March 17, 2021

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

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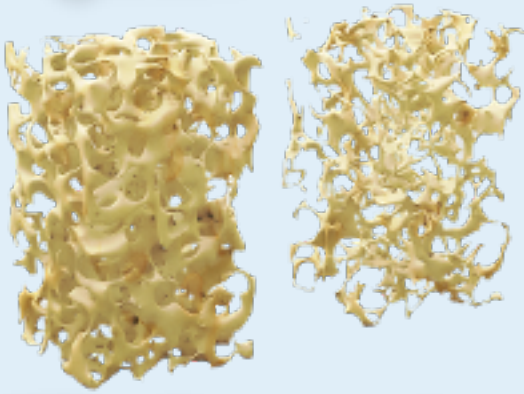

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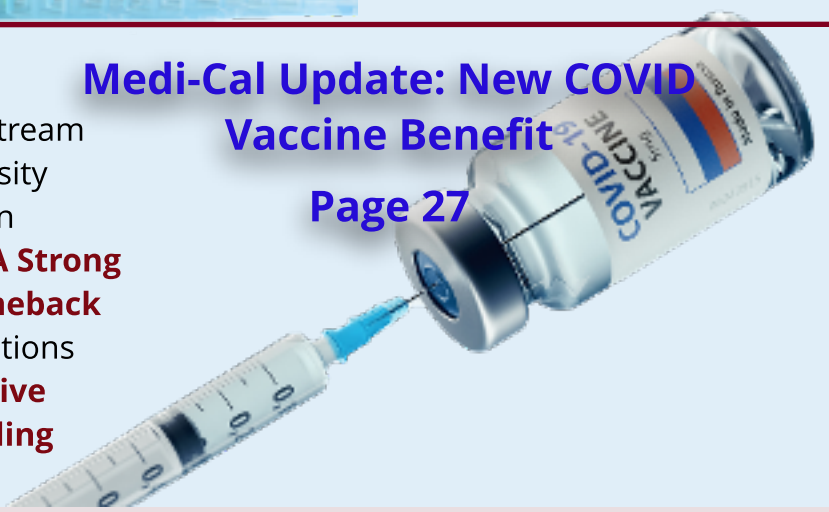

- **Charging For Nursing Time**
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FAST LINKS

CHARGING FOR NURSING TIME

Q. We have an outpatient hospital department that provides a variety of services. The department is called "Special Procedures". Examples of the services provided are GI endonscopies, infusion services and minor procedures. The nursing staff also provides services that are not chargeable, such as dressing changes on patients with chronic wounds.

This occurs whenever our wound clinic cannot see the patient for the dressing change. They also see patients for one-off and unique situations. Recently, they had a patient who needed peripheral IV access started for a home infusion. When a patient receives services that are not otherwise chargeable, how should we charge for the nurses' time?

A. **Answer:** We aren't entirely sure, based on your brief description, that the services mentioned are non-billable.

It's our view that there are four general criteria to evaluate whether a hospital service is billable – the answer to each of these questions must be "yes":

- Was the service performed on the order of a physician (or non-physician practitioner) responsible for the care of the patient?
- Is the service medically necessary?
- Does the service require the expertise of professional personnel, and was that professional acting within their state scope of practice?Was the service performed in licensed hospital space?

With regard to wound care, if the dressing change was ordered by a provider, medically necessary, and required the professional expertise of a nurse – for instance a negative pressure dressing – then the hospital could report G0463 (HOSPITAL OUTPATIENT CLINIC VISIT FOR ASSESSMENT AND MANAGEMENT OF A PATIENT).

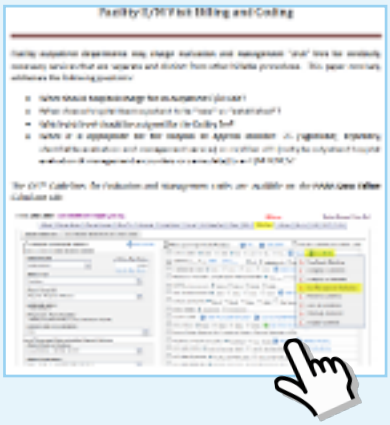
G0463 is a Medicare HCPCS code which some payors may not recognize; commercial payers may accept an E/M code in the 99202-99215 range. I've attached our paper on billing facility fee E/M charges for more information on that topic.

The IV start is a little more complicated; you didn't mention why the hospital was starting the IV if the patient was to receive the infusion in the home setting, nor did you say whether the peripheral IV catheter was an routine IV start, or a central line. A central line placement would be a billable service, of course.

At any rate, if the service truly is non-billable, some hospital departments track employee productivity by means of statistical charges. These charges are priced at $0, so they don't show up on claims, but the statistic helps managers to justify the staff time consumed by non-billable tasks.Here's a little more information on generally what Medicare expects in the way of documentation for billable outpatient hospital services. The CMS publication "PROVIDER COMPLIANCE TIPS FOR ORDERING HOSPITAL OUTPATIENT SERVICES" (February 2018) has been taken off the internet by CMS, but I kept a copy – it is attached to this email. It says, in part:

"The following documentation is required for hospital outpatient services to be covered under the Medicare health benefit:

- Documentation that supports medical necessity of the outpatient service (e.g. physician's office visit note, or progress note, etc.)
- A signed and dated physician's order for the outpatient service
- Documentation showing that the service was rendered



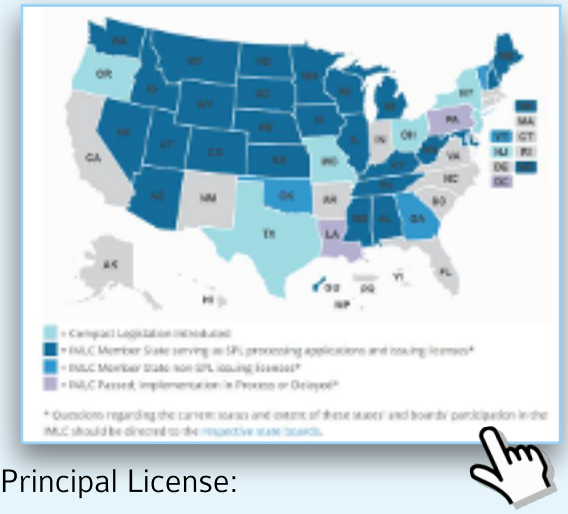
INTERSTATE TELEHEALTH

Q. Can we bill for a telehealth encounter if the patient is currently living out of state? Once of our doctors saw a patient today via telehealth, and then it became apparent that she was no longer in Colorado.

A. **Answer:** In general, providers must be licensed in the state in which the patient is located to practice medicine, including telehealth. Depending on state law where the patient is located, telehealth services might be allowed under very limited circumstances. However, if there is any doubt as to whether the provider is licensed to practice medicine in the state where the patient is located, we do not recommend offering or billing for the telehealth visits to patients located out of state.

Some states, like Ohio, will permit physicians licensed in contiguous states to provide telehealth to patients located in Ohio, but there are several other requirements that must be met – it's not a free-for-all. The details of state law must be understood before extending care across state lines.

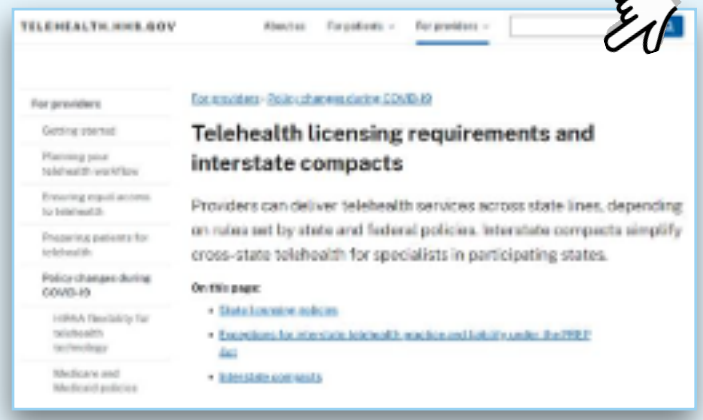
Additionally, the physician's malpractice liability insurer may exclude coverage for any services performed in a state in which the physician is not licensed, thereby exposing the physician and the organization to uninsured malpractice liability.



You may be interested to learn that the federal government, through the Department of Health and Human Services, has created an Interstate Medical Licensing Compact (IMLC) to facilitate medical licensing for individuals across state lines. Eligible physicians can qualify to practice medicine across state lines within the Compact if they meet the Compact's agreed-upon eligibility requirements. Physicians may apply through the Compact for licensure in multiple states, receiving separate licenses from each state in which they intend to practice. The states chosen must be participants in the Compact. There are also provisions for other health professionals, i.e. nurses, physical therapists, etc.

It appears that Colorado is participating in the Interstate Medical Licensure Compact (IMLC); the acronym SPL stands for State of Principal License:

https://www.imlcc.org/participating-states/



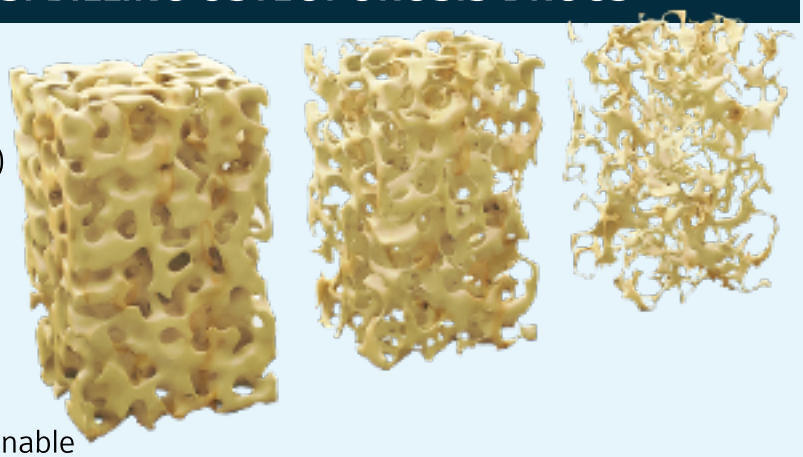
The license to practice medicine is still issued by the individual states – just as they would be using the standard licensing process – but because the application for licensure in these states is routed through the Compact, the overall process of gaining a license is significantly streamlined. Physicians receive their licenses much faster and with fewer burdens. Approximately 80% of U.S. physicians meet the criteria for licensure through the Compact. Here's a link and an excerpt regarding telehealth from the IMLC website:

https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/telehealth-licensing-requirements-and-interstate-compacts/

The rules and policies of the compact are found at

https://www.imlcc.org/imlc-commission/compact-policies-rules-and-laws/

HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS



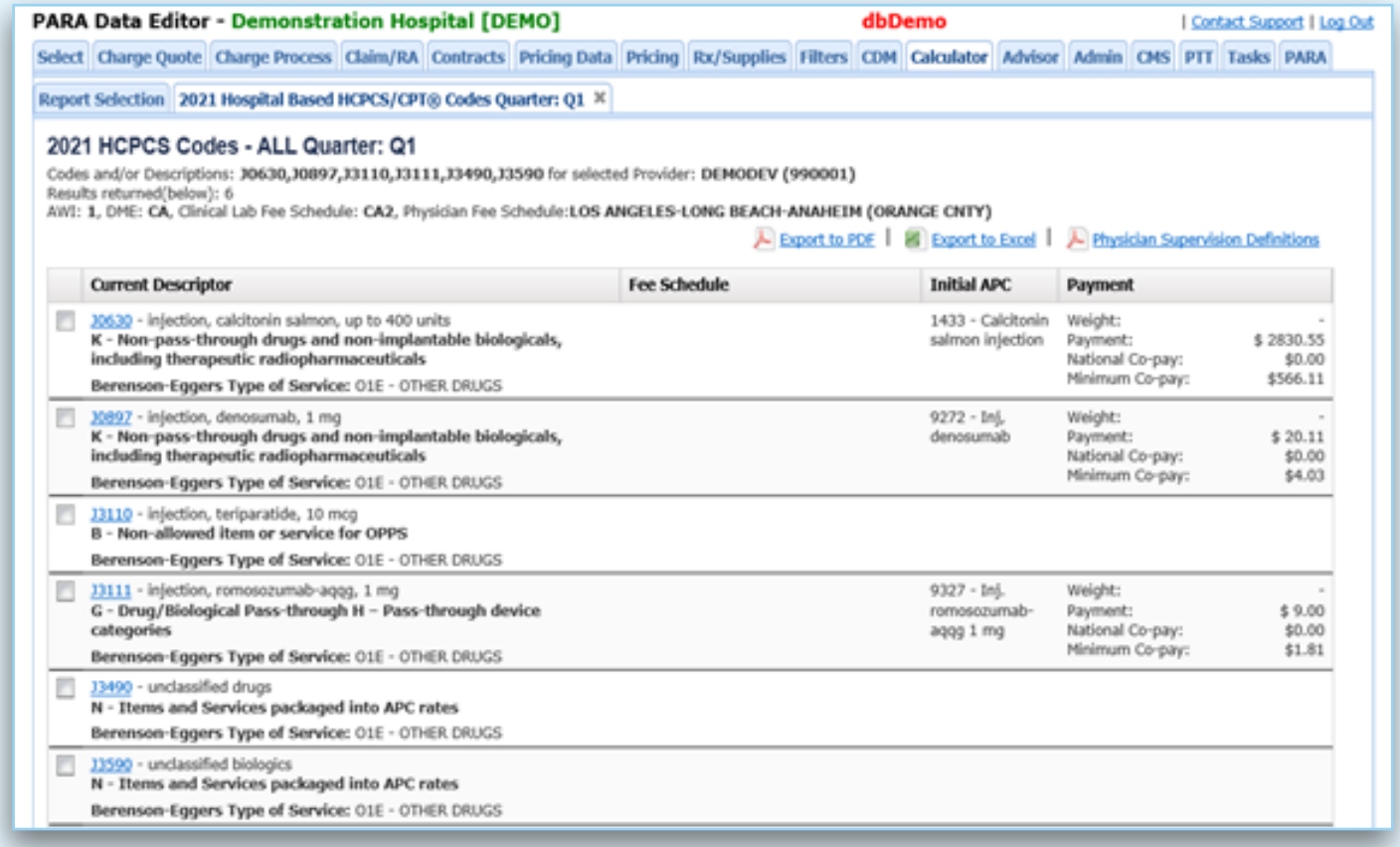
In Home Health, consolidated billing rules require the primary home health agency (HHA) to bill osteoporosis drugs for beneficiaries meeting the coverage requirements for these drugs, if the patient is under a certified HHA-PPS episode.

The actual Osteoporosis drug (s) are excluded from reimbursement under the Home Health Prospective Payment System (HHA-PPS) and are instead reimbursed to providers on a reasonable cost basis.

Reimbursement for administering the drug is included in the HH-PPS episode payment. The primary HHA should submit these charges with other skilled nursing visits on the HH-PPS claim using type of bill (TOB) 329, along with all other applicable home health related services provided by the HHA during the episode.

Providers seeking reimbursement for this service should:

- Ensure the beneficiary is entitled to Medicare Part B
- The date of service for the covered osteoporosis drug(s) must fall within the start and end-dates of an existing HHA PPS episode
- The provider number on the claim for osteoporosis drug(s) must also match the provider number that established the home health episode during which the drug(s) were administered
- Of note: HHAs should be aware if Medicare denies the skilled nursing visit during which the osteoporosis drug was administered, the charges for the drug will not be paid as well by Medicare.



HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS

In addition to the usual information that is required on an HHA -PPS Medicare claim, the following table will identify the specific data that is required for osteoporosis drug(s) reporting:

Field Name	Description
Type of bill (TOB)	34X – HHA visit(s) provided on an outpatient basis
Statement dates from/To	Enter the dates of service for the billing period. NOTE: these dates should fall within the "FROM" and "TO" dates for the HH-PPS episode of care being provided by the primary HHA
Revenue Code	Enter the revenue code 0636 - Pharmacy
HCPCS	Enter the appropriate HCPCS code: J0630 – Drugs containing calcitonin J3110 – Drugs containing teriparatide (Forteo) J0897 - Drugs containing denosumab (Xgeva, Prolia) J3111 - Drugs containing romosozumab-aqqg (Evenity) J3490 – Drugs that are FDA approved and awaiting a specific HCPCS assignment J3590 - Drugs that are FDA approved and awaiting a specific HCPCS assignment (Tymlos)
Total Unit/Covered Unit	Enter units as defined by HCPCS code: **J0630** – 1 unit for every 100-400 units furnished during billing period 2 units for every 401-800 units furnished during billing period 3 units for every 801 -1200 units furnished during billing period 4 units for every 1201 -1600 units furnished during billing period 5 units for every 1601 -2000 units furnished during billing period 6 units for every 2001- 2400 units furnished during billing period **J3110** – Report 1 units for every 10mcg furnished during billing period J0897 - Report 1 unit for each 1mg dose provided during the billing period J3111 – Report 1 unit for each 1mg does provided during the billing period **J3490** – Report units as defined by the HCPCS code
Total Charges	Enter the charge per revenue code for the osteoporosis drug
Service date	Enter the line item **date of service** the drug was provided
Diagnosis Codes	Enter the ICD-9 code 733.01 (for DOS on or before October 01, 2015), or the ICD-10 code M810 (for DOS on or after October 01, 2015)

HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS

References for this article:

https://www.cms.gov/files/document/r10670otn.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10670	**Date: March 12, 2021**
	Change Request 12016

Transmittal 10552, dated January 5, 2021, is being rescinded and replaced by Transmittal 10670, dated, March 12, 2021 to update the effective date from date of service to receipt date. All other information remains the same.

