RUGs IV calculation which only used therapy and nursing components and was weighted by therapy minutes in the higher categories. In PDPM, therapy minutes will not be used in the case-mix calculation, however, they will be required as part of the discharge assessment process.

The five designated case mix components are:

1. Physical Therapy (PT)
1. Occupational Therapy (OT)
1. Speech/Language Pathology (SLP)
1. Nursing Non-therapy Ancillaries

These five components will be combined with a non-case mix amount to calculate daily reimbursement.

SLP will be required to use the presence of comorbidities (i.e.; aphasia, CVA/TIA/stroke, hemiplegia/paralysis, TBI, tracheostomy care, present of ventilator or respiratory, laryngeal cancer, apraxia, dysphagia, ALS, oral cancers and speech /language deficits), cognitive impairment and

## CY2020 SNF PROVIDERS: WHAT IS THE PDPM?

the presence of swallowing disorders or the need for a mechanically altered diet to determine the case mix.

The NTA case mix is determined by the need for extensive service covered through the MDS and the part-c risk adjusted model. Points are associated with the services and a total determined, which would place the resident in a case-mix group for NTA.

The table below demonstrates how the daily rate for PDPM is calculated by case-mix component for each resident.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PT | PT Base Rate | X | PT CMI | X | PT Adjustment Factor | = | Primary Reason for SNF Stay, Functional Status, variable over time (16 Groups) |
| + | | | | | | | |
| OT | OT Base Rate | X | OT CMI | X | OT Adjustment Factor | = | Primary Reason for SNF stay, Functional Status, variable over time (16 Groups) |
| + | | | | | | | |
| SLP | SLP Base Rate | X | SLP CMI | | | = | Primary Reason for SNF Stay, Cognitive Status, Swallowing Problems, mechanically altered Diet, SLP related comorbidities (12 Groups) |
| + | | | | | | | |
| Nursing | Nursing Base Rate | X | Nursing CMI | | | = | Clinical info, Functional Status, Extensive Services, Presence of Depression, Restorative Nursing (25 Groups – PDPM RUG) |
| + | | | | | | | |
| NTA | NTA Base Rate | X | NTA CMI | X | NTA Adjustment Factor | = | Co-morbidities present, Extensive Services received, variable over time (6 Groups) |
| + | | | | | | | |
| Non-Case Mix | Non-Case Mix Base Rate | | | | | | |

# CY2020 SNF PROVIDERS: WHAT IS THE PDPM?

It should be noted, PDPM does not completely do away with the RUGS IV methodology. The Nursing Component uses a modified non-therapy RUG calculation that places residents into one of the 25 categories instead of the previous 43 nursing categories that were under the 66 Grouper. The 25 PDPM RUGs reduces the number of end-splits determined by ADL calculations.

An additional change within the PDPM from the previous RUG IV is the ADL score has been updated to include Section GG items. These items are used to calculate LTPAC cross-setting measures as required by the IMPACT Act of CY2014.

In PDPM, the four late loss ADLs used in the calculation for RUGS IV would be replaced with items from section GG; an eating and toileting item, three transfer items and two bed mobility items.

Refer to the table below:

| | |
|---|---|
| GG0130A1 | Self-care: Eating |
| GG0130B1 | Self-care: Oral Hygiene |
| GG0130C1 | Self-care: Toileting Hygiene |
| GG0170B1 | Mobility: Sit to lying |
| GG0170C1 | Mobility: Lying to sitting on the side of bed |
| GG0170D1 | Mobility: Sit to stand |
| GG0170E1 | Mobility: Chair/bed-to-chair transfer |
| GG0170F1 | Mobility: Toilet Transfer |
| GG0170J1 | Mobility: Walk 50 feet with 2 turns |
| GG0170K1 | Mobility: Walk 150 feet |

Nursing CMIs will use staffing data to reflect nursing utilization during care. In addition, PDPM is expected to add an 18% increase for the nursing component when the resident is diagnosed with HIV/AIDS.

Payments for Nursing and Speech/Language Pathology will remain constant through the resident's stay however, PT, OT and Non-therapy Ancillaries will see variable rates over the length of stay. PT and OT will see downward adjustments of 2% at day 20 and then a further 2% decrease every 7th day thereafter. NTA will decrease by two-thirds starting at day 4.

**So how is this going to impact Skilled Nursing Organizations?**

1. PDPM is designed to push SNFs to take on more clinically complex residents.
2. Homes will need to start evaluating current care and staff resources to determine if they are prepared for this shift or will they need to implement systems and training for staff to meet the criteria for this program
3. Therapy that was previously incentivized in the previous payment model is not included in the case mix calculations but the need for therapy based on care requirements is predicted to be the same. PDPM requires 75% of all therapy delivered be individually provided:
    - Concurrent and group therapies are capped at 25% of total minutes provided, which is a decrease from 50% in RCS-1
4. CMS is predicting that non-profit organizations should see an increase of 1.9%, while government providers should see increases of approximately 4.2%. Smaller SNF providers should see modest increases, while those providers running homes over 100 certified beds may see declines in revenue.