SUBJECT: Modification to Existing Common Working File (CWF) Edits for Osteoporosis Drug Codes Billable on Home Health Claims

I. SUMMARY OF CHANGES: This change request adds instructions to modify the existing CWF edits '5384' and '7283' for billing and paying additional codes for osteoporosis drugs under the home health benefit.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Chapter 7, Section 50.4.3

50.4.3 – Covered Osteoporosis Drugs

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Sections 1861(m) and 1861(kk) of the Act provide for coverage of FDA approved injectable drugs for the treatment of osteoporosis. These drugs are expected to be provided by an HHA to female beneficiaries who are currently receiving services under an open home health plan of care, who meet existing coverage criteria for the home health benefit and who meet the criteria listed below. These drugs are covered on a cost basis when provided by an HHA under the circumstances listed below.

The home health visit (i.e., the skilled nurse's visit) to administer the drug is covered under all fee-for-service Medicare (Part A or Part B) home health coverage rules (see section 30 above). Coverage of the drug is limited to female beneficiaries who meet each of the following criteria:

HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
Chapter 10 Sections: 10, 20 and 90.1

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 10254, 07-31-20)
(Rev. 10274, 08-07-20)

https://www.cms.gov/files/document/r10274cp.pdf

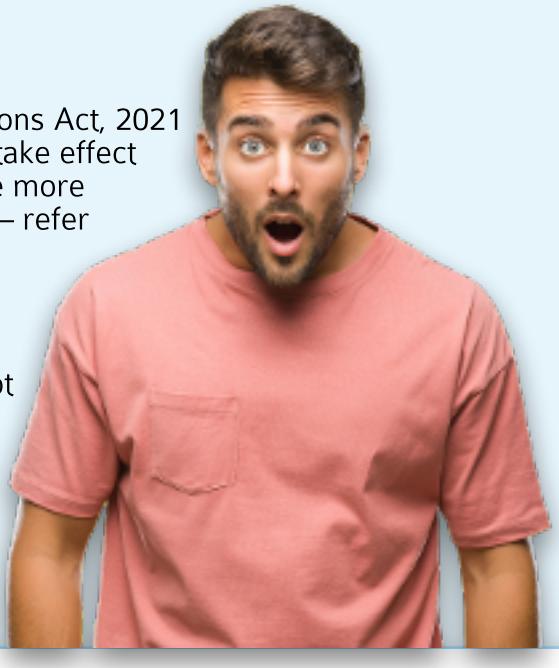
CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10274	**Date: August 7, 2020**
	Change Request 11846

SUBJECT: Update to Osteoporosis Drug Codes Billable on Home Health Claims

I. SUMMARY OF CHANGES: This change request adds instructions for billing and payment of additional codes for osteoporosis drugs under the home health benefit.

EFFECTIVE DATE: January 1, 2021 - Claims received on and after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

CONSOLIDATED APPROPRIATIONS ACT, 2021 -- NO SURPRISES ACT



Background and Overview

The No Surprises Act was part of the Consolidated Appropriations Act, 2021 signed into law on December 27, 2020.The provisions will not take effect until 1/1/2022, and agency rulemaking during 2021 will provide more specific guidance.The full text is published at the following link – refer to Division BB:

https://www.govtrack.us/congress/bills/116/hr133/text/enr

Surprise billing is the unexpectedly high financial liability that can be incurred by an insured patient when the patient does not know that a healthcare provider or facility is out-of-network, learning that the insurance benefits for medical expenses are minimal only after the services have been performed.

Surprise bills can arise in an emergency when the patient has no ability to select the facility or provider rendering the services. Surprise bills are also a commonplace when a patient receives planned care, for example when a patient receives care at an in-network facility but finds out after the fact that a provider who treated the patient is out-of-network, such as pathologists, radiologists, and anesthesiologists.

Division BB

Private Health Insurance and Public Health Provisions

Sec. 1. Table of contents

The table of contents of the division is as follows:

Division BB—Private Health Insurance and Public Health Provisions

Sec. 1. Table of contents.

Title I—No Surprises Act

The new law establishes a required process to resolve payment disputes between plans and providers, so that patient liability is not used as leverage between the provider and the plan.The legislation allows negotiation between the parties and imposes a prescribed arbitration process if negotiations fail. The arbitration methodology is applicable to providers and payers, with the most notable provider being air ambulances. The new law does not include a minimum negotiated payment rate to trigger arbitration.

The arbitration process, as outlined in the law, can be described as a baseball-style; meaning each party submits an offer and basis for that offer, and the mediator selects one of the offers. The decision is final, and payment must be made within thirty (30) days. Providers and payers cannot initiate a new arbitration process for ninety (90) days for the same items or services.

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The table below indicates the key takeaways of the new law:

Issue	Provision
Covered Services	Emergency services (including certain stabilization), air ambulances, and non-emergency services provided at an in-network facility by an out-of-network provider are covered.
Patient Responsibility	The patient is only responsible for the cost-sharing amount that would apply if the services had been provided at in-network facility or provider.
Minimum Payment	There is no minimum or median rate.
Notice and Consent	For non-emergency services, if providers meet specified notice and consent requirements, they may balance bill the patient.
Treatment of Ancillary Services	Providers may not balance bill for ancillary services (as defined in the CAA).
Independent Dispute Resolution (or arbitration)	After a 30-day negotiating period, if no agreement reached, an independent dispute resolution entity is selected and has thirty (30) days to determine payment amount. Payment must be one of the amounts submitted by either party. The party has thirty (30) days to make the payment.

While the framework is now law, many of the requirements will require additional agency rulemaking. Detailed regulations will be promulgated to establish the independent dispute resolution process. With the changes to the Presidential Administration and the implementation date of January 01, 2022, this leaves room for stakeholder input.Proposed regulations are expected to be published by mid-year.

Highlights of the prohibitions contained within the "no surprises" billing rules and dispute resolution process are provided below.Additional details contained within regulations to be promulgated during 2021 will be reported when they are finalized.

Prohibition on Balance Billing: Emergency Situations

The CAA prohibits providers and plans from balance billing patients for emergency services, regardless of the in-network or out-of-network status of the facility or provider treating the patient. The patient is only responsible for the cost-sharing amount, such as; co-payments and deductibles, that would apply if the services had been provided at in-network facility and in-network provider.

Patient cost-sharing cannot be greater than the recognized amount and will count toward any in-network deductible or out-of-pocket maximums. This recognized amount may either be

- Determined by existing state law or state regulations, or
- *If no state law is in place, the qualifying payment amount (defined in the CAA as "the median contracted rate recognized by the plan as the total maximum payment provided on January 31, 2019, for the same or similar item or service, by a similar provider, in the same geographic region") and,

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- The qualifying payment amount will be increased annually by the consumer price index

The plan will be required to send a payment or notice of denial to the provider within thirty (30) days following the receipt of the initial bill from the provider.

*HHS will establish a methodology to determine this amount.

HHS, in conjunction with US Department of Labor and Treasury, must issue regulations by July 01, 2021, to establish the following:

- Methodology the plan will use to determine the qualifying payment amount differentiating by individual market, large group market and same group market
- Any information the plan must share with the out-of-network facility or provider when determining the payment amount
- Geographic regions, taking into account access to items and services in rural and underserved areas, including health professional shortage areas
- Process to receive complaints of violations of the requirements

In addition, HHS in conjunction with US Department of Labor and Treasury, must issue regulations by October 01, 2021, to establish an audit process to ensure that plans are applying the qualifying payment amount for emergency services.

HHS in conjunction with US Department of Labor and Treasury would also need to issue regulations that would apply to

- Balance Billing Non-Emergency Situations, and
- Air Ambulances

Notice and Consent

HHS, is working in conjunction with the Departments of Labor and Treasury, to issue guidance on Notice and Consents by July 01, 2021. The guidance will consist of the consent format and details of the requirements.

In the scenario of non-emergency services, the law lays out specific notice and consent requirements that, if met, permit balance billing. This exception does not apply to certain ancillary services outlined below:

Providers who are eligible to request a consent waiver must include a written notice to the patient no later than 72 hours before the date on which the items or services are provided. This notice must include the following information:

- Notification that the provider or facility is out-of-network
- Clear statement that consent is optional and the patient can seek care from an in-network provider
- Good faith estimates of the amount the patient may be charged
- If the service is to be furnished by an out-of-network provider in an in-network facility, a list of in-network providers who are able to provide the service
- Information on whether prior authorization is needed

Once the patient received the notice, the patient has the option to consent. The notice must be signed by the patient where the patient acknowledges that they were provided with written notice and informed about the payment, indicating how it may affect cost-sharing. The consent must include the date on which the patient received the notice and the date on which the patient signed the consent.

The plan must retain the consent for seven (7) years.

Ancillary Services

If the out-of-network provider meets certain notice and consent requirements, the patient may be balanced billed. This, however, does not apply for specified ancillary services.

The specific ancillary services outlined below, may not be balance billed regardless of whether they are provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists and intensivists

1. Services provided at an in-network facility related to
    - Emergency Medicine
    - Anesthesiology
    - Pathology
    - Radiology
    - Laboratory and Neonatology
2. Diagnostic services
    - Including radiology and laboratory services
3. Items and services provided by a non-participating provider if there is no participating provider who can furnish such item or service at the facility
4. Other items and services provided by other specialty practitioners as HHS specifies through future rulemaking.

HHS may, through rulemaking, establish and periodically update a list of advanced diagnostic laboratory tests that would not be subject to this prohibition and thus would be eligible for the balance billing notice and consent exception rule.

Independent Dispute Resolution (IDR) Process

To assist with payment disputes between providers and plans, the law will enable the use of an arbitration process, which is known as independent dispute resolution (IDR). This process will be utilized to settle disputed emergency and non-emergency services that fall within the definitions of surprised billing prohibitions.

This process must be initiated within thirty (30) days of the provider receiving an initial payment or notice of denial of payment from the plan. The provider and plan then have up to thirty (30) days for open negotiation. During this allotted time period, the provider and plan can attempt to come to agreement without formally initiating the IDR process. The provider and plan do not have to use all thirty (30) days if either party wishes to go to arbitration.

However, following the end of the thirty (30) days, the provider or plan have four (4) days to initiate the IDR process. The initiating party must notify the other party and HHS. The parties can continue to negotiate after one (1) party initiates the IDR process.

Providers and plans can consolidate (or batch) similar items and services in the IDR process. However, payment for the items and services must be made by the same plan, and the items and services must be furnished by the same provider or facility, be related to the treatment of a similar condition and be furnished within a thirty (30) day window. HHS has discretion to determine an alternative window for use in limited situations.

The law requires HHS, in conjunction with the Department of Labor and Treasury to issue regulations detailing the IDR resolution process and required documentation within one (1) year of enactment, or December 27, 2021.

For each calendar quarter beginning in CY 2022, HHA must publish specified performance metrics on the IDR process.

Independent Dispute Resolution (IDR) Entities

Entities must have medical, legal or other expertise to make the required determinations. Entities may not be a health plan or provider, or affiliated with plans or providers. The certification period lasts for five (5) years.

In addition, while the law does not speak to the ideal number of certified IDR entities, it does state that the process should allow for a sufficient number of entities. HHS may issue other requirements in forthcoming regulations..

The law requires HHS, in conjunction with the Department of Labor and Treasury, to establish a process to certify and re-certify IDR entities.

In addition, HHS is also tasked with providing a method by which the parties involved in the arbitration can choose from the available certified IDR entities. The parties have three (3) days to choose. If no agreement is made, HHS will choose the IDR entity with six (6) days.

Payment Determination

Once the IDR entity is chosen, the arbiter has thirty (30) days to issue a payment determination. Within ten (10) days of the IDR entity selection, the two parties must submit a payment offer and other information requested by the IDR entity. The IDR entity has been granted the flexibility to consider other factors, such as:

- Similar payment amounts in the same geographic region (which will be defined by HHS)
- The training level, experience, quality and outcomes measurements of the provider or facility
- The market share held by the out-of-network provider or plan in the geographic region
- The condition and complexity of the care needed
- Teaching status, case mix and scope of services of the out-of-network facility
- Demonstration of good faith efforts by the provider or plan to enter into network agreements, and if available and relevant, contracted rates for the previous four (4) years

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The CAA includes separate factors for IDR entity consideration for air ambulances. These include:

- Quality and outcomes measurements of the provider that furnished such services;
- Acuity of the individual receiving such services or the complexity of the services;
- Training, experience and quality of the medical personnel
- Ambulance, vehicle type
- Population density of the pick-up location
- Demonstrations of good faith efforts (or lack thereof) by the participating provider or facility, or the plan, or issuer, to enter into network agreements
- If applicable, contracted rates between provider and the plan, or issuer, as applicable, during the previous four (4) plan years

The IDR entity may NOT consider such factors as usual and customary charges or the payment amount for the same item or service by a public payer, for example, Medicare or Medicaid.

The final payment amount must be one of the amounts submitted by either party. Once the payment determination is made, it is final and binding, and is not subject to further judicial review, except in specific circumstances. The party that initially submitted the request for the IDR process may not initiate another IDR process with the same party for the same item or service for a 90-day period. The final payment must be made within 30 days of the final determination.

HHS has discretion to modify any of these deadlines under extenuating circumstances (which HHS also can define), with the exception of the date required to establish the IDR process (one year from enactment) and the 30-day deadline for final payment.

Further, within two (2) years of enactment, HHS, in conjunction with Departments of Labor and Treasury, will issue a report examining plans' pattern or practice of routine denial, low payment or down-coding of claims, or other abuse of the 90-day period.

Cost of Independent Dispute Resolution Process

The party whose offer is not chosen must pay all fees charged by the IDR entity. If the parties reach an agreement independently, but within the IDR process period, the IDR fees will be split between the parties.

In addition to the cost of the IDR entity, HHS may prescribe fees for parties that participate in the IDR process to offset expenditures by HHS in carrying out the IDR process.

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Patient Protections

The CAA allows for some flexibility for patients when choosing certain providers. The following requirements are in effect for plan years on or after January 01, 2022.

- If a plan requires the patient to identify a primary care provider, the patient can choose a participating primary care provider
- If a plan requires the patient to identify a pediatric primary care provider, the patient can choose any in-network physician (including allopathic or osteopathic) who specializes in pediatrics
- A plan cannot require a referral or authorization for women who seek obstetrical or gynecological care from an in-network provider who specializes in obstetrics or gynecology

Also, beginning January 01, 2022, providers will be required to make a one-page notice available to insured patients with information regarding surprise billing prohibitions, including state requirements, as well as contact information for state and federal entities to report surprise billing violations.

Plans will be required to include deductible information, out-of-pocket maximum limitations and customer assistance information on electronic or physical beneficiary insurance cards.

Treatment of Uninsured under CAA

The law establishes a separate provider-patient dispute resolution process for uninsured individuals. The patient must have been billed "substantially in excess of" a good faith estimates of the expected charges from a provider or plan. Similar to the arbitration process for insured patients, HHS is tasked with establishing a process for certifying IDR entities and a method for selecting a certified IDR entity. These entities will determine a payment amount. There are similar administration fees that must be established by HHS.

This section of the law is not as descriptive as other provisions, and there are no set time frames associated with the resolution process. HHS is required to issue regulations by January 01, 2022 for all of the components outlined in this section of the law.

Enforcement

Both states and HHS are permitted to enforce provisions of the law. Violations are subject to civil money penalties up to $10,000. HHS has the ability to establish a hardship exemption for these penalties and waive the penalties for providers and facilities that did not knowingly violate the requirements laid out in the law.

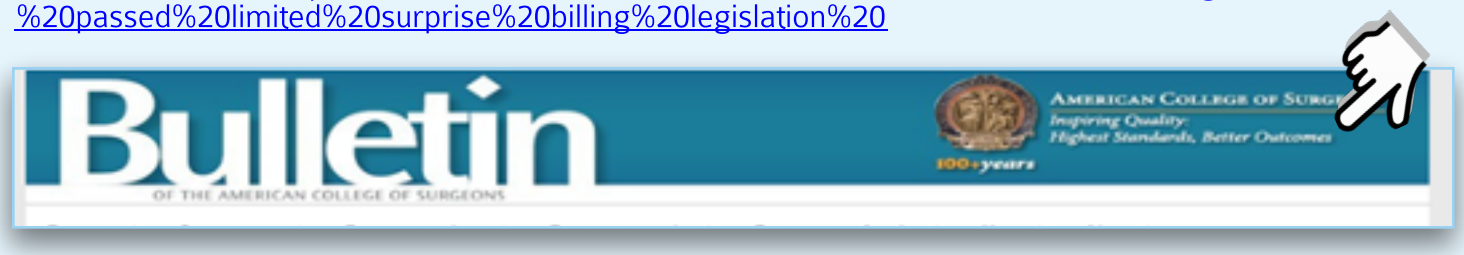
Interaction with state laws

Several states have already enacted comprehensive surprise billing laws. The new federal law defers to **existing state requirements with respect to state-established payment amounts, meaning the CAA does not fully preempt or otherwise displace state payment standards.**

States can continue to pass surprise billing laws and regulations in the future.

CONSOLIDATED APPROPRIATIONS ACT, 2021 -- NO SURPRISES ACT

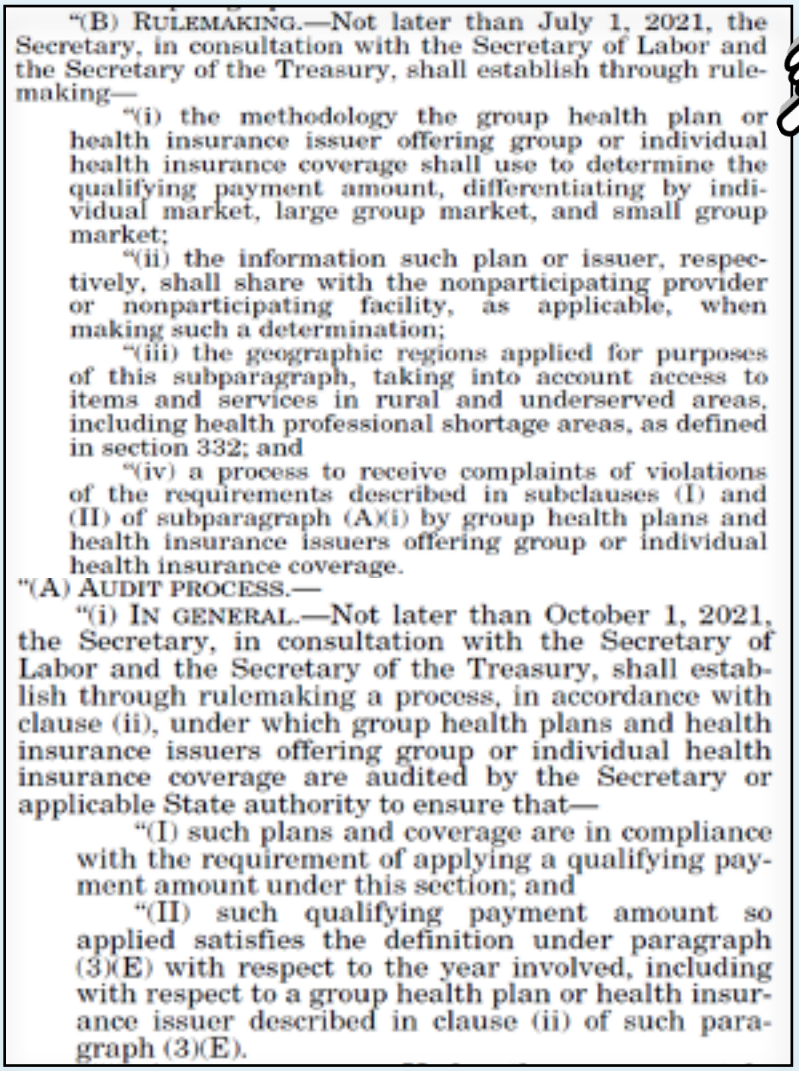
https://bulletin.facs.org/2019/11/state-legislatures-consider-surprise-billing-legislation-in-2019/#:~:text=As%20of%20January%202019%2C%20the%20Commonwealth%20Fund%20noted,Virginia%29%20had%20passed%20limited%20surprise%20billing%20legislation%20



In conclusion, surprise billing provisions in CAA means that opportunities for advocacy have shifted from Congress to the Administration. The surprise billing law has drawn criticism and praise, with providers, plans and patient groups sometimes advocating for differing positions. With the details of many important policies subject to agency rule making, stakeholders should be prepared to advocate for favorable definitions, processes and time frames.

References for this article:

https://www.govtrack.us/congress/bills/116/hr133/text



"(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking—

"(i) the methodology the group health plan or health insurance issuer offering group or individual health insurance coverage shall use to determine the qualifying payment amount, differentiating by individual market, large group market, and small group market;

"(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

"(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332; and

"(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering group or individual health insurance coverage.

"(A) AUDIT PROCESS.—

"(i) IN GENERAL.—Not later than October 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary or applicable State authority to ensure that—

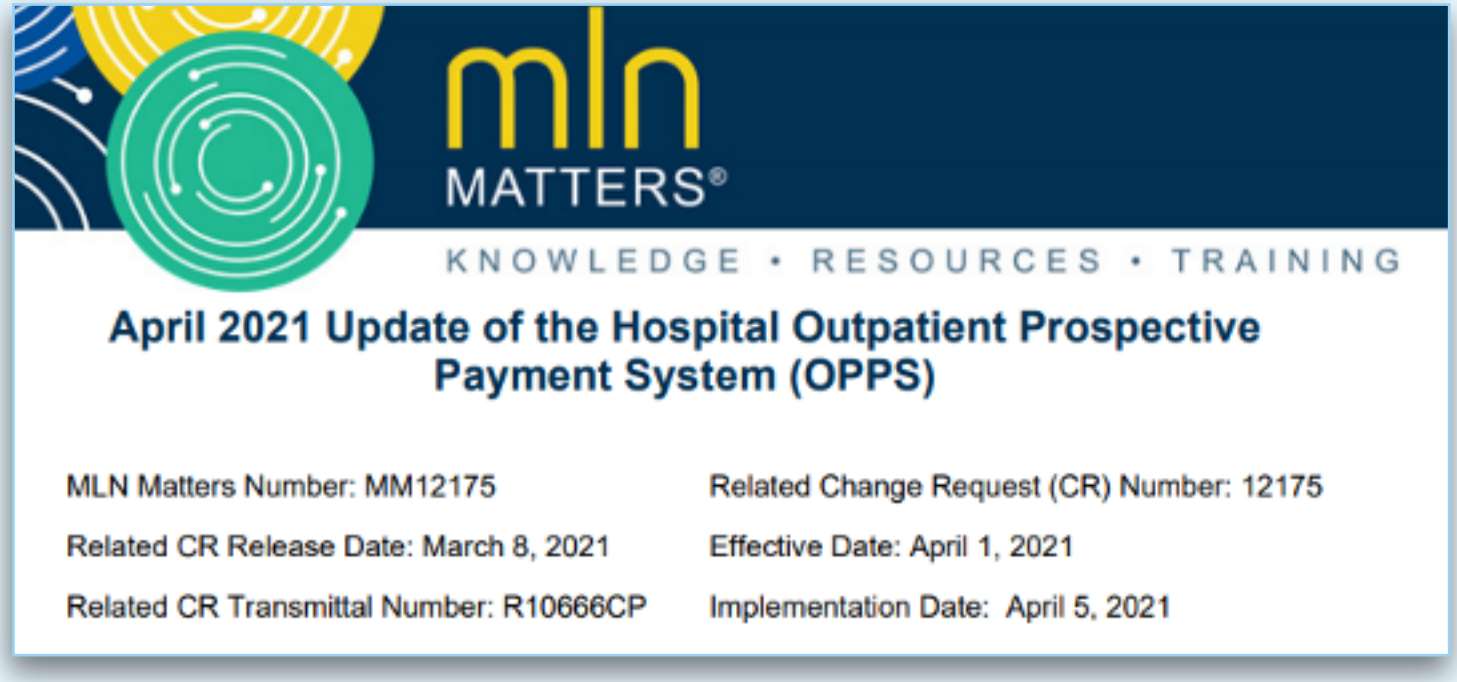
"(I) such plans and coverage are in compliance with the requirement of applying a qualifying payment amount under this section; and

"(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

APRIL 1, 2021 OPPS UPDATES

CMS issued Transmittal R1066CP with an MLN article "April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)" on March 8, 2021.Eighteen HCPCS were deleted effective 4/1/2021, some of the deleted codes have been replaced with new HCPCS codes.Most of the newly added HCPCS were for proprietary laboratory testing and new pharmaceuticals.

https://www.cms.gov/files/document/mm12175.pdf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April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM12175 | Related Change Request (CR) Number: 12175

Related CR Release Date: March 8, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10666CP | Implementation Date: April 5, 2021

PARA will advise chargemaster clients by email of any line items in the hospital CDM require update as a result of a deleted HCPCS code; we will also provide a replacement HCPCS where available.(To take full advantage of **PARA** chargemaster support, clients are encouraged to upload a current CDM at least quarterly.)

The following summarizes the OPPS updates effective April 1, 2021.

- **Revised APC assignment:** Effective April 1, 2021, CMS reassigned OPPS APCs to Pfizer and Moderna COVID-19 administration codes. (The HCPCS are unchanged, only the payment APC changed.)

Old APC	APC Desciption	New APC	APC Description
1492	New Technology – Level 1B ($11-$20)	**9397**	Covid-19 Vaccine Administration Dose 1 of 2
1493	New Technology – Level 1C ($21-$30)	**9398**	Covid-19 Vaccine Administration Dose 2 of 2 or Single Dose Product

APRIL 1, 2021 OPPS UPDATES

Administration codes assigned rates from Addendum B will be available at the following webpage:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

*Note:At time of print, the Addendum A and B updates were not yet published on the CMS.gov website

Addendum A and Addendum B Updates

Updates of Addendum A and B are posted quarterly to the OPPS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates, that are in effect at the beginning of each quarter. The quarterly updates of Addendum A and Addendum B reflect the OPPS Pricer changes that are part of the quarterly OPPS recurring update notification transmittals.

The COVID vaccine codes with updated APC assignments are below:

Labeler	HCPCS	Type	Long Description
Pfizer	91300	Vaccine Product	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use
Pfizer	0001A	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **first dose**
Pfizer	0002A	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **second dose**
Moderna	91301	Vaccine Product	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use
Moderna	0011A	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **first dose**
Moderna	0012B	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **second dose**

APRIL 1, 2021 OPPS UPDATES

- **Johnson & Johnson COVID-19 Vaccine:** Effective February 27, 2021, under the FDA Emergency Use Authorization (EUA) of the Johnson & Johnson (Janssen) COVID-19 vaccine, providers may report HCPCS91303 for the vaccine product and 0031A for its single-dose administration. The payment rates will be published in the April Addendum B

- **Monoclonal AB Therapy for COVID-19:** CMS establish new HCPCS codes for Monoclonal Antibody Therapy treatments for COVID-19 effective on the date the FDA provided an EUA for each. Medicare covers these treatments during the Public Health Emergency (PHE) in accordance with Section 3713 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Medicare covers and pays for the monoclonal therapy through the COVID-19 vaccine program. Medicare expects that, at least initially, providers will receive the drug products free of charge.When the provider receives the product at no cost, Medicare will reimburse the administration of the monoclonal antibody drugs when reported with the unique M-code, it is not necessary to report the drug itself on claims to Medicare.

The following chart lists the effective dates and payment rates for each monoclonal antibody therapy code.

Monoclonal Drug	Effective Date	HCPCS	Description	Payment
Bamlanivimab	11/9/2020	M0239	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring	$309.60
		Q0239	Injection, bamlanivimab-xxxx, 700 mg	$ 0.01
Casirivimab / Imdevimab	11/21/2020	M0243	intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring	$309.60
		Q0243	Injection, casirivimab and imdevimab, 2400 mg	$ 0.01
Bamlanivimab / Etesevimab	02/09/2021	M0245	Bamlan and etesev infusion	$309.60
		Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	$ 0.01

- New PLA Codes:Effective April 1, 2021, the AMA established the six following Proprietory Lab Analyses (PLA) codes; these have been assigned OPPS status A (paid under fee schedule) or Q4 (conditionally packaged laboratory services): (See following page.)

APRIL 1, 2021 OPPS UPDATES

CPT®	Description	OPPS SI
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements	A
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia	Q4
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffinembedded tumor tissue	A
0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage	A
0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens	A
0247U	Obstetrics (preterm birth), insulin-like growth factor–binding protein 4 (IBP4), sex hormone–binding globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-risk stratification for spontaneous preterm birth	Q4

- **New HCPCS Code C9776:** Effective April 1, 2021, report add-on code HCPCSC9776for intra-operative near-infrared fluorescence imaging of major extra hepatic bile duct(s) with intravenous administration of indocyanine green. This laser technique, which uses indocyanine (ICG) green, provides enhanced real-time visualization of cystic, common bile, or common hepatic ducts during open or laparoscopic cholecystectomy procedures.

HCPCS Code	Short Descriptor	Long Descriptor	OPPS SI	OPPS APC
C9776	Fluo bile duct imaging w/icg	Intraoperative near-infrared fluorescence imaging of major extra-hepatic bile duct(s) (e.g., cystic duct, common bile duct and common hepatic duct) with intravenous administration of indocyanine green (icg) (list separately in addition to code for primary procedure)	N	N/A

APRIL 1, 2021 OPPS UPDATES

- **New HCPCS Code C9777:** Effective April 1, 2021, report C9777 for Esophageal Mucosal Integrity Testing by Electrical Impedance.This procedure is used to detect esophageal mucosal changes that result from chronic Gastroesophageal Reflux Disease (GERD) or Eosinophilc Esophagitis (EoE.)

HCPCS Code	Short Descriptor	Long Descriptor	OPPS SI	OPPS APC
C9777	Esophag mucosal integ add-on	Esophageal mucosal integrity testing by electrical impedance, transoral (list separately in addition to code for primary procedure)	N	N/A

- **Change of Long Descriptor for HCPCS C9761:** Effective October 1, 2020, the long descriptor for HCPCS code C9761 as shown below

HCPCS Code	Old Long Descriptor	New Long Descriptor	OPPS SI	OPPS APC
C9761	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy (ureteral catheterization is included) and vacuum aspiration of the kidney, collecting system and urethra if applicable	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable.	J1	5375

- **Change of Long Descriptor for HCPCS C9761:** Effective October 1, 2020, the long descriptor for HCPCS code C9761 as shown below

HCPCS Code	Old Long Descriptor	New Long Descriptor	OPPS SI	OPPS APC
C9761	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy (ureteral catheterization is included) and vacuum aspiration of the kidney, collecting system and urethra if applicable	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable.	J1	5375

APRIL 1, 2021 OPPS UPDATES

- **Status Indicator Corrections:** In the January 1, 2021 Addendum B, CMS incorrectly listed G2061, G2062 and G2063 with a status indicator of A (paid by MACs under a fee schedule or payment system other than OPPS.) These codes were deleted effective December 31, 2020 and were replaced with CPT® codes 98970, 98971 and 97972 which CMS incorrectly assigned to status indicator B (Not paid under OPPS.) To correct these errors, CMS made the following changes with a retroactive effective date of January 1, 2021.

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
G2061	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes	D	N/A
G2062	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes	D	N/A
G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes	D	N/A
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	A	N/A
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	A	N/A
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	A	N/A

- **Additional Status Indicator Changes:** In the January 2021 OPPS, CMS incorrectly assigned G2010 and G2012 with status indicator of A (Paid by MACs under a fee schedule or payment system other than OPPS.)G2211 was incorrectly assigned status indicator of N (payment is packaged into payment for other services.) To correct these errors, each of these codes are assigned status indicator B (Not paid under OPPS) with an effective date of January 1, 2021.

APRIL 1, 2021 OPPS UPDATES

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	B	N/A

Status Indicator Corrections: In the January 1, 2021 Addendum B, CMS incorrectly listed G2061, G2062 and G2063 with a status indicator of A (paid by MACs under a fee schedule or payment system other than OPPS.) These codes were deleted effective December 31, 2020 and were replaced with CPT® codes 98970, 98971 and 97972 which CMS incorrectly assigned to status indicator B (Not paid under OPPS.) To correct these errors, CMS made the following changes with a retroactive effective date of January 1, 2021.

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
G2011	Brief communication technologybased service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	B	N/A
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established	B	N/A

APRIL 1, 2021 OPPS UPDATES

- **Change of HCPCS for DecisionDx-Melanoma test:** When DecisionDx-Melanoma test was approved as an ADLT on May 17, 2019, there was no CPT® code assigned to the test .In the October 2019 Update to OPPS labs were instructed to report this test with an unlisted code,81599(unlisted multianalyte assay with algorithmic analysis) with identifier ZB1D4.

  Effective January 1, 2021,DecisionDx-Melanomatest was assigned CPT® code81529(Oncology (cutaneous melanoma), mrna, gene expression profiling by real-time rt-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis).CPT® code 81529 was assignedstatus indicator A (Paid by MACs under a fee schedule or payment system other than OPPS.)

  Also, effective January 1, 2021, the status indicator for the unlisted code81599was returned to E1 (Not paid by Medicare when submitted on outpatient claims - any outpatient bill type.)

- **TIVUS™:** A treatment for pulmonary arterial hypertension (PAH),Therapeutic Intravascular Ultrasound (TIVUS) employs a catheter in an intravascular technology that interrupts nerve conduction surrounding blood vessels and other structures.The ultrasound waves heat the nerves to necrosis which interrupts nerve conduction.This ablation results in decreasing sympathetic hormones from the nerves, which, in turn, relaxes and reduces resistance and pressure in the vessels.