# CY2020 SNF PROVIDERS: WHAT IS THE PDPM?

This table demonstrates the basic differences between RUGs IV and PDPM:

| Item | RUGs IV | PDPM |
|---|---|---|
| Definition | Residents are classified into a RUG grouper based on the care provided for the period covered.<br>Residents can fall into more than one RUG score in this methodology, but the one with the highest associated case-mix index is used for reimbursement. | Residents are classified into one of 10 clinical categories based on primary diagnosis.<br>The category determines the case-mix index OT and PT.<br>Nursing uses PDPM RUG. SLP and Non-therapy Ancillaries are determined by co-morbidities present.<br>The indexes are added together and combined with a non-case mix component for the total daily rate reimbursed. |
| Case Mix Components | Nursing<br>Therapy (PT, OT, SLP) | Physio Therapy (PT)<br>Occupation Therapy (OT)<br>Speech/Language Pathology (SLP)<br>Non-therapy Ancillary (NTA)<br>Nursing |
| ADL/Function Scoring | MDS Section G | MDS Section GG |
| Total Number of groups | 66 | 28, 800<br>PT/OT – 16 groups<br>SLP – 12 groups<br>NTA – 6 groups<br>Nursing – 25 groups |
| Reimbursement | 1. # of minutes of therapy<br>2. Nursing Service delivered<br>-Payment is uniform through the period covered by the MDS assessment | 1. Clinical Category/Nursing PDPM RUG<br>2. Function Score (Therapy minutes not counted toward reimbursement)<br>- Nursing and SLP rates remain constant<br>- OT/PT rates decline over LOS - 2% for every 7 days after day 20<br>- NTA rates decline after day 3 by 2/3rd |

# CY2020 SNF PROVIDERS: WHAT IS THE PDPM?

| Item | RUGs IV | PDPM |
|---|---|---|
| MDS Assessments | 5 Scheduled MDS assessments:<br>- 5-day<br>- 14-day<br>- 30-day<br>- 60-day<br>- 90-day<br>Additional Unscheduled Assessments:<br>- Other Medicare Required Assessment<br>- Start of Therapy<br>- Change of Therapy<br>- End of Therapy<br>- Significant Changes in Condition<br>- Discharge Assessment | 1 Scheduled MDS Assessment<br>- 5- day<br>Additional Unscheduled Assessments:<br>- Discharge Assessment<br>- Interim Payment Assessment (IPA<br>An IPA will be rare and will be required in the following circumstances:<br>1. For all Part A residents on transition to PDPM<br>2. When these criteria are met: there is a changed in first tier classification AND the resident would not be expected to return to original status in 14 days. |

**Recommendations for preparing for PDPM Implementation:**

1. Providers should begin by reviewing current processes from end-to-end. This activity will assist in determining what processes will need to be changed to meet the criteria for PDPM

2. Training staff on the shift in data capture will be a key point to a successful PDPM implementation. For example, staff need to ensure that all diagnosis and conditions are collected as soon as possible to ensure accurate coding on the MDS

3. Coding staff will need it identify the primary diagnosis that maps to a clinical category where possible

4. Communicating to physicians about the upcoming changes and educating them on the new categories and importance of a correct diagnosis is critical for a successful adoption of PDPM

5. Review of therapy contracts is critical for identifying the business impact from the therapy perspective to avoid any surprises once the facility implements PDPM

# CODING AND REIMBURSEMENT FOR COLD THERAPY CUBE

IS it durable medical equipment or a retail product? Hospitals often now use this new product in the Operating Suites, but how can hospital bill for its use?


To clarify, we first answer the following questions:

1. Are these considered DME?
2. What is the definition of DME?
3. Is there a L code for this?
4. Do organizations/clients charge for this?

In follow up to the questions regarding the correct reporting process for Cold Therapy Cube, the following applies:

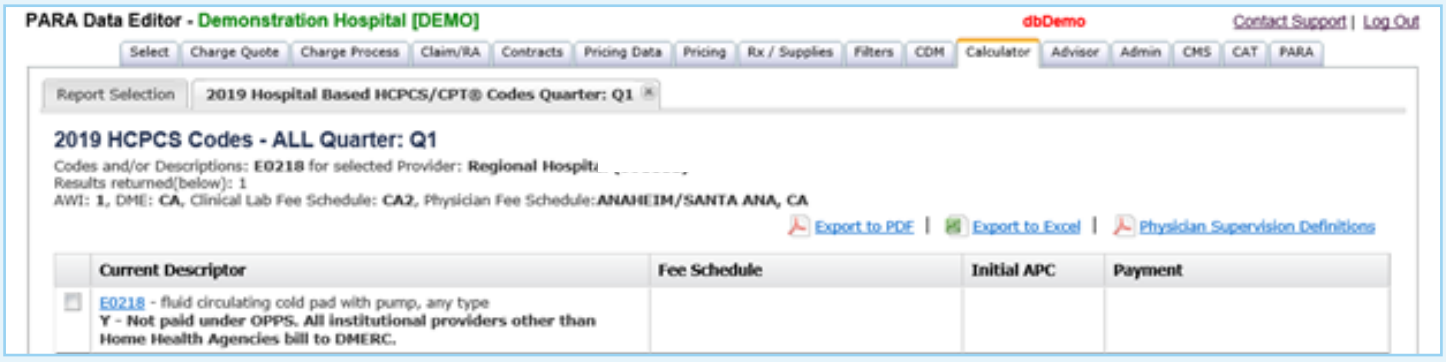
1. The item is not DME, rather it is classified as a Class II Medical Device. It is currently being used in a hospital/clinic setting in Post-Operative, Arthroscopic Procedures, Reconstructive Procedures, Plastic Surgery, General Surgery, Post-Trauma, Chronic Pain and Physical Therapy. However, because the device is utilizing the same basic concept as hot/cold packs, the therapy does not meet medical necessity criteria

2. 2. The reporting code is E0218

3. 3. The device can be reported using revenue codes 0271 or 0947

This is an inexpensive purchase item that costs between $200.00 to $350.00 depending on where it is purchased. Patients can purchase the item for home use at stores such as Target or WalMart. There is no separate reimbursement for the item.