  Effective April 1, 2021, the OPPS status of the TIVUS procedure HCPCS code0632T(percutaneous transcatheter ultrasound ablation of nerves innervating thepulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imagingguidance) from E1 (excluded from coverage) to toJ1(hospital Part B services paid through a comprehensive APC.)-

  Additional information on TIVUS is available through the following webpage: https://sonivie.com/tivus

- **Drugs, Biologicals and Radiopharmaceuticals**
  - **New Pass-through Status:** The following HCPCS codes will be assigned Pass-Through Status indicator G effective April 1, 2021:

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
C9704	Injection, lumasiran, 0.5 mg	G	9407
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	G	9395
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg	G	9406

APRIL 1, 2021 OPPS UPDATES

- **Expiring Pass-through Status:** Effective April 1, 2021, pass-through status on the following HCPCS codes will change from a status indicator G to K (Paid under OPPS by APC.)

HCPCS Code	Long Descriptor	Jan 2021 OPPS SI	Apr 2021 OPPS SI	Apr 2021 APC
C9462	Injection, delafloxacin, 1 mg	G	K	9462
J0185	Injection, aprepitant, 1 mg	G	K	9463
J0517	Injection, benralizumab, 1 mg	G	K	9466
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	G	K	9469
J7203	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu	G	K	9468
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	G	K	9174
J9311	Injection, rituximab 10 mg and hyaluronidase	G	K	9467
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	K	9035
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	K	9194
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	G	K	9036

APRIL 1, 2021 OPPS UPDATES

- **Newly Established HCPCS Codes for Drugs, Biologicals and Radiopharmaceuticals:** The following seven new codes will replace current HCPCS codes beginning April 1, 2021

New HCPCS	Old HCPCS	Long Descriptor	OPPS SI	APC
A9592	C9068	Copper cu-64, dotatate, diagnostic, 1 millicurie	G	9383
J1427	C9071	Injection, viltolarsen, 10 mg	G	9386
J1554	C9072c	Injection, immune globulin (asceniv), 500 mg	G	9392
J7402	C9122	Mometasone furoate sinus implant, (sinuva), 10 micrograms	G	9346
J9037	C9069	Injection, belantamab mafodontin-blmf, 0.5 mg	G	9384
J9349	C9070	Injection, tafasitamab-cxix, 2 mg	G	9385
Q2053	C9073	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9391

- **Two HCPCS are deleted effective April 1, 2021:**

New HCPCS	Long Descriptor	OPPS SI	APC
J7333	Hyaluronan or derivative, visco-3, for intra-articular injection, per dose	N	N/A
J7401	Mometasone furoate sinus implant, 10 micrograms	N	N/A

- **Retroactive Status Indicator Changes:** The following drug status indicator change is retroactive from January 1, 2021, through March 31, 2021:

HCPCS Code	Long Descriptor	Old OPPS SI	New OPPS SI	APC
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg	E2	K	9406

APRIL 1, 2021 OPPS UPDATES

- **Updates on Drugs and Biologicals with payments based on Average Sales Price (ASP):**

  - Most nonpass-through, Non 340B Program = ASP +6 percent of reference product for biosimilars)
  - Nonpass-through, acquired through 340B Program = ASP – 22.5 percent of 340B acquired biosimilar
  - Single payment of ASP + 6 percent for pass-through to provide payment for the acquisition cost and pharmacy overhead
  - Based on OPPS/ASC final rule comments, values for many drugs and biologicals changed based on sales price from third quarter CY 2020.The full updated list will be available at the April 2021 update of OPPS Addendum A and B :

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

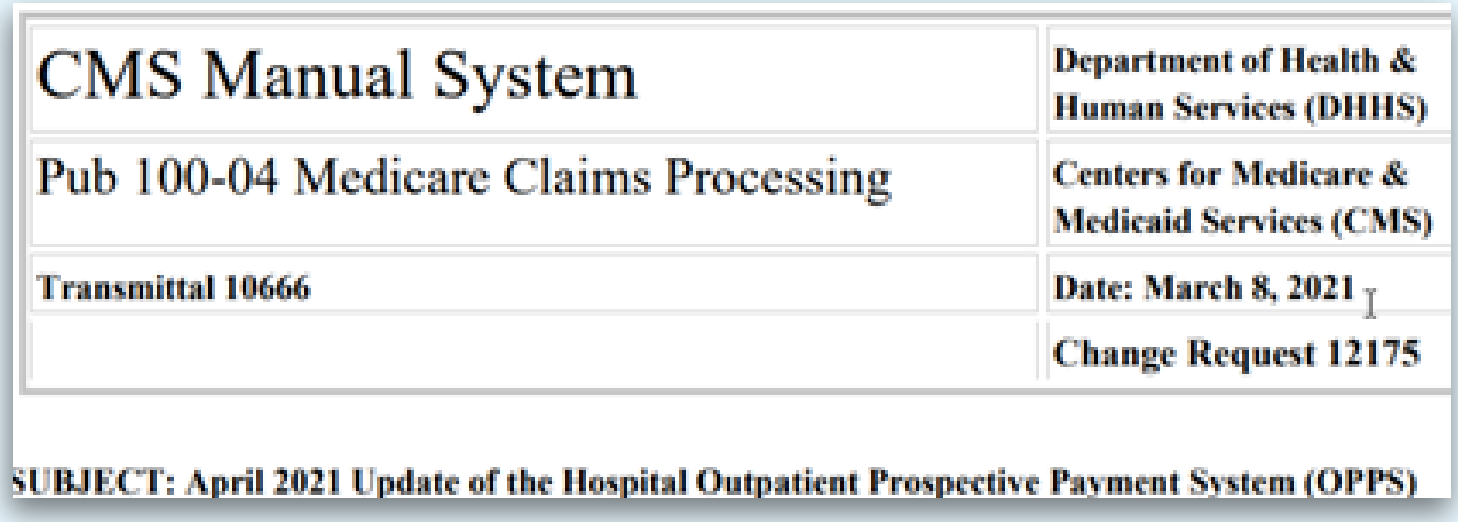
- **Restated ASP Methodology Payment Rates:** quarterly retroactive correction to some drugs and biological payment rates will be available on the first date of the quarter at the following CMS website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates

- **Coverage Determination:** CMS reminds us that HCPCS codes and payment rates demonstrate how services, products, or procedures may pay if covered by Medicare.To determine coverage, consult the local MAC for HCPCS code coverage limitations.

CMS References:

- Change Request (CR) 12175/ Medicare Claim Processing Transmittal 10666:https://www.cms.gov/files/document/r10666cp.pdf



CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10666	Date: March 8, 2021
	Change Request 12175

SUBJECT: April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Addendum A and Addendum B Updates:*

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

***Not available at time of this print (3/15/2021)**

MARCH MEDI-CAL UPDATE: NEW COVID VACCINE BENEFIT

Medi-Cal has announced that the new Janssen COVID-19 vaccine recently released by Johnson & Johnson will be a payable benefit effective for dates of service on or after February 27, 2021. This vaccine can only be administered to patients 18 years of age and older.

When billed appropriately, the vaccine will be reimbursed at $28.39 for a 0.5mL dose.

It is important to note that providers shouldnotreport CPT Code 91303(severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, DNA, spike protein, adenovirus type 26 [Ad26] vector, preservative free, 5x1010viral particles/0.5 mL dosage, for intramuscular use)for the Janssen vaccine; this CPT Code is not currently a Medi-Cal benefit and providers are reminded that at this time, only the administration of the vaccine is reimbursable, not the vaccine itself.

The billing guidelines listed below must be followed for claims to be reimbursed:
https://files.medi-cal.ca.gov/pubsdoco/Janssen_COVID19_Vaccine.aspx

Pharmacy Claims:

- Use NDC 59676058005
- Claim quantity dispensed must be submitted as 0.5mL per administered vaccine
- Use Submission Clarification Code (SCC) 2 (Other Override) to indicate that a COVID-19 vaccine is being administered and billed
    - Since the Janssen COVID-19 vaccine is a one-dose vaccine, providers do not need to submit SCC 6 (Starter Dose)

Electronic Submissions:

Electronic claims should also adhere to the updated Medi-CalNCPDP Payer Sheet. Notable NCPDP D.0 submission details providers should be aware of include:

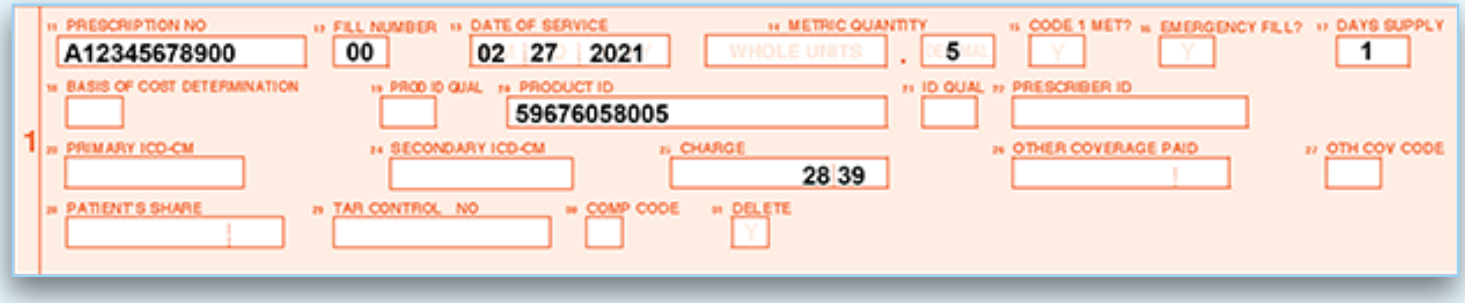
- Use of the value "MA" (Medication Administered) in the Professional Service Code (440-E5) field is not supported in Medi-Cal and submission of that code may result in a claim denial
- Use of the value "PH" (Preventive Health Care) in the Reason for Service Code (439-E4) field is not supportedin Medi-Cal and submission of that code may result in a claim denial
- Use of the value "3N" (Medication Administered) in the Result of Service Code (441-E6) field is not supported in Medi-Cal and submission of that code may result in a claim denial
- Use of the value "15" in the Basis of Cost Determination (423-DN) field is not supported in Medi-Cal and submission of that code may result in a claim denial. Providers are instructed to submit the value "01" instead.

- The Quantity Dispensed (field 442-E7) should be submitted with the value that represents the quantity of drug product administered.Submission Clarification Code (field 420-DK) should be submitted with a SCC code value of 2

MARCH MEDI-CAL UPDATE: NEW COVID VACCINE BENEFIT

The examples below are included for reference only. Providers should note that these are merely an example, and should adjust to their billing situation as would be appropriate.

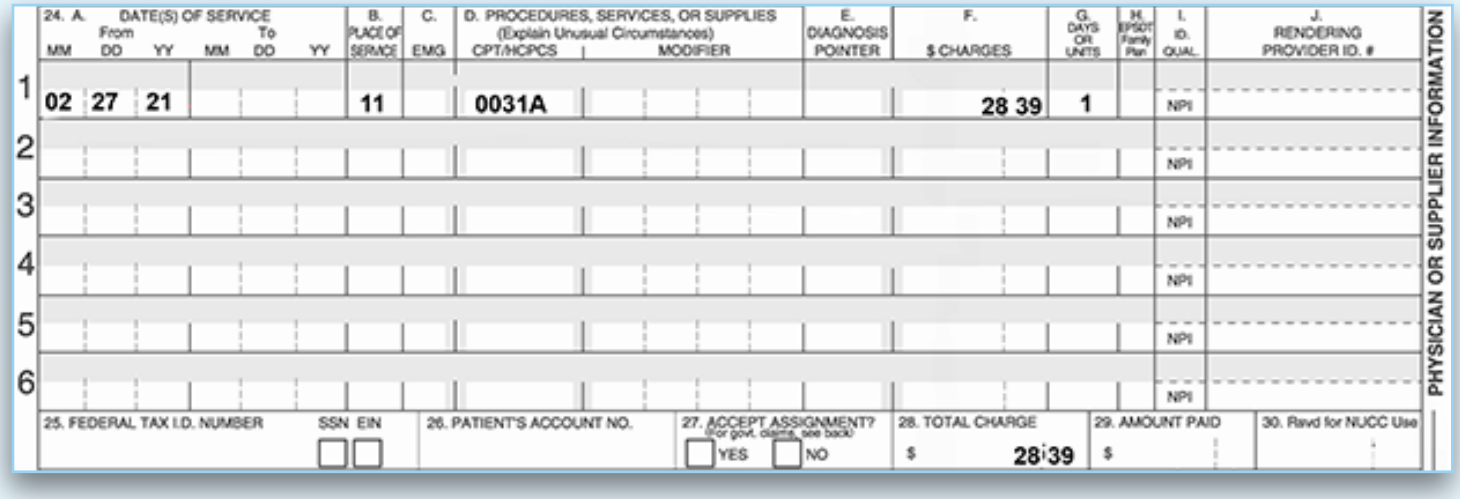
Hard Copy Submissions:



Medical and Outpatient Claims:

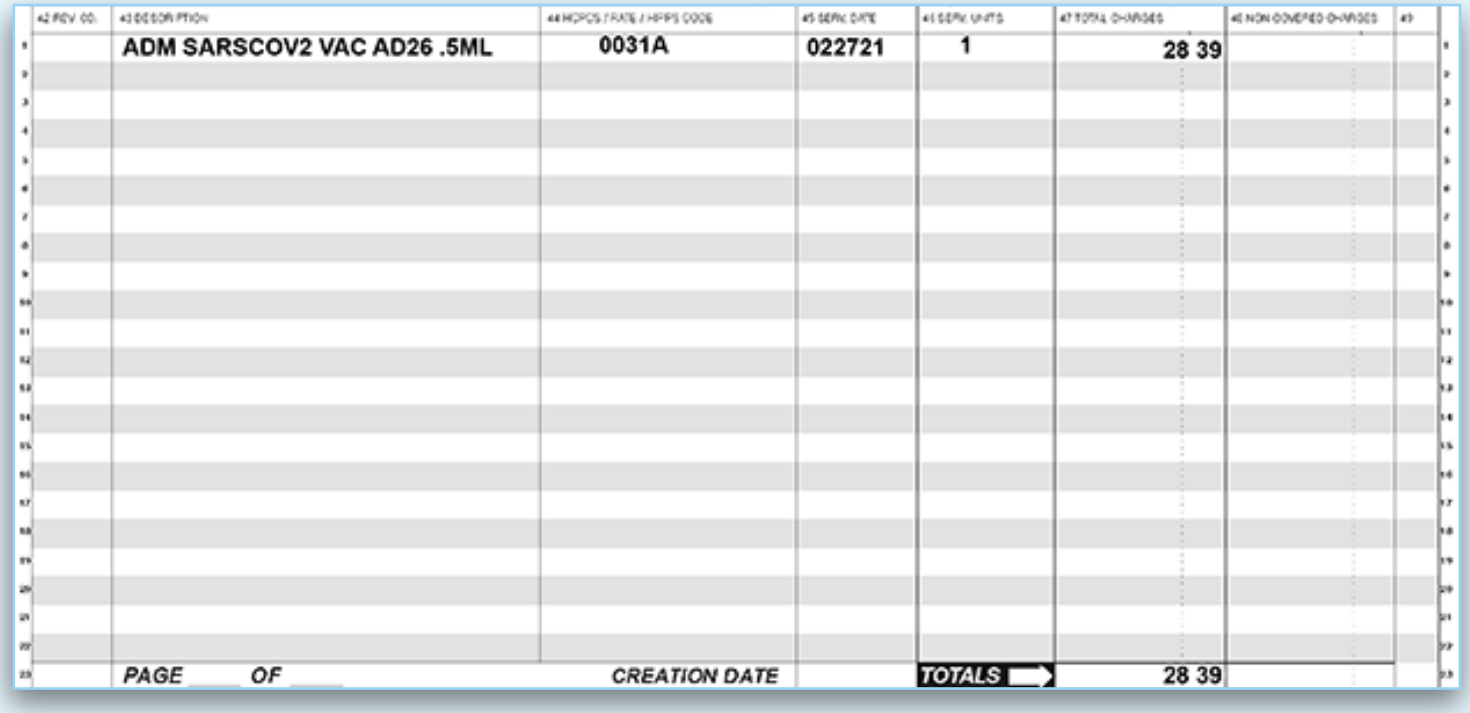
- Bill using Administration Code 0031A
- There are no special instructions for hard copy or electronic Medical or Outpatient submissions

1) Janssen vaccine administration on a CMS-1500



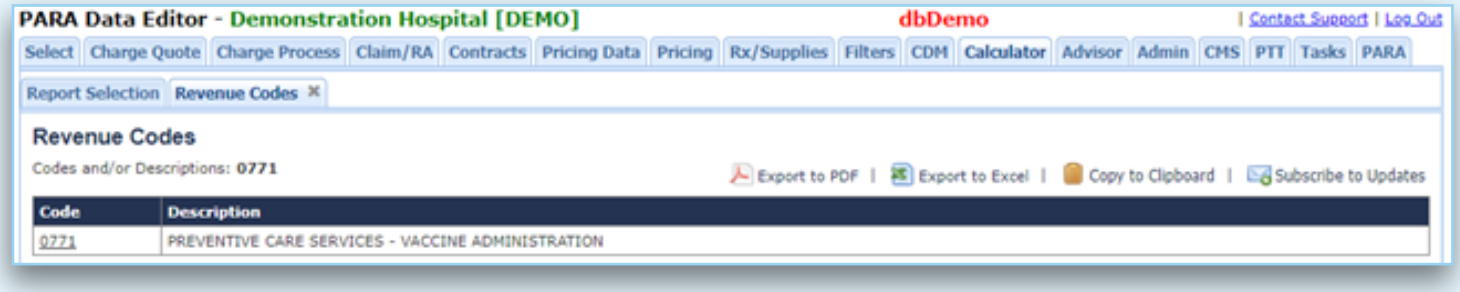
MARCH MEDI-CAL UPDATE: NEW COVID VACCINE BENEFIT

2) Janssen vaccine administration on a UB-04:

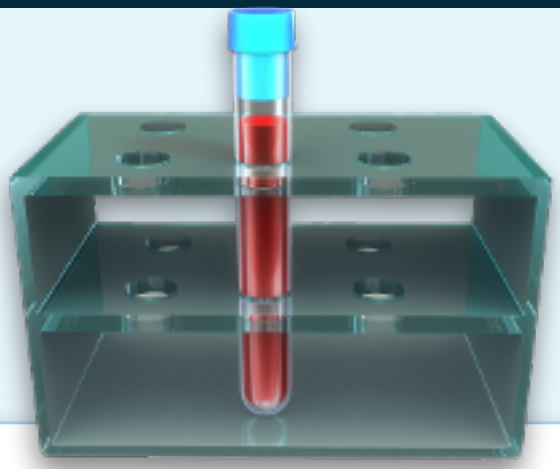


42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	ADM SARSCOV2 VAC AD26 .5ML	0031A	022721	1	28 39		
	PAGE ___ OF ___	CREATION DATE		TOTALS	28 39		

Medi-Cal has not made a revenue code recommendation at this time. However, Medicare is requiring 0771.