Here's **PARA's** recommendation: Complete an analysis on which procedures the device is being used in Post-operative and include the cost of the device in the OR procedure or the Post-Operative Room Rate.




For more information on how it's used, click on the link below.

https://www.breg.com/products/cold-therapy/devices/cube-cold-therapy/

# 2019 CATEGORY III AMA RELEASE

The American Medical Association (AMA) has released mid-year Category III changes for the 2020 CPT® production cycle. These codes are effective July 1, 2019. Twenty new Category III codes ranging from 0543T to 0562T have been added. These codes can be found in the **PARA Data Editor Calculator**.

**New Category III Codes include:**

Transapical Mitral Valve Repair (MVR) – 0543T – 0545T

**PARA - Healthcare Financial Services**

| Code | Current Description |
|---|---|
| 0543T | Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae |
| 0544T | Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture |
| 0545T | Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach |

Radiofrequency spectroscopy and Bone-Material quality testing – 0546T – 0547T

**PARA - Healthcare Financial Services**

| Code | Current Description |
|---|---|
| 0546T | Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report |
| 0547T | Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score |

Transperineal Periurethral Balloon Continence device – 0548T – 0551T

**PARA - Healthcare Financial Services**

| Code | Current Description |
|---|---|
| 0548T | Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy |
| 0549T | Transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy |
| 0550T | Transperineal periurethral balloon continence device; removal, each balloon |
| 0551T | Transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume |

Laser Therapy and Percutaneous Transcatheter placement 0552T – 0553T

**PARA - Healthcare Financial Services**

| Code | Current Description |
|---|---|
| 0552T | Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional |
| 0553T | Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention |

# 2019 CATEGORY III AMA RELEASE

Bone Strength and Fracture Risk analysis – 0554T – 0557T

**PARA - Healthcare Financial Services**

| Code | Current Description |
|---|---|
| 0554T | Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report |
| 0555T | Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data |
| 0556T | Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density |
| 0557T | Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report |

Anatomic Model 3-D printed image data sets –0559T -0562T

**PARA - Healthcare Financial Services**

| Code | Current Description |
|---|---|
| 0559T | Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure |
| 0560T | Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure) |
| 0561T | Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide |
| 0562T | Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure) |

Category III codes are temporary CPT® codes identified with five characters (four numerical digits followed by a T). They allow data collection for emerging technologies, services, procedures, and service paradigms, unlike the use of unlisted codes, which does not offer the opportunity for the collection of specific data.

If a Category III code is available, this code must be reported in lieu of a Category I unlisted code. Category III codes may or may not eventually receive a Category I CPT® code. New codes or revised codes in this section are released semi-annually via the AMA CPT® website to expedite dissemination for reporting. Codes approved for deletion are published annually with the full set of temporary codes for emerging technology, services, procedures, and service paradigms in the CPT® code set.

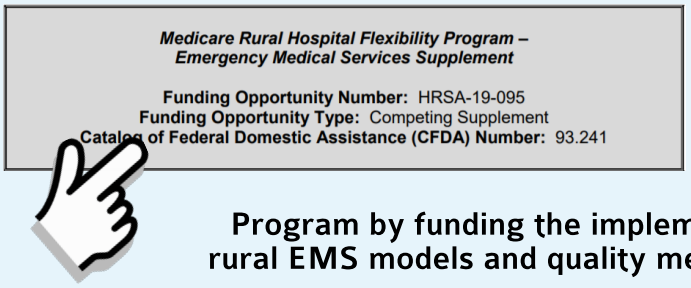
# RURAL HOSPITAL PROGRAM GRANTS AVAILABLE

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

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

## 340B Drug Pricing Program

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

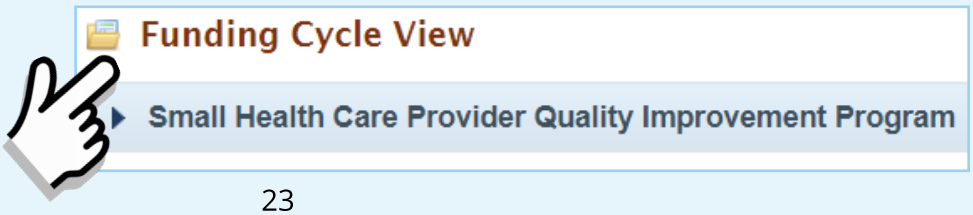




## Medicare Rural Hospital Flexibility Program - Emergency Medical Service Supplement

**Provides up to $250,000 to build an evidence base for rural EMS activities in the Flex Program by funding the implementation of demonstration projects of sustainable rural EMS models and quality metrics, and by sharing the results of those projects with rural EMS stakeholders. Application Deadline: April 5, 2019**

## Small Healthcare Provider Quality Improvement Program

**Provides up to $200,000 per year for three years to demonstrate improvement in rural healthcare, specifically for measuring patient outcomes, chronic disease management, increased engagement between providers and patients, and integration of mental/behavioral health programs in rural communities.**
**Application Deadline: April 22, 2019**