MEDI-CAL UPDATED BILLING POLICY FOR IMMUNE GLOBULINS



Superseding communication from the California Department of Health Services (DHCS), Medi-Cal has introduced new changes for billing and claims submission of various HCPCS and CPT® codes for Physician Administered Drugs (PAD).

Biologicals are billed with both HCPCS and CPT® codes. HCPCS codes often are more specific than CPT® codes. Providers are instructed to report the corresponding HCPCS code listed in the table below:

Procedure Codes	Procedure Descriptions	Code(s) to Bill with
90281	Immune globulin (Ig), human, for intramuscular use	J1460 or J1560
90283	Immune globulin (IgIV), human, for intravenous use	J1459, J1556, J1557, J1561, J1566, J1568, J1569, J1572 or J1599
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each	Bill J1555 (Cuvitru) & J1559 (Hizentra) Continue to bill 90284 for all other immune globulins used for subcutaneous infusions
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use	J0850
90384	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular	J2790 or J2791
90385	Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use	J2788
90386	Rho(D) immune globulin (RhIgIV), human, for intravenous use	J2791 or J2792
90389	Tetanus immune globulin (TIg), human, for intramuscular use	J1670

For Gammagard Liquid, Gammaked, Gammunex-C and Cutaquig, providers will report with CPT® code 90284.

For providers who previously rebilled with CPT® codes and had claims denied, Medi-Cal has instructed providers to rebill with the appropriate HCPCS codes. New Treatment Authorization Requests (TARS) are not necessary for the rebilling of claims. For claims that are outside of timely filing limitations, the restriction is waived, and providers may resubmit previously denied claims.

https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30510_02.aspx

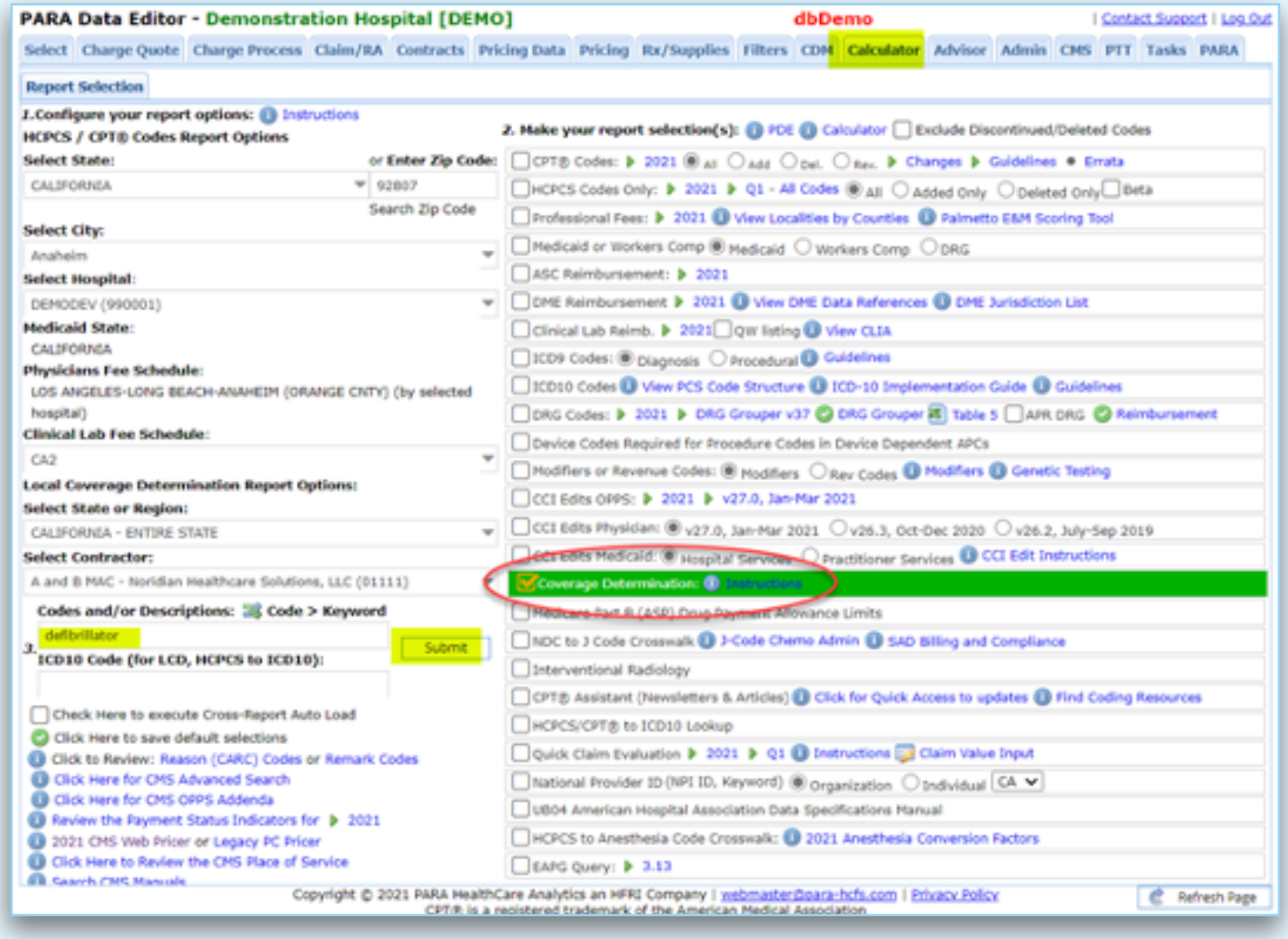
CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

Medicare's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) began as a fairly straightforward matching game.

A particular service must report one of the covered diagnoses to support medical necessity. The most common medical necessity requirements apply to lab tests--most major EHR systems offer a built-in medical necessity evaluator to determine if the referring physician provided a covered ICD10 diagnosis code and assist in generating an ABN if the diagnosis is insufficient.

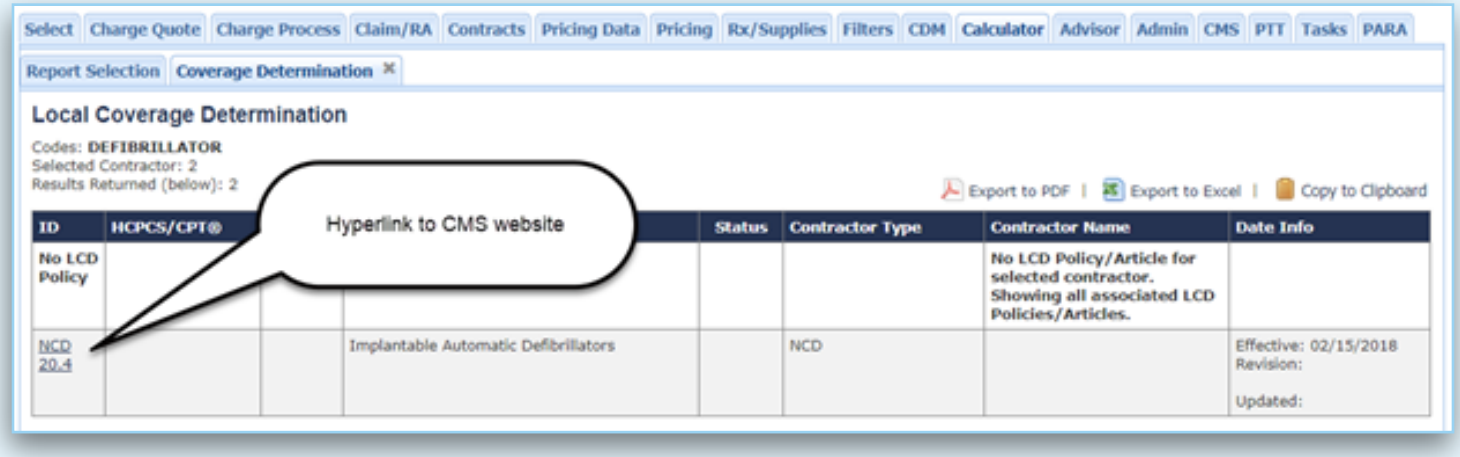
However, over the years, medical necessity requirements have become more complex, particularly for high-dollar procedures such as Implantable Cardiac Defibrillators and PET scans.

Many hospitals have no effective process to check more complex medical necessity requirements. **PARA recommends adopting processes that add documentation to support medical necessity to the hospital medical record prior to billing Medicare for services subject to an NCD or LCD.** This may be accomplished through documenting an attestation from the performing or ordering provider as a precondition of providing expensive surgical services.We provide a few examples on the last two pages of this paper. Medicare coverage information (NCDs and LCDs) is available on the **PARA Data Editor Calculator** feature – enter a HCPCS or a keyword into the "Codes and/or Descriptions" field, and select the report "Medicare Coverage" on the right, as illustrated:



CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

The resulting report will offer a hyperlink to the NCD or LCD or Local Coverage Article with details on the requirements to establish medical necessity (screenshot on the following page.)



Since October 2020, Medicare's Recovery Audit Contractors (RAC's) have been auditing whether hospital medical records support the medical necessity requirements for automatic implantable cardio defibrillators (AICD's.) Here's a link to Medicare's Approved Recovery Audit Contractor Issues List:

[0195-Implantable Automatic Defibrillator- Inpatient Procedure: Medical Necessity and Documentation Requirements | CMS]

Issue Name	0195-Implantable Automatic Defibrillator- Inpatient Procedure: Medical Necessity and Documentation Requirements
Date	2020-10-06
Review Type	Complex
Provider Type	Inpatient Hospital
MAC Jurisdiction	All A/B MACs

Description

The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.

CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

The requirements of NCD 20.4, which apply to most AICD patients, include evidence of the physician's *"formal shared decision making visit"* with the patient before undergoing an AICD procedure. In most cases, the hospital medical record will not contain information on a physician visit performed outside the hospital. The RACs have seized upon this weakness in documentation – and have identified an easy and rewarding target for high-dollar RAC recoveries.

Within a few minutes of receiving the hospital medical records for an AICD case, RAC auditors can determine whether the hospital's AICD procedure documentation includes evidence of the"formal shared decision making visit." Claims without the documentation are identified as non-covered, and the RAC promptly sends a recoupment request.The recoupment of an inpatient AICD case is generally between $30,000 and $80,000 – a big payday for light work at the expense of hapless hospitals which didn't comprehend the need to obtain evidence of the shared decision making visit for the hospital record.

While it may seem unfair to hold hospitals responsible for physician activities, the Medicare Program Integrity Manual explains that when an entity responds to an additional documentation request, the entity audited is responsible for submitting documentation that meets medical necessity requirements, even if that documentation exists in the records of another entity:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.2.3.3 - Third-party Additional Documentation Request

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

...

Unless otherwise specified, the MAC, RAC and UPIC shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, RAC and UPIC.

Hospitals should carefully evaluate whether complex medical necessity requirements have been met before performing expensive procedures, rather than finding out at a later date that payments will be recouped due to a RAC audit.

PARA advises hospitals to prepare brief physician attestations such as those found on the following pages and incorporate this documentation into the hospital medical record prior to performing services subjected to complex medical necessity standards.

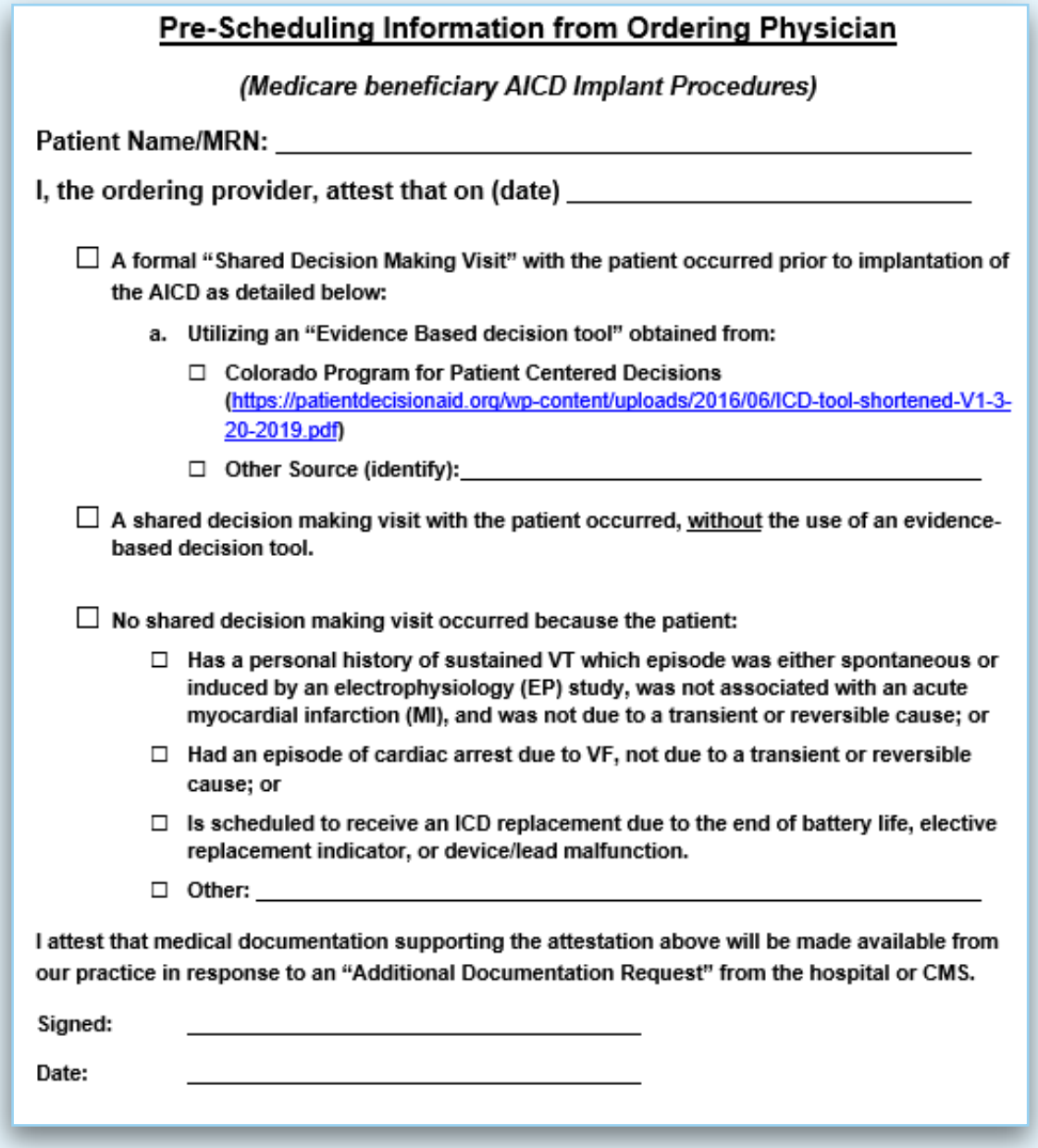
Please note that the attestations must offer both medically necessary rationale and the opportunity to report a non-qualifying rationale – hospitals should not "drive" physicians to select only the options that support medical necessity.

CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

However, suppose a physician's response indicates that a Medicare beneficiary service does not meet Medicare medical necessity standards. In that case, the hospital should decline to schedule or perform the procedure unless and until the patient has signed an Advance Beneficiary Notice indicating that the patient accepts full financial liability.

Additional information about Medicare's Advance Beneficiary Notice can be found at:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN



Pre-Scheduling Information from Ordering Physician

(Medicare beneficiary AICD Implant Procedures)

Patient Name/MRN: _____

I, the ordering provider, attest that on (date) _____

☐ **A formal "Shared Decision Making Visit" with the patient occurred prior to implantation of the AICD as detailed below:**

a. Utilizing an "Evidence Based decision tool" obtained from:

☐ **Colorado Program for Patient Centered Decisions (https://patientdecisionaid.org/wp-content/uploads/2016/06/ICD-tool-shortened-V1-3-20-2019.pdf)**

☐ **Other Source (identify):** _____

☐ **A shared decision making visit with the patient occurred, without the use of an evidence-based decision tool.**

☐ **No shared decision making visit occurred because the patient:**

☐ **Has a personal history of sustained VT which episode was either spontaneous or induced by an electrophysiology (EP) study, was not associated with an acute myocardial infarction (MI), and was not due to a transient or reversible cause; or**

☐ **Had an episode of cardiac arrest due to VF, not due to a transient or reversible cause; or**

☐ **Is scheduled to receive an ICD replacement due to the end of battery life, elective replacement indicator, or device/lead malfunction.**

☐ **Other:** _____

I attest that medical documentation supporting the attestation above will be made available from our practice in response to an "Additional Documentation Request" from the hospital or CMS.

Signed: _____

Date: _____

Physicians:Your attestation will add required documentation to the hospital medical record to ensure that Medicare's medical necessity requirements have been met.For more information, review the requirements at
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10865.pdf

CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

Supporting Information from Ordering Physician

(Required for Medicare beneficiary FDG PET imaging orders)

I, the ordering provider, attest that this order for an FDG PET study is reasonable and necessary for the following reasons (check all that apply.)

The study will:

- ☐ **Inform an initial treatment strategy**
- ☐ **Inform Subsequent treatment strategy**
- ☐ **Avoid an invasive diagnostic procedure that may be unnecessary**
- ☐ **Determine the optimal location to perform an invasive procedure that is necessary**
- ☐ **Guide clinical management of the patient depending on the staging of the cancer identified**
- ☐ **Identify the stage of cancer after a standard diagnostic workup been completed, but the stage of cancer remains in doubt**
- ☐ **Confirm the stage of cancer following a conventional imaging study which was deemed insufficient for clinical management of the patient**
- ☐ **Other (explain):** _____

_____

I attest that I have provided, and will provide upon request, medical documentation supporting the rationale provided above in support of this PET study order.

Signed: _____

Date: _____

Physicians: Your attestation will inform the hospital which modifier to report, and will serve to document the hospital medical record that Medicare's medical necessity requirements have been met.

The modifiers required by Medicare are:

PI - PET or PET/Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing.

PS - PET or PET/CT to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treatment physician determines that the PET study is needed to inform subsequent anti-tumor strategy.

RCM IN 2021: ROADMAP TO A STRONG FINANCIAL COMEBACK

Throughout 2020, the COVID-19 pandemic threw hospitals an array of unprecedented challenges, but 2021 is the ultimate opportunity for your organization to bounce back.

The changing environments, staffing shortages and new regulations weren't easy for any organization, but you can ensure the best possible financial outcomes in 2021 by:

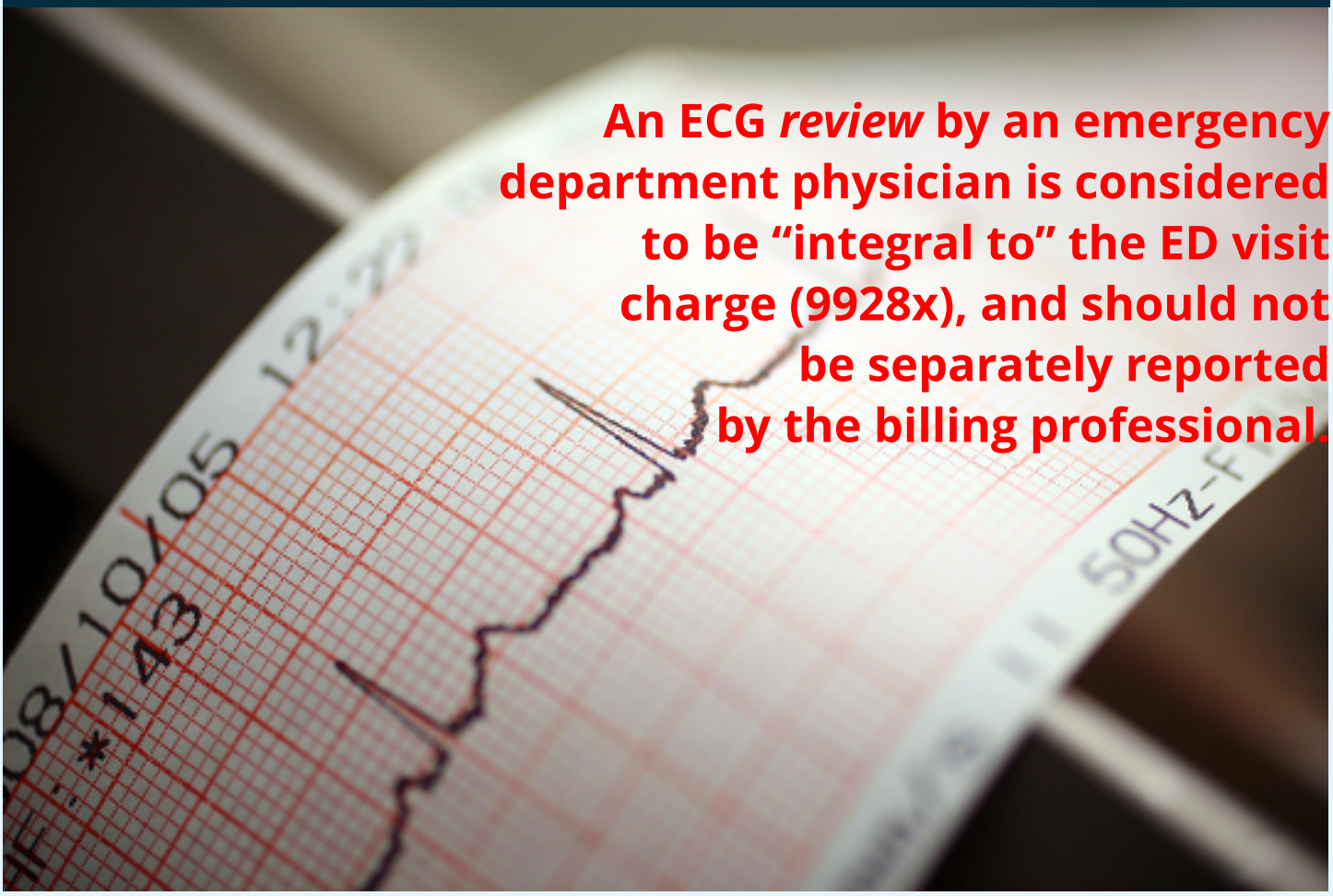
- Optimizing staff efficiency
- Staying on top of current inventory changes
- Identifying where and how to maximize revenue

How prepared is your organization to bounce back from the COVID-19 financial challenges?

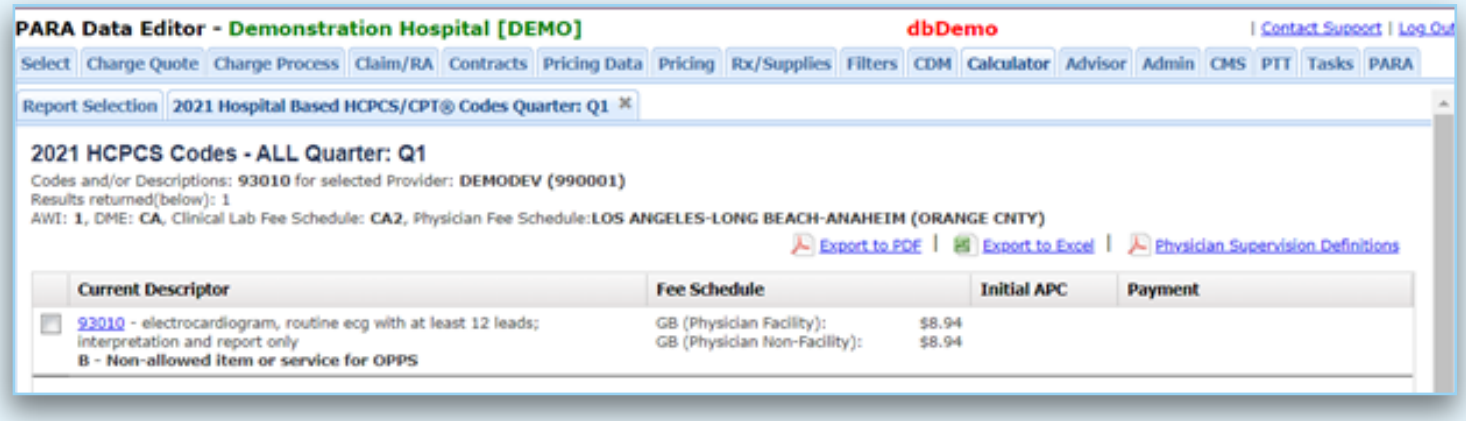
Download this recorded webinar and listen to Daniel Low, Director of Operations at Healthcare Financial Resources, detail how to implement an action plan that will help your organization improve its bottom line.

Click here: https://www.hfri.net/resources/download-our-webinar-rcm-in-2021-roadmap-to-a-strong-financial-comeback/

ECG INTERPRETATIONS IN THE EMERGENCY SETTING



On the other hand, an appropriately documented ECG interpretation, if completed, is reported as a professional fee with CPT® 93010 – unless the professional fee is subject to a facility medical staff policy which limits reporting ECG interpretations to only certain highly qualified members of the medical staff, which is a common practice.



ECG INTERPRETATIONS IN THE EMERGENCY SETTING

The documentation supporting the interpretation of an ECG must support a full evaluation.A review alone is not separately billable.For example, documentation for 93010 would be insufficient if it reported only"Normal sinus rhythm."Appropriate documentation of a complete interpretation should include:

- Rate
- Rhythm
- Axis
- P waves
- PR interval
- QRS complex
- QT interval
- ST-segment
- T waves
- Overall impression of the ECG (e.g. ST-elevation myocardial infarction)

Guidance on billing for ECG interpretations is available from:

- The Medicare Claims Processing Manual, Chapter 13 - Radiology Services and Other Diagnostic Procedures
- The American College of Emergency Physicians offers information on its website

Excerpts from both the Claims Manual and the ACEP website are provided on the following pages

Medicare Claims Processing Manual (cms.gov)

100.1 - X-rays and EKGs Furnished to Emergency Room Patients

(Rev. 1, 10-01-03)

The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital. (See 42 CFR 415.120(a).)

A/B MACs (B) generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service.

This is because the review is already included in the emergency department evaluation and management (E/M) payment. For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code.

An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).Generally, A/B MACs (B) must pay for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier "-77") only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.

ECG INTERPRETATIONS IN THE EMERGENCY SETTING

When A/B MACs (B) receive only one claim for an interpretation, they must presume that the one service billed was a service to the individual beneficiary rather than a quality control measure and pay the claim if it otherwise meets any applicable reasonable and necessary test.

ACEP // X-Ray - EKG FAQ

How do I document my ECG interpretation? Do I need a separate page for my interpretation?

Answer

Medicare does not require that the ECG interpretation be recorded on a separate piece of paper; rather a complete written interpretation can be recorded within the emergency department treatment record. However, some Medicare carriers have independently established more restrictive criteria.

An interpretation and report is different than a review. CPT® does not clearly state a documentation standard. CPT® does state that there must be a "separate, signed, written and retrievable report." Some ED Groups do this by creating an area within the chart for ECG interpretation.Medicare states that the report must be a complete written report similar to that usually prepared by a specialist in the field and should be consistent with the service furnished.

Medicare policy also states an "interpretation and report" should address the findings, relevant clinical issues, and comparative data when available. "ECG normal" is deemed an insufficient interpretation and report. Individual carriers may develop their own standards. You should review the local coverage determinations for your carrier on a regular basis.

DEVICE-INTENSIVE PROCEDURE BILLING -- BYPASS EDIT 92

Since breast biopsy procedures 19081, 19083, and 19085 were added to Medicare's "Device-Intensive" list of codes on 1/1/2021, numerous clients have inquired what HCPCS code should be used to report for the device when reporting these procedures.These procedures are new to Medicare's list of "Device-intensive" codes, which must be billed with a device code on the same claim – but not all cases actually result in the implantation of a tissue marker or a brachytherapy source.

PARA previously advised clients to report the following device codes, as appropriate to the case:

- If a brachytherapy source was implanted, report C2638
- If a tissue marker is implanted, report A4648
- If only a needle is used for localization, report C1889

2021 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **C2638,A4648,C1889** for selected Provider: **DEMODEV (990001)**
Results returned(below): 3
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**LOS ANGELES-LONG**

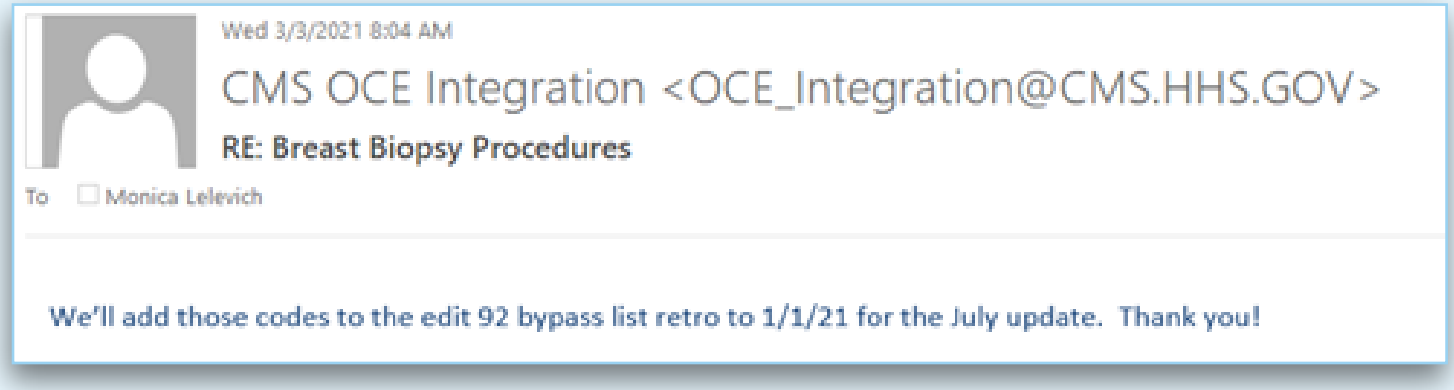
Current Descriptor	Fee Schedule
A4648 - tissue marker, implantable, any type, each **N - Items and Services packaged into APC rates** **Berenson-Eggers Type of Service:** I1E - STANDARD IMAGING - NUCLEAR MEDICINE	
C1889 - implantable/insertable device, not otherwise classified **N - Items and Services packaged into APC rates** **Berenson-Eggers Type of Service:** D1A - MEDICAL/SURGICAL SUPPLIES	
C2638 - brachytherapy source, stranded, iodine-125, per source **U - Brachytherapy sources** **Berenson-Eggers Type of Service:** I4B - IMAGING/PROCEDURE - OTHER	

We also suggested that modifier CG might be used to bypass the CMS edit that requires a device code; however, a sharp-eyed reader of the PARA Weekly pointed out that 19081-19083 are not among the HCPCS that are eligible for the CG modifier.Codes which are not on the "Edit 92 Bypass list" cannot resolve Edit 92 with modifier CG.

(We thank the reader for his prompt observation, permitting us to correct our advice in this article.)

DEVICE-INTENSIVE PROCEDURE BILLING -- BYPASS EDIT 92

We wrote to the Medicare Integrated Outpatient Code Editor team to suggest that CMS add the breast biopsy procedures to the "Edit 92 bypass" list of codes; they responded that they have agreed to do so, and will make that change retroactive to 1/1/2021, but not until the July 1, 2021 update.



Wed 3/3/2021 8:04 AM

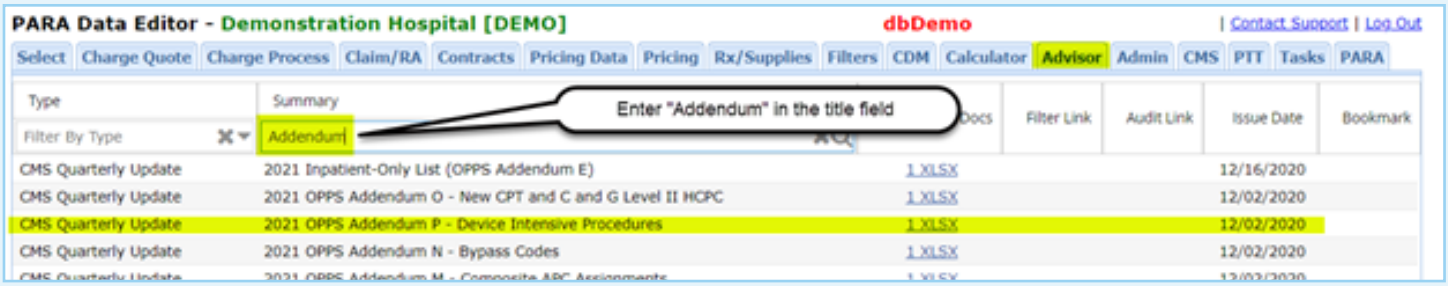
CMS OCE Integration <OCE_Integration@CMS.HHS.GOV>

RE: Breast Biopsy Procedures

To Monica Lelevich

We'll add those codes to the edit 92 bypass list retro to 1/1/21 for the July update. Thank you!