# 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 7, 2019**

**News & Announcements**

- Reducing Opioid Misuse Letter
- New Medicare Card: Need an MBI?
- CMS Improving Nursing Home Compare in April
- Comparing Hospital Quality: CMS Updates Consumer Resources
- Promoting Interoperability Programs: Attestation Deadline Extended to March 14
- CY 2018 eCQM Data: Submission Deadline Extended to March 14
- Hospice Provider Preview Reports: Review Your Data by March 31
- LTCH Provider Preview Reports: Review Your Data by April 3
- IRF Provider Preview Reports: Review Your Data by April 3
- Interoperability and Patient Access to Health Data: Comments on New Proposals due May 3
- Clinical Diagnostic Laboratories: New Resources about the Private Payor Rate-Based CLFS
- SNF Provider Threshold Report
- 2019 QRDA I Voc.xml File
- Whole Hospital Approach to Mass Casualties
- Medicare Beneficiaries at a Glance Infographic
- Help Your Patients Make Informed Food Choices

**Provider Compliance**

- Bill Correctly for Device Replacement Procedures — Reminder

**Claims, Pricers & Codes**

- Laboratory Panel Billing Requirements
- Average Sales Price Files: April 2019
- Medicare Diabetes Prevention Program: Valid Claims

**Upcoming Events**

- Dementia Care & Psychotropic Medication Tracking Tool Call — March 12
- Open Payments: Transparency and You Call — March 13
- Data Interoperability across the Continuum: CMS Data Element Library Call — March 19
- SNF Value-Based Purchasing Program: Phase One Review and Corrections Call — March 20

# WEEKLY IT UPDATE

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

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


## March 8, 2019 Update

| Week Ending | Platform | Tab | Enhancement | User Action |
|---|---|---|---|---|
| March 8th, 2019 | Multi-Browser/IE | Calculator | April 2019 Medically Unlikely Edits from CMS have been loaded into the PDE Calculator. | Users can view MUE values on the detail pop-up within the HCPCS query. MUE values are also displayed on Quick Claim results. |
| March 8th, 2019 | Multi-Browser/IE | Calculator | NDC-HCPCS Crosswalk has been updated for April 2019. | Users can query NDC codes in the PDE Calculator to find any associated J codes. |
| March 8th, 2019 | Multi-Browser/IE | Calculator | April 2019 ASP Pricing File from CMS has been loaded into the PDE Calculator. | Users can query drug codes to find payment allowance limits. |
| March 8th, 2019 | Multi-Browser/IE | Calculator | National Coverage Determination and Local Coverage Determination queries on the PDE Calculator have been consolidated. Users can query HCPCS and ICD10 codes to find any NCD or LCDs for the selected Contractor. You can also search by LCDID. Articles are queryable by Keyword, Article ID or NCD ID. | Users can query HCPCS, ICD10, LCD and NCD codes to find the most current Coverage Determination information. |

## Previous Updates

| Week Ending | Platform | Tab | Enhancement | User Action |
|---|---|---|---|---|
| March 1st, 2019 | Multi-Browser/IE | Calculator | January 2019 CPT Assistant added to Calculator | Users can query CPT Assistant documents and view 10+ years of PDF versions. |

| Week Ending | Platform | Tab | Enhancement | User Action |
|---|---|---|---|---|
| February 15th, 2019 | Multi-Browser/IE | Calculator | Berenson-Eggers Type of Service codes have been added to the HCPCS query results in the PDE Calculator. | The BETOS code and description will display at the end of the HCPCS descriptor on the query results, where applicable. |
| February 15th, 2019 | Multi-Browser/IE | Calculator | Modifier listing has been updated in the PDE Calculator | Users can query information on all valid modifiers. This query now includes the latest 2019 updates. |

| Week Ending | Platform | Tab | Sub-Tab | Enhancement | User Action |
|---|---|---|---|---|---|
| January 25th, 2019 | Multi-Browser/IE | Calculator | | November 2018 CPT Assistant added to Calculator | Users can query CPT Assistant documents and view 10+ years of PDF versions. |
| January 25th, 2019 | Multi-Browser/IE | Calculator | | 2019 Anesthesia Conversion Factors have been added to the Calculator | |

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

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

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

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

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

| Type | Summary | CR # | Supporting Docs | Filter Link | Audit Link | Issue Date | Bookmark |
|---|---|---|---|---|---|---|---|
| Med Learn | Enter Summary Search Criteria Here | | | | | | |
| Med Learn | MM11003 Implementation to Exchange the List of Electronic Medica... | N/A | 1 Doc | | | 02/22/19 | |
| Med Learn | MM11087 Ensuring Organ Acquisition Charges Are Not Included in t... | N/A | 1 Doc | | | 02/22/19 | |
| Med Learn | MM10901 Local Coverage Determinations (LCDs) | N/A | 1 Doc | | | 02/15/19 | |
| Med Learn | MM11099 January 2019 Update of the Hospital Outpatient Prospect... | N/A | 1 Doc | | | 01/18/19 | |
| Med Learn | MM11076 Calendar Year (CY) 2019 Annual Update for Clinical Labor... | N/A | 1 Doc | | | 01/18/19 | |
| Med Learn | MM11146 Clinical Laboratory Fee Schedule – Medicare Travel Allow... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11126 Quarterly Update to the National Correct Coding Initiativ... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11097 Quarterly Update for the Temporary Gap Period of the Du... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11085 2019 Durable Medical Equipment Prosthetics, Orthotics, ... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11080 New Waived Tests | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM10901 Local Coverage Determinations (LCDs) | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM10848 Medicare Claims Processing Manual, Chapter 30 Revisions | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM10567 Skilled Nursing Facility Advance Beneficiary Notice of Non... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM 11108 - January 2019 Update of the Ambulatory Surgical Cent... | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM 11072 - Updates to Immunosuppressive Guidance | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM 10782 - Home Health Rural Add-on Payments Based on County... | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM11049 - Ensuring Only the Active Billing Hospice Can Submit a ... | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM10666 New Physician Specialty Code for Undersea and Hyperbar... | N/A | 1 Doc | | | 12/21/18 | |
| Med Learn | MM11073 Claim Status Category and Claim Status Codes Update | N/A | 1 Doc | | | 12/21/18 | |
| Med Learn | MM11021 Implementation of Changes In The End-Stage Renal Dise... | N/A | 1 Doc | | | 12/14/18 | |
| Med Learn | MM11064 Calendar Year 2019 Update For Durable Medical Equipme... | N/A | 1 Doc | | | 12/14/18 | |
| Med Learn | MM11062 Updates To The Inpatient Psychiatric Facility Benefit Polic... | N/A | 1 Doc | | | 12/14/18 | |
| Med Learn | MM11019 Rural Health Clinic and Federally Qualified Health Center ... | N/A | 1 Doc | | | 12/11/18 | |
| Med Learn | MM110838 Durable Medical Equipment, Prosthetics, Orthotics, And ... | N/A | 1 Doc | | | 12/11/18 | |
| Med Learn | MM11044 Quarterly Update To The National Correct Coding Initiativ... | N/A | 1 Doc | | | 11/28/18 | |
| Med Learn | MM11031 Ambulance Inflation Factor for Calendar Year 2019 and P... | N/A | 1 Doc | | | 11/28/18 | |
| Med Learn | MM10907 Next Generation Accountable Care Organization (NGACO... | N/A | 1 Doc | | | 11/28/18 | |
| Med Learn | MM11039 Implement Operating Rules Phase III Electronic Remittan... | N/A | 1 Doc | | | 11/16/18 | |

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**The link to this Med Learn MM11066**

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# Revising the Remittance Advice Messaging for the 20-Hour Weekly Minimum for Partial Hospitalization Program Services

MLN Matters Number: MM11066 Revised

Related Change Request (CR) Number: 11066

Related CR Release Date: February 25, 2019

Effective Date: July 1, 2019

Related CR Transmittal Number: R2265OTN

Implementation Date: July 1, 2019

**Note: We revised this article on February 25, 2019, to reflect the revised CR11066 issued on that date. The revised CR did not impact the content of the article. In the article, we did revise the CR release date, transmittal number, and the web address of the CR. All other information remains the same.**

## PROVIDER TYPE AFFECTED

This MLN Matters Article is for hospitals and Community Mental Health Centers (CMHCs) submitting Partial Hospitalization Program (PHP) claims to Medicare Administrative Contractors (MACs) for PHP services provided to Medicare beneficiaries.

## PROVIDER ACTION NEEDED

CR11066 revises remittance advice informational messaging, effective July 1, 2019, to give supplemental and educational information to the hospitals and CMHCs submitting PHP claims where the patient did not get the minimum 20 hours per week of therapeutic services required by a PHP plan of care. The CR applies to claims with a Line Item Date of Service (LIDOS) on or after July 1, 2019. Make sure your billing staffs are aware of these updates.

## BACKGROUND

PHP services are intensive outpatient services provided in lieu of inpatient hospitalization for mental health conditions. CR11066 is intended to increase provider awareness of the regulations at 42 Code of Federal Regulation (CFR) 410.43(c)(1) and 42 CFR 410.43(a)(3). These regulations state that PHPs are intended for patients who require a minimum of 20 hours per week of therapeutic services, as evidenced in their plan of care. PHP services include only those services a provider furnishes in accordance with a physician certification and plan of care as specified under 42 CFR 424.24(e).