Medicare identifies the list of "device-intensive" HCPCS in the annual OPPS addendum P.



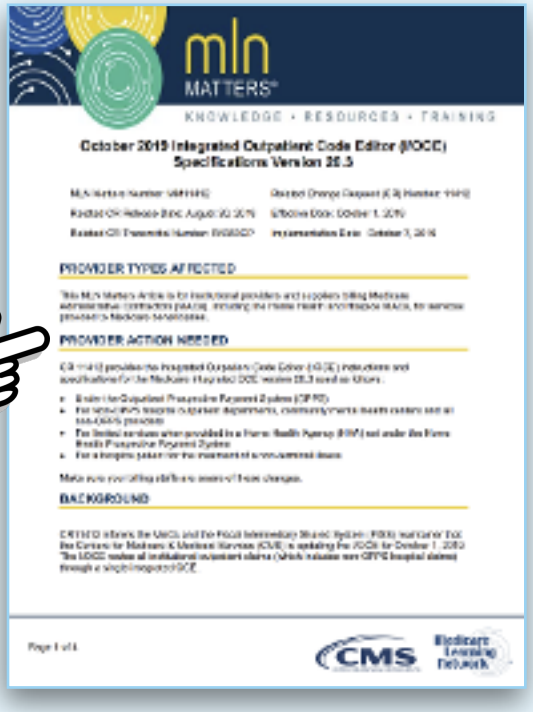
However, the "Edit 92 Bypass" indicator is maintained in a completely separate location, well out of view for all but the most determined researchers– under column DC of the "Data_HCPCS" file published under the Integrated Outpatient Code Editor quarterly release files.A zero ("0") in column DC indicates that the device-intensive procedure is not eligible for modifier CG to resolve the edit:

https://www.cms.gov/apps/aha/license.asp?file=/files/zip/iocev220r0quarterlydatafiles.zip

	A	D	E	DC
1	HCPCS	DESCRIPTION	APC	BYPASS_E92_MODIFIER
3073	19081	Bx breast 1st lesion	00005	0
3074	19081	Bx breast 1st lesion	05073	0
3075	19081	Bx breast 1st lesion	05072	0
3076	19082	Bx breast add lesion	00000	0
3077	19082	Bx breast add lesion	00000	0
3078	19083	Bx breast 1st lesion	00005	0
3079	19083	Bx breast 1st lesion	05073	0
3080	19083	Bx breast 1st lesion	05072	0

DEVICE-INTENSIVE PROCEDURE BILLING -- BYPASS EDIT 92

The list of the "Bypass Edit 92" -eligible codes as published in the January 2021 IOCE quarterly update file is provided at the end of this paper.


mln MATTERS
KNOWLEDGE • RESOURCES • TRAINING
October 2019 Integrated Outpatient Code Editor (IOCE) Specifications Version 26.3
PROVIDER TYPES AFFECTED
PROVIDER ACTION NEEDED
BACKGROUND
CMS

The "Bypass Edit 92" list was developed to permit hospitals to report a "device-intensive" procedure when the procedure description does not necessarily require a device.For example, 64595 - REVISION OR REMOVAL OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER.If the device was simply removed, the hospital would not report it as a cost on the claim.Consequently, CMS announced in October 2019 that modifier CG would permit the hospital to bypass the Outpatient Claims Editor edit 92 – but only for some of the device-intensive procedures:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11412.pdf

"Implement logic to bypass edit 92 when a device procedure is reported with modifier CG. The edit is bypassed only if the device procedure reported with modifier CG is on the "Edit 92 Modifier Bypass" list."

However, if a procedure is not listed as permitting an "Edit 92 Bypass", the hospital must report a device HCPCS – the CG modifier will not prevent a claim rejection.Device-intensive HCPCS represents codes for which at least 31% of OPPS reimbursement has been calculated to be attributed to a device.The purpose of this identification is to ensure that claims for these procedures accurately represent the cost of the device – if the device were obtained at no cost (due to a manufacturer recall or warranty, for example), hospitals are required to report the value of the free device with value code FC, and Medicare will reduce APC reimbursement according to the percentage calculated by each HCPCS.If the hospital failed to report the device, CMS would be unable to determine whether the device was provided to the hospital without cost.

The 2021 OPPS Final Rule explains that HCPCS C1889 is available for procedures which may not use an implant, but consume a device not assigned a device HCPCS.Here are pertinent excerpts:

https://www.govinfo.gov/content/pkg/FR-2020-08-12/pdf/2020-17086.pdf (page 48865)

> "For CY 2017 and subsequent years, we also specified that any device code, when reported on a claim with a device-intensive procedure, will satisfy the edit. In addition, we created HCPCS code C1889 to recognize devices furnished during a device-intensive procedure that are not described by a specific Level II HCPCS Category C-code.
>
> Reporting HCPCS code C1889 with a device-intensive procedure will satisfy the edit requiring a device code to be reported on a claim with a device-intensive procedure. In the CY 2019 OPPS/ASC final rule with comment period, we revised the description of HCPCS code C1889 to remove the specific applicability to device-intensive procedures (83 FR 58950). For CY 2019 and subsequent years, the description of HCPCS code C1889 is "Implantable/insertable device, not otherwise classified".

DEVICE-INTENSIVE PROCEDURE BILLING -- BYPASS EDIT 92

"In addition, we created HCPCS code C1889 to recognize devices furnished during a device-intensive procedure that are not described by a specific Level II HCPCS Category C-code. Reporting HCPCS code C1889 with a device-intensive procedure will satisfy the edit requiring a device code to be reported on a claim with a device-intensive procedure.

In the CY 2019 OPPS/ASC final rule with comment period, we revised the description of HCPCS code C1889 to remove the specific applicability to device-intensive procedures (83 FR 58950). For CY 2019 and subsequent years, the description of HCPCS code C1889 is "Implantable/insertable device, not otherwise classified".The current list of device-dependent HCPCS which are eligible to be reported to Medicare without a device code if modifier CG is appended appears on the following pages.In July of 2021, we expect the breast biopsy procedures to be added to this list."

Device-intensive procedures which allow an Edit 92 bypass (modifier CG-eligible)

HCPCS	DESCRIPTION
0200T	Perq sacral augmt unilat inj
23473	Revis reconst shoulder joint
23515	Treat clavicle fracture
23615	Treat humerus fracture
23616	Treat humerus fracture
23630	Treat humerus fracture
23680	Treat dislocation/fracture
24370	Revise reconst elbow joint
24371	Revise reconst elbow joint
24545	Treat humerus fracture
24546	Treat humerus fracture
24575	Treat humerus fracture
24579	Treat humerus fracture
24635	Treat elbow fracture
24666	Treat radius fracture
24685	Treat ulnar fracture
25515	Treat fracture of radius
25525	Treat fracture of radius
25526	Treat fracture of radius
25545	Treat fracture of ulna
25574	Treat fracture radius & ulna
25575	Treat fracture radius/ulna
27696	Repair of ankle ligaments
27792	Treatment of ankle fracture
27814	Treatment of ankle fracture
27822	Treatment of ankle fracture
27823	Treatment of ankle fracture
27826	Treat lower leg fracture
27827	Treat lower leg fracture
27828	Treat lower leg fracture
27832	Treat lower leg dislocation

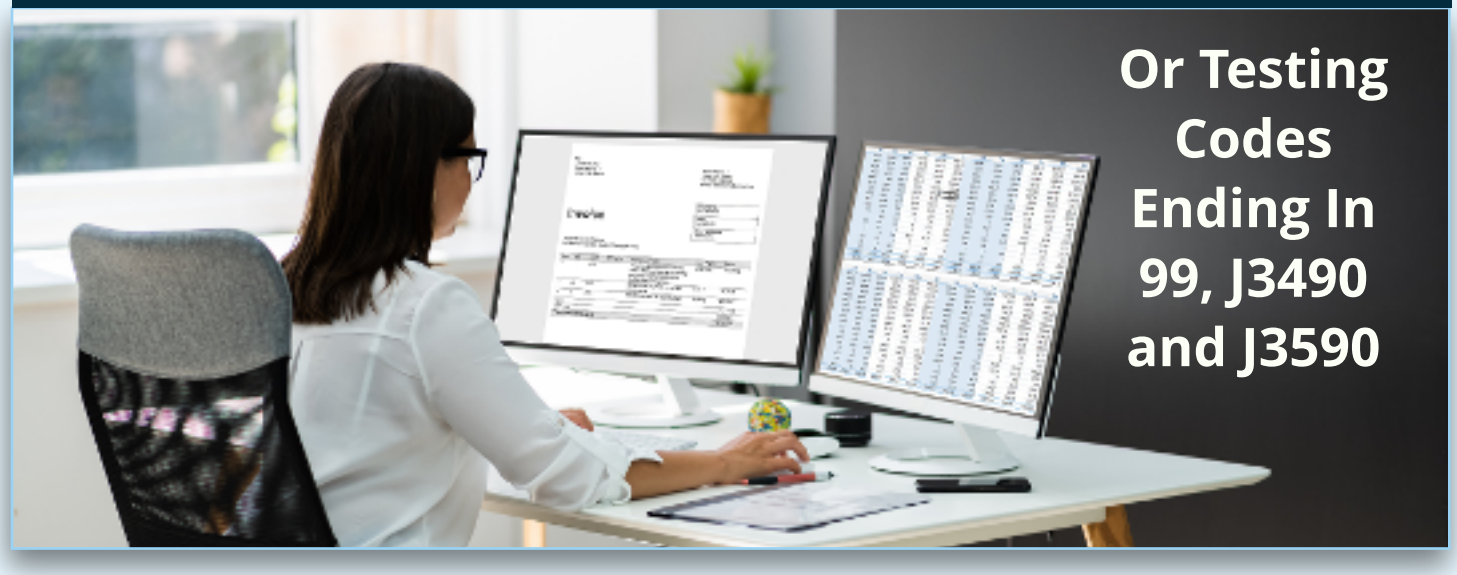
DEVICE-INTENSIVE PROCEDURE BILLING -- BYPASS EDIT 92

Device-intensive procedures which allow an Edit 92 bypass (modifier CG-eligible), continued.

HCPCS	DESCRIPTION
28300	Incision of heel bone
28415	Treat heel fracture
28420	Treat/graft heel fracture
28445	Treat ankle fracture
28465	Treat midfoot fracture each
28485	Treat metatarsal fracture
28555	Repair foot dislocation
28585	Repair foot dislocation
28615	Repair foot dislocation
29855	Tibial arthroscopy/surgery
29856	Tibial arthroscopy/surgery
33220	Repair lead pace-defib dual
33226	Reposition l ventric lead
33233	Removal of pm generator
33235	Removal pacemaker electrode
36261	Revision of infusion pump
36904	Thrmbc/nfs dialysis circuit
37192	Redo endovas vena cava filtr
37244	Vasc embolize/occlude bleed
43773	Lap replace gastr adj device
45327	Proctosigmoidoscopy w/stent
57288	Repair bladder defect
59072	Umbilical cord occlud w/us
61888	Revise/remove neuroreceiver
61888	Revise/remove neuroreceiver
62350	Implant spinal canal cath
63663	Revise spine eltrd perq aray
63664	Revise spine eltrd plate
64448	Njx aa&/strd fem nerve nfs
64569	Revise/repl vagus n eltrd
64569	Revise/repl vagus n eltrd

HCPCS	DESCRIPTION
64595	Revise/rmv pn/gastr stimul
64910	Nerve repair w/allograft
64912	Nrv rpr w/nrv algrft 1st
65779	Cover eye w/membrane suture

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS



All medical billers and AR follow-up teams have experienced billing or claim denials because there is a "miscellaneous" HCPCS on a claim. The reason is because miscellaneous codes do not provide adequate information for the item being billed.

Unlike established HCPCS for standard procedures and testing, most payers will manually calculate the reimbursement for the claim line reporting the miscellaneous item or testing. To do this process, however, the provider is expected to supply the additional information on the claim upon submission.

The type of information required however, varies on the type of miscellaneous service or item that is being reported on the claim. For example:

- If the service is a surgery, an operative report will be required to be submitted with the claim submission. This allows the payer to review the procedure and adjudicate the claim correctly
- If the service is a diagnostic test, clinical notes should be included. The clinical notes should clearly and precisely describe the patient's diagnosis, the full name of the test performed and the results of the test
- If the item is a DME item, the name of the item, a full description of the item, the name of the manufacturer, the product code/number and a copy of the invoice should be included with the claim submission
- If the miscellaneous item is a drug, the claim should contain the full name of the drug, the manufacturer, strength and dosage, NDC code for the drug and route of administration. This would apply to anesthesia agents
- **Special note for 80299: The name of the drug being tested must be indicated in Box 19 of the CMS 1500 claim form (remarks field) or in Box 80 of the UB04 claim

In the tables on the follow pages of this article, are examples of various procedures and items for which this article is applicable.

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Anesthesia	
Code	**Description**
01999	Unlisted anesthesia procedure(s)
Surgery	
15999	Unlisted procedure, excision pressure ulcer
17999	Skin, mucous membrane and subcutaneous tissue
19499	Breast
20999	Musculoskeletal system, general
21089	Unlisted maxillofacial prosthetic procedure
21299	Unlisted craniofacial and maxillofacial procedure
21499	Unlisted musculoskeletal procedure, head
21899	Unlisted procedure, neck or thorax
22899	Spine
22999	Abdomen, musculoskeletal system
23929	Shoulder
24999	Humerus or Elbow
25999	Forearm or Wrist
26989	Hands or Fingers
27299	Pelvis or Hip Joint
27599	Femur or Knee
27899	Leg or Ankle
28899	Foot or Toes
29799	Casting or Strapping
29999	Arthroscopy
30999	Nose
31299	Accessory Sinuses
31599	Larynx
31899	Trachea, Bronchi
32999	Cardiac Surgery
36299	Vascular Injection

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Surgery, continued	
Code	**Description**
37501	Unlisted vascular endoscopy procedure
37799	Unlisted procedure, vascular surgery
38129	Unlisted laparoscopy procedure, spleen
38589	Lymphatic System
38999	Unlisted procedure, hemic or lymphatic system
39499	Mediastinum
39599	Diaphragm
40799	Lips
40899	Vestibule of Mouth
41599	Tongue, floor of mouth
41899	Dentoalveolar structures
42299	Palate, uvula
42699	Salivary glands or ducts
43289	Unlisted Laparoscopy procedure, esophagus
43499	Unlisted procedure, esophagus
43659	Unlisted Laparoscopy procedure, stomach
43999	Unlisted procedure, stomach
44238	Unlisted Laparoscopy procedure, intestine, except rectum
44799	Unlisted procedure, intestine
44899	Merckel's diverticulum and the mesentery
44979	Unlisted laparoscopy procedure, appendix
45499	rectum
45999	Unlisted procedure, rectum
46999	anus
47379	Unlisted laparoscopy procedure, liver
47399	Unlisted procedure, liver
47579	Unlisted laparoscopy procedure, biliary tract
47999	Unlisted procedure, biliary tract
48999	Pancreas
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
49659	Hernioplasty, herniorrhaphy, herniotomy
49999	Unlisted procedure, abdomen, peritoneum and omentum
50549	Unlisted laparoscopy procedure, renal
50949	ureter
51999	bladder
53899	Urinary system
54699	testis
55559	Spermatic cord
55899	Unlisted procedure, male genital system
58578	Unlisted Laparoscopy procedure, uterus

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Surgery, Continued	
Code	**Description**
58579	Unlisted hysteroscopy procedure, uterus
58679	Unlisted Laparoscopy Procedure, oviduct, ovary
58999	Unlisted procedure, female genital system (non-obstetrical)
59897	Unlisted fetal invasive procedure, including ultrasound guidance
59898	Unlisted laparoscopy procedure, maternity care and delivery
59899	Unlisted procedure, maternity care and delivery
60659	Unlisted laparoscopy procedure, endocrine system
60699	Unlisted procedure, endocrine system
64999	Nervous system
66999	Anterior segment of eye
67299	Posterior segment
67399	Ocular muscle
67599	Orbit
67999	Eyelids
68399	Conjunctiva
68899	Lacrimal system
69399	External ear
69799	Middle ear
69949	Inner ear
69979	Temporal bone, middle fossa approach
Radiology	
76496	Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)
76497	Unlisted computed tomography procedure (e.g., diagnostic, interventional)
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
76499	Unlisted diagnostic radiographic procedure
76999	Unlisted ultrasound procedure (e.g., diagnostic, interventional)
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77399	Medical radiation physics, dosimetry and treatment devices, and special services
77499	Therapeutic radiology treatment management
77799	Clinical brachytherapy
78099	Unlisted endocrine procedure, diagnostic nuclear medicine
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
78599	Unlisted respiratory procedure, diagnostic nuclear medicine
78699	Unlisted nervous system procedure, diagnostic nuclear medicine
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine
79999	Radiopharmaceutical therapy, unlisted procedure