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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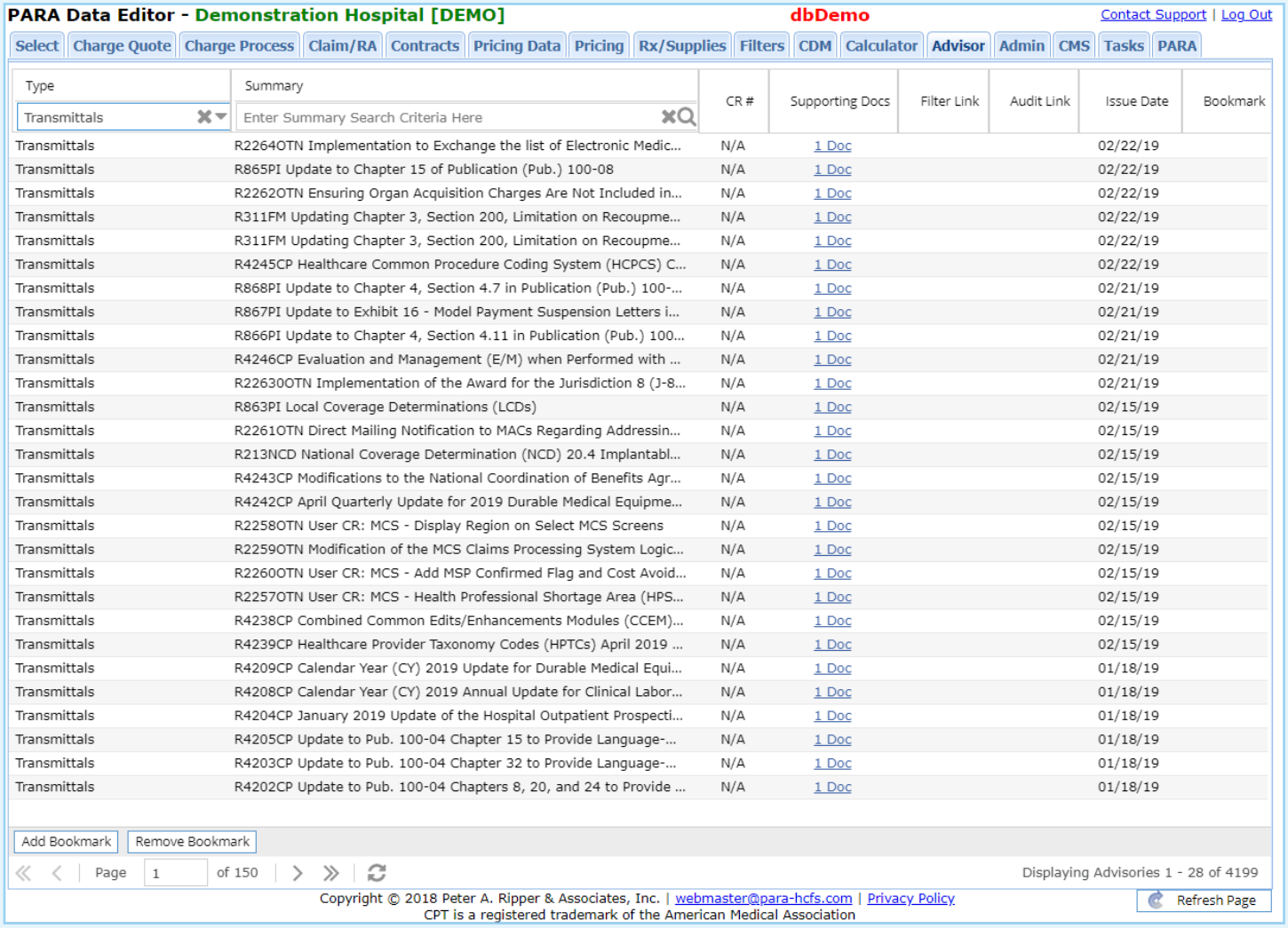
There were SEVEN new or revised Transmittals released this week.

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

7

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



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

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

| Type | Summary | CR # | Supporting Docs | Filter Link | Audit Link | Issue Date | Bookmark |
|---|---|---|---|---|---|---|---|
| Transmittals | Enter Summary Search Criteria Here | | | | | | |
| Transmittals | 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 | |
| Transmittals | R311FM Updating Chapter 3, Section 200, Limitation on Recoupme... | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R4245CP Healthcare Common Procedure Coding System (HCPCS) C... | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R868PI Update to Chapter 4, Section 4.7 in Publication (Pub.) 100-... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R867PI Update to Exhibit 16 - Model Payment Suspension Letters i... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R866PI Update to Chapter 4, Section 4.11 in Publication (Pub.) 100... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R4246CP Evaluation and Management (E/M) when Performed with ... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R22630OTN Implementation of the Award for the Jurisdiction 8 (J-8... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R863PI Local Coverage Determinations (LCDs) | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R2261OTN Direct Mailing Notification to MACs Regarding Addressin... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R213NCD National Coverage Determination (NCD) 20.4 Implantabl... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R4243CP Modifications to the National Coordination of Benefits Agr... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R4242CP April Quarterly Update for 2019 Durable Medical Equipme... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R2258OTN User CR: MCS - Display Region on Select MCS Screens | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R2259OTN Modification of the MCS Claims Processing System Logic... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R2260OTN User CR: MCS - Add MSP Confirmed Flag and Cost Avoid... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R2257OTN User CR: MCS - Health Professional Shortage Area (HPS... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R4238CP Combined Common Edits/Enhancements Modules (CCEM)... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R4239CP Healthcare Provider Taxonomy Codes (HPTCs) April 2019 ... | N/A | 1 Doc | | | 02/15/19 | |
| Transmittals | R4209CP Calendar Year (CY) 2019 Update for Durable Medical Equi... | N/A | 1 Doc | | | 01/18/19 | |
| Transmittals | R4208CP Calendar Year (CY) 2019 Annual Update for Clinical Labor... | N/A | 1 Doc | | | 01/18/19 | |
| Transmittals | R4204CP January 2019 Update of the Hospital Outpatient Prospecti... | N/A | 1 Doc | | | 01/18/19 | |
| Transmittals | R4205CP Update to Pub. 100-04 Chapter 15 to Provide Language-... | N/A | 1 Doc | | | 01/18/19 | |
| Transmittals | R4203CP Update to Pub. 100-04 Chapter 32 to Provide Language-... | N/A | 1 Doc | | | 01/18/19 | |
| Transmittals | R4202CP Update to Pub. 100-04 Chapters 8, 20, and 24 to Provide ... | N/A | 1 Doc | | | 01/18/19 | |

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**The link to this Transmittal R4250CP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4250** | **Date: March 8, 2019** |
| | **Change Request 11165** |

**SUBJECT: Update to Chapter 30 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to provide language-only changes for updating the New Medicare Card Project-related language in Chapter 30 of Pub. 100-04. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

**EFFECTIVE DATE: April 8, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 8, 2019**
***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 30/50.14/CMS Regional Office (RO) Referral Procedures |
| R | 30/140.6.2/Initial Physician Notices |
| R | 30/140.7/Processing Beneficiary Requests for Appeal |
| R | 30/150.8/Processing Initial Denials |
| R | 30/150.9/Processing Beneficiary Requests for Appeal |
| R | 30/150.13/CMS Regional Office (RO) Referral Procedures |
| R | 30/200.6.3/Exhibit 2 – The Detailed Notice of Discharge (CMS 10066) and Form Instructions |

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

**The link to this Transmittal R2268OTN**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 2268** | **Date: March 8, 2019** |
| | **Change Request 10912** |

**SUBJECT: Instructions Relating to the Self-Disallowance Requirement for Determining Jurisdiction over Appeals**

**I. SUMMARY OF CHANGES:** This Change Request (CR) provides updated direction related to the evaluation of the self-disallowance requirement for determining Provider Reimbursement Review Board (PRRB) and Medicare Administrative Contractor (MAC) hearing officer jurisdiction over appeals of cost reports with a reporting period that ended on or after December 31, 2008 and began before January 1, 2016, when the appeals were pending or initiated on or after April 23, 2018.

**EFFECTIVE DATE: April 8, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 8, 2019**

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

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

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

**III. FUNDING:**

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

**One Time Notification**

**The link to this Transmittal R5pr242**

# Medicare
## Provider Reimbursement Manual
### Part 2, Provider Cost Reporting Forms and Instructions, Chapter 42, Form CMS-265-11

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

**Transmittal 5** **Date: March 8, 2019**

| HEADER SECTION NUMBERS | NEW PAGES | REPLACE PAGES |
|---|---|---|
| Table of Contents | 42-1 - 42-2 (2 pp.) | 42-1 - 42-2 (2 pp.) |
| 4200 - 4200.1 | 42.3 - 42.4 (2 pp.) | 42.3 - 42.4 (2 pp.) |
| 4203.2 - 4205 (Cont.) | 42-7 - 42-14 (8 pp.) | 42-7 - 42-14 (8 pp.) |
| 4205.1 (Cont.) - 4206 (Cont.) | 42-17 - 42-22 (6 pp.) | 42-17 - 42-22 (6 pp.) |
| 4208 - 4208 (Cont.) | 42-25 - 42-26 (2 pp.) | 42-25 - 42-26 (2 pp.) |
| 4211 (Cont.) - 4212 | 42-35 - 42-36 (2 pp.) | 42-35 - 42-36 (2 pp.) |
| 4214.1 - 4216 (Cont.) | 42-41 - 42-44 (4 pp.) | 42-41 - 42-44 (4 pp.) |
| 4290 (Cont.) - 4290 (Cont.) | 42-303 - 42-306 (4 pp.) | 42-303 - 42-306 (4 pp.) |
| | 42-309 - 42-310 (2 pp.) | 42-309 - 42-310 (2 pp.) |
| | 42-313.4 - 42-314 (2 pp.) | 42-313.4 - 42-314 (2 pp.) |
| | 42-317 - 42-318 (2 pp.) | 42-317 - 42-318 (2 pp.) |
| 4295 - 4295 (Cont.) | 42-501 - 42-504 (4 pp.) | 42-501 - 42-504 (4 pp.) |
| | 42-513 - 42-514 (2 pp.) | 42-513 - 42-514 (2 pp.) |
| | 42-525 - 42-526 (2 pp.) | 42-525 - 42-526 (2 pp.) |
| | 42-531 - 42-538 (8 pp.) | 42-531 - 42-538 (8 pp.) |

**NEW COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: ESRD changes effective for cost reporting periods ending on or after January 31, 2019.**

This transmittal updates Chapter 42, Independent Renal Dialysis Facility Cost Report, Form CMS-265-11, by clarifying and correcting the existing instructions, forms, and electronic cost report (ECR) specifications.

Revisions include:

- Worksheet S, Part I:
  - Clarifies the instructions for line 11.
  - Adds line 12 for reporting the cost report Medicare utilization status.
- Worksheet S, Part II:
  - Adds line 10.02 to report low Medicare utilization for the cost reporting period.
- Worksheet A:
  - Corrects the instructions for column 7.
  - Clarifies the instructions for column 8.

**CMS-Pub. 15-2-42**

**The link to this Transmittal R2269OTN**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 2269** | **Date: March 7, 2019** |
| | **Change Request 10656** |

**Transmittal 2257, dated February 15, 2019, is being rescinded and replaced by Transmittal 2269, dated, March 7, 2019 to remove BRs 10656.2 & 10656.3. These reports (HBDR2011 & H99RDPDD) should not be updated since no-pay remittances do not create checks and would never change either of the reports. BR 10656.4 is being revised to change the report name to H99RDPDM and BR 10656.5 report name is changing to H99RDPDQ. All other information remains the same.**

**SUBJECT: User CR: MCS - Health Professional Shortage Area (HPSA) No Pay Remittances Should Not Be Sent for Do Not Forward (DNF) Provider**

**I. SUMMARY OF CHANGES:** This Change Request (CR) will update the MCS system to ensure HPSA remittances are not sent if the cycle date is within the Do Not Forward (DNF) effective and termination date. Once the cycle date is after the termination date, the HPSA remittances will be sent. MCS will also update reporting to track HPSA No Pay Remittances.

This was formerly User CR 57958.

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

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

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

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

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
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**IV. ATTACHMENTS:**
**One Time Notification**

**The link to this Transmittal R187SOMA**

# CMS Manual System

## Pub. 100-07 State Operations Provider Certification

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

**Transmittal 187** **Date: March 6, 2019**

**SUBJECT: Revision to the State Operations Manual (SOM 100-07) Appendix Q**

**I. SUMMARY OF CHANGES: Revisions to the State Operations Manual Appendix Q –**

**REVISED MATERIAL - EFFECTIVE DATE: March 6, 2019**
**IMPLEMENTATION DATE: March 6, 2019**

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

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

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| N | Appendix Q Entire Appendix |

**III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.**

**IV. ATTACHMENTS:**

| | |
|---|---|
| | **Business Requirements** |
| X | **Manual Instruction** |
| | **Confidential Requirements** |
| | **One-Time Notification** |
| | **One-Time Notification -Confidential** |
| | **Recurring Update Notification** |

***Unless otherwise specified, the effective date is the date of service.**

**The link to this Transmittal R2267OTN**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 2267** | **Date: March 6, 2019** |
| | **Change Request 11065** |

**Transmittal 2227, dated January 25, 2019, is being rescinded and replaced by Transmittal 2267, dated, March 6, 2019 to change the effective and implementation dates and to add HIGLAS as a responsible party. All other information remains the same.**

**SUBJECT: New State Code for CA, FL, LA, MI, MS, OH, PA, TN and TX**

**I. SUMMARY OF CHANGES:** A new State Code is assigned to CA, FL, LA, MI, MS, OH, PA, TN and TX. The new State Codes are in addition to the State Code the state already possesses.

**EFFECTIVE DATE: April 22, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 22, 2019 - Shared System Maintainer Hours are Billed to the July 2019 Quarterly Release**

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

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

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

**III. FUNDING:**
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**IV. ATTACHMENTS:**

**One Time Notification**

**The link to this Transmittal R214NCD**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-03 Medicare National Coverage Determinations | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 214** | **Date: March 6, 2019** |
| | **Change Request 10878** |

**Transmittal 210, dated November 30, 2018, is being rescinded and replaced by Transmittal 214, dated, March 6, 2019 to extend the implementation date 30 days and update the attached diagnosis code list. This instruction is being re-communicated to include attachment that was omitted. The Transmittal number, Date issued and all other information remain the same.**

**SUBJECT: National Coverage Determination (NCD90.2): Next Generation Sequencing (NGS)**

**I. SUMMARY OF CHANGES: CMS IS SENSITIVE TO THE CONCERNS OF ITS STAKEHOLDERS REGARDING THE INTERPRETATION OF THIS POLICY AND WILL WORK WITH THE MACS TO ADJUST THEIR RESPECTIVE CLAIMS PROCESSING SYSTEMS ACCORDINGLY. THANK YOU FOR YOUR PATIENCE AS WE WORK THROUGH THESE OUTSTANDING ISSUES.**

**The purpose of this Change Request (CR) is to inform contractors that effective March 16, 2018, the Centers for Medicare & Medicaid Services covers diagnostic laboratory tests using next generation sequencing when performed in a Clinical Laboratory Improvement Amendments- certified laboratory when ordered by a treating physician and when specific requirements are met.**

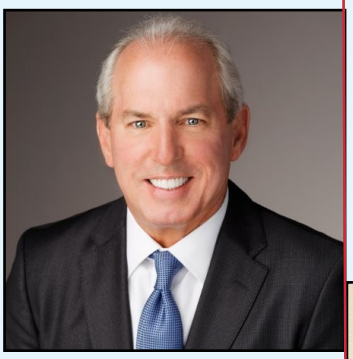
**THIS CHANGE REQUEST (CR) AND PUBLICATION (PUB.) 100-03 MANUAL TRANSMITTAL REFLECTS THE AGENCY'S FINAL DECISION DATED MARCH 16, 2018, REGARDING THE NATIONAL COVERAGE DETERMINATION (NCD) 90.2, ON NEXT GENERATION SEQUENCING (NGS). A SUBSEQUENT CR WILL BE RELEASED AT A LATER DATE THAT CONTAINS A PUB. 100-04 CLAIMS PROCESSING MANUAL UPDATE AND FURTHER, ACCOMPANYING INSTRUCTIONS. UNTIL THAT TIME, THE MEDICARE ADMINISTRATIVE CONTRACTORS (MACS) SHALL BE RESPONSIBLE FOR IMPLEMENTING NCD 90.2.**

This revision to the Medicare National Coverage Determinations Manual is a national coverage determination (NCD). NCDs are binding on Medicare Administrative Contractors (MACs) with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

**EFFECTIVE DATE: March 16, 2018**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 8, 2019 - 120 days from issuance of initial CR10878 issued on 11/30/18—A/B MACs**

***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***

# Contact Our Team



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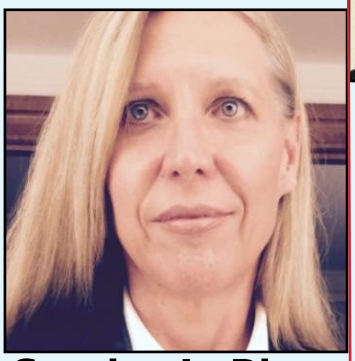

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