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Pathology – Laboratory	
Code	**Description**
80299	Quantitation of drug, not elsewhere classified
81099	Unlisted urinalysis procedure
84999	Unlisted chemistry procedure
85999	Unlisted hematology and coagulation procedure
86849	Unlisted immunology procedure
86999	Unlisted transfusion medicine procedure
87999	Unlisted microbiology procedure
88099	Unlisted necropsy (autopsy) procedure
88199	Unlisted cytopathology procedure
88299	Unlisted cytogenetic study
88399	Unlisted surgical pathology procedure
89240	Unlisted miscellaneous pathology test
89398	Unlisted reproductive medicine laboratory procedure
Medicine	
Code	**Description**
90399	Unlisted immune globulin
90749	Unlisted vaccine/toxoid
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion
90899	Unlisted psychiatric service or procedure
90999	Unlisted dialysis procedure, inpatient or outpatient
91299	Unlisted diagnostic gastroenterology procedure
92499	Unlisted ophthalmological service or procedure
92700	Unlisted otorhinolaryngological service or procedure
93799	Unlisted cardiovascular service or procedure
94799	Unlisted pulmonary service or procedure
95199	Unlisted allergy/clinical immunologic service or procedure
95999	Unlisted neurological or neuromuscular service or procedure
96549	Unlisted chemotherapy service or procedure
96999	Unlisted special dermatological service or procedure
97039	Unlisted modality service or procedure (specify type and time if constant attendance)
97139	Unlisted therapeutic service or procedure (specify)
97799	Unlisted physical medicine/rehabilitation service or procedure
99199	Unlisted special service, procedure, or report
99600	Unlisted home visit service or procedure
Evaluation and Management	
Code	**Description**
99429	Unlisted preventive medicine service
99499	Unlisted evaluations and management service

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Miscellaneous A Codes	
Code	**Description**
A4335	Incontinence supply, miscellaneous
A4421	Ostomy supply, miscellaneous
A4913	Miscellaneous dialysis supplies, NOS
A9698	Non-radioactive contrast imaging material, not otherwise classified, per study
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
A9999	Miscellaneous DME supply or accessory, not otherwise specified
Miscellaneous E Codes	
Code	**Description**
E1399	Durable Medical Equipment, miscellaneous
Miscellaneous G Codes	
Code	**Description**
G0235	PET Imaging, any site NOS
Miscellaneous J Codes	
Code	**Description**
J3490	Unclassified drugs
J3590	Unclassified biologics
J7599	Immunosuppressive drug, NOC
J7699	NOC drugs, inhalation solutions, administered through DME
J7799	NOC drugs, other than inhalation drugs, administered through DME
J8498	Antiemetic drug, rectal suppository, NEC
J8499	Prescription drug, oral, non-chemotherapeutic, NOS
J8597	Antiemetic drug, oral, NOS
J8999	Prescription drug, oral, chemotherapeutic, NOS
J9999	NOC, antineoplastic drug
Miscellaneous L Codes	
Code	**Description**
L8499	Unlisted procedure for miscellaneous prosthetic services
L8699	Unlisted procedure for miscellaneous implant services
Miscellaneous Q Codes	
Code	**Description**
Q4050	Cast supplies for unlisted types and material of casts
Q4051	Splint supplies, misc. (includes thermoplastics, strapping, fasteners, padding and other supplies
Q4082	Drug or biological NEC, Part B drug competitive acquisition program

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Miscellaneous S Codes	
Code	**Description**
S8189	Tracheostomy supply NOS
S3870	Comparative Genomic Hybrization (CGH)
Miscellaneous V Codes	
Code	**Description**
V2199	Not otherwise classified – single vision lens
V2797	Vision supply, accessory or component of another HCPCS vision code
V2799	Vision service, miscellaneous
V5299	Hearing service, miscellaneous

COVID-19 UPDATE

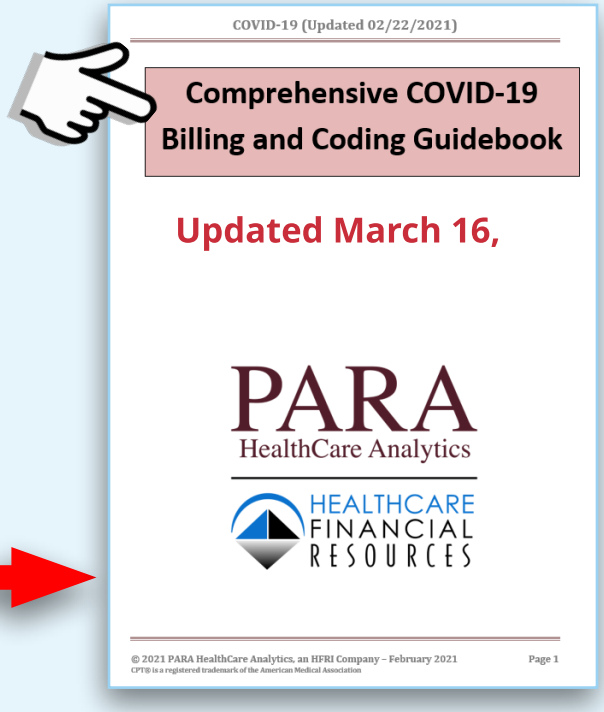
PARA HealthCare Analytics *continues to update COVID-19 coding and billing information based on frequently changing guidelines and regulations from CMS and payers. All coding must be supported by medical documentation.*

What you will find in this important update:

- New link to the CDC ICD-10 tool
- Updated information on Remdesivir, the FDA-approved COVID-19 treatment for most adults
- New MAC payment link and table for pricing of COVID-19 lab tests
- Updated language for RHCs and FQHCs regarding billing of MABs and vaccines
- Easier to read sections for Condition Codes and Modifiers
- New information on the CR/DR

https://apps.para-hcfs.com/para/Documents/COVID-19%20(Updated%2003-16-2021).pdf

Download the updated Comprehensive COVID-19 Billing and Coding Guidebook by clicking the link above or the document to the right.



PAMA LAB TEST PRIVATE PAYOR RATE REPORTING

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THE COMPLIANCE GUIDE

PARA
HealthCare Analytics

HEALTHCARE
FINANCIAL
RESOURCES

2021

There is still time to achieve readiness for the critical Price Transparency Rule.

PARA can help.

THE CLOCK IS TICKING

DATES, RULES & REGS

The CMS final rule (CMS-1717-F2) aims to make hospital price information readily available to patients, so they can compare costs and make more informed healthcare decisions. Meeting the deadline and maintaining compliance will be no small endeavor for providers. Complying with the mandate will be a large undertaking that requires multi-disciplinary coordination. ***PARA HealthCare Analytics and HFRI can help navigate the dates, the rules and the regulations****.*

REQUIREMENT #1

By January 1, 2021, hospitals are required to be in compliance with the Hospital Price Transparency requirements set forth in the CY 2020 Hospital Outpatient PPS Policy Changes (CMS-1717-FS).

REQUIREMENT #2

A comprehensive machine-readable file that includes the specific standard charges for all hospital items and services.

REQUIREMENT #3

A consumer-friendly display that includes the standard charges for at least 300 "shoppable" services that are grouped with charges for ancillary services that ar customarily provided by the hospital.

SOLUTIONS FOR HOSPITALS

THE PARA PTT

In speaking with hospital associations, clients, and business vendor groups, we are finding that we are one of the only vendors who can completely satisfy, to the letter of the law, both CMS requirements in a fully customizable manner.

Providers will need to publish both machine-readable format files and the patient facing price estimator is a value-add service for enhancing price transparency.

PARA will use the CMS Extract file embedded in the Price Transparency Tool tab via the **PARA Data Editor** to build the shoppable items/bundles. This can be done by the hospital, coupled with **PARA's** guidance to ensure all primary procedures are linked to its customarily paired ancillary services.

Turnaround time for the **Price Transparency Tool** is 60 days from submission of completed data.

There is no limit at this time on how many clients **PARA** can assist with the CMS' 2021 price transparency requirements as we are constantly monitoring workload and innovating our automation to support the data mining need for this initiative.

FROM <THIS, TO THIS>

TAKING CONSUMERS FROM THE STONE AGE TO THE DIGITAL AGE

MEET THE TEAM

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CAPABILITIES AND SERVICES

To ensure consumers will be able to browse for healthcare services in the same way they shop for other goods and services online, hospitals partner with **PARA HealthCare Analytics**, an HFRI company that has been providing hospitals and health systems with pricing, reimbursement, coding, and contract management services since 1985.

PARA works closely with clients to deploy robust and accurate pricing capabilities for area healthcare consumers. The **PARA** solution includes a patient-facing estimator engineered to deliver user-friendly, procedure-level estimates reflecting patients' specific coverage limits.

Providing consumers with the ability to effectively shop for healthcare services is essential as more employers transition to high-deductible health plans.

Peter Ripper, CEO of **PARA HealthCare Analytics**, has led his team to design a solution that will provide meaningful, easy-to-understand information for healthcare consumers.

With the healthcare providers facing a range of new financial pressures due to the COVID-19 pandemic, **PARA** has pushed to ensure that the critical but complex transparency rule can be implemented in a timely, cost-effective and consumer-friendly manner. We look forward to helping other systems who may be struggling to achieve price transparency.

WATCH YOUR HOSPITAL'S BRIGHT FUTURE UNFOLD

With The Help Of Our Price Transparency Tool

PRESS HERE

DEMO

REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

NOTE: This update removes advice regarding modifiers FB and FC, which are not required on outpatient claims for no-cost or reduced-cost implantable devices effective January 1, 2014.

The Health and Human Services Office of the Inspector General (OIG) released a new audit report in November of 2020 advising Medicare to recoup payments from hospitals that improperly claimed reimbursement for medical devices supplied at a reduced cost for specific patients.Both inpatient (IPPS) and outpatient (OPPS) claims with billing deficiencies related to credited medical devices were found.

Hospitals Did Not Comply With Medicare Requirements for Reporting Cardiac Device Credits A-01-18-00502 11-16-2020 (hhs.gov)

Hospitals Did Not Comply With Medicare Requirements for Reporting Cardiac Device Credits

11-16-2020 | A-01-18-00502 | Complete Report | Report in Brief

Why OIG Did This Audit

Prior OIG audits with audit periods ranging from 2005 through 2016 found that hospitals did not always comply with Medicare requirements for reporting credits received from manufacturers for medical devices that were replaced. Specifically, hospitals did not always report to CMS device manufacturer credits that they received. One prior review estimated that services related to the replacement of seven recalled and prematurely failed cardiac medical devices cost Medicare $1.5 billion during calendar years 2005 through 2014.

How OIG Did This Audit

We obtained a list of warranty credits from the device manufacturers and matched the device recipients to the Medicare enrollment database to determine which recipients were Medicare beneficiaries. Next, we matched the beneficiaries to the Medicare National Claims History to identify claims that had a cardiac device replacement procedure for which the date of service matched to the device replacement procedure date on the credit listing. We evaluated compliance with selected billing requirements.

When an implanted device is eligible for a free or discounted replacement due to a manufacturer’s defect or risk management policy, hospitals are required to report the discounts on their claims for the device's implantation. Under both Medicare reimbursement systems (Outpatient Prospective Payment System (OPPS) and Inpatient Prospective Payment System (IPPS)), facility reimbursement rates are calculated to compensate the hospital for both the cost of the surgical procedure and the cost of the device itself.

REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

Hospitals must identify cost savings due to free or discounted devices on the facility claim by reporting a modifier, a condition code, and a value code.This information is in turn used by Medicare to adjust its payment to the facility.If the hospital fails to report the discounted cost on its claim, the hospital can be overpaid by Medicare – and will be obligated to return the over payment as soon as the problem comes to light.

The special billing requirements apply if:

- the device is replaced without cost to the provider or the beneficiary
- the provider receives full credit for the cost of a replaced device, or
- the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45(a))

Outpatient Billing Instructions – In summary, the outpatient billing instructions require reporting the credits using three points of information on the claim:A nominal charge on the device HCPCS, a value code, and a condition code.

Nominal Charge: If the device was furnished to the hospital without cost, report the HCPCS for the device with a charge of $0.00 if the billing system permits; otherwise, report only a nominal charge of up to $1.00.(This serves to allow the claim to pass required device code edits).If the device was furnished not free, but at a reduced cost, the hospital may report a charge in keeping with its usual markup.(The adjustment to Medicare's APC payment is made based on the amount reported with the value code, not the billed charge.)If a hospital receives a credit for a replacement medical device, the charges to Medicare should also be appropriately reduced.

Value code FD: Value code FD must be reported with the amount of the devicecredit(not the reduced device cost, but the value of the credit) in the amount portion for value code:

- FD "Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)"

A condition code: hospitals report one of the following condition codes when the value code "FD" is present on the claim:

- 49 - Product Replacement within Product Lifecycle—Replacement of a product earlier than the anticipated lifecycle
- 50 - Product Replacement for Known Recall of a Product—Manufacturer or FDA has identified the product for recall and therefore replacement
- 53 - Initial placement of a medical device provided as part of a clinical trial or free sample.(This condition code is for outpatient claims that have received a device credit upon initial medical device placement in a clinical trial or a free sample.It does not apply to inpatient claims.)

Inpatient Billing Instructions – The same value code FD (reporting the value of the credit, not the cost)and either condition code 49 or 50 must be reported on inpatient claims if devices were supplied at no cost or with a credit of 50% or more against the ordinary expense.Note that condition code 53 is not appropriate for inpatient claim reporting. A full list of the DRGs which are subject to the device credit policy is provided at the end of this paper.

REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

Pertinent excerpts from the following chapters of the Medicare Claims Processing Manual are provided on the following pages; specifically:

- **Chapter 3 - Inpatient Hospital Billing**, section 100.8 – Replaced Devices Offered Without Cost or With a Credit is provided
- **Chapter 4,Part B Hospital (Including Inpatient Hospital Part B and OPPS)**, sections 61.3.1 through 61.3.4 and 61.3.5 through 61.3.6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf

Medicare Claims Processing Manual, Chapter 3 -Inpatient Hospital Billing

100.8 – Replaced Devices Offered Without Cost or With a Credit

(Rev. 2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-12)

Background

To identify and track claims billed for replacement devices, CMS issued CR 4058 on November 4, 2005. This CR provided instructions for billing and processing claims with the following condition codes:

- 49 Product Replacement within Product Lifecycle—Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly
- 50 Product Replacement for Known Recall of a Product—Manufacturer or FDA has identified the product for recall and therefore replacement

Policy

Beginning with discharges on or after October 1, 2008, CMS reduces Medicare payment when a replacement device is received by the hospital at a reduced cost or with a credit that is 50 percent or greater than the cost of the device, and when the assigned MS-DRG for the claim is one of the MS-DRGs applied to this policy.

For a list of MS-DRGs for which this policy applies to, please see the IPPS Final Rule.

This adjustment is consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay.

Billing Procedures (Discharges on or after October 1, 2008)

To correctly bill for a replacement device that was provided with a credit or no cost, hospitals must use the combination of condition code 49 or 50, along with value code FD. The condition code 49 or 50 will identify a replacement device while value code FD will communicate to Medicare the amount of the credit, or cost reduction, received by the hospital for the replaced device.

REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

Payment (Discharges on or after October 1, 2008)

Medicare deducts the partial/full credit amount, reported in the amount for value code FD, from the final IPPS reimbursement when the assigned MS-DRG is one of the MS-DRGs applied to this policy.

Reminder about Charging for Recalled Devices

As a reminder, section 2202.4 of the Provider Reimbursement Manual, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device.If a hospital receives a credit for a replacement medical device, the charges to Medicare should also be appropriately reduced.

Outpatient Hospital Billing- Chapter 4,Part B Hospital (Including Inpatient Hospital Part B and OPPS)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf#

61.3.5 - Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital or When the Hospital Receives a Full or Partial Credit for the Replacement Device Beginning January 1, 2014 (Rev. 3181, Issued: 01-30-15, Effective: 07-01-15, Implementation: 07-06-15).

Effective January 1, 2014, when a hospital furnishes without cost an initial placement of a medical device as part of a clinical trial or a free sample medical device or when a hospital furnishes without cost a new replacement device or with a credit of 50 percent or more of the cost of a new replacement from a manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Medical Device). Also effective January 1, 2014 hospitals must report one of the following condition codes when the value code "FD" is present on the claim:

- 49 Product Replacement within Product Lifecycle—Replacement of a product earlier than the anticipated lifecycle
- 50 Product Replacement for Known Recall of a Product—Manufacturer or FDA has identified the product for recall and therefore replacement
- 53 Initial placement of a medical device provided as part of a clinical trial or free sample— Code is for outpatient claims that have received a device credit upon initial medical device placement in a clinical trial or a free sample

Chapter 4,Part B Hospital (Including Inpatient Hospital Part B and OPPS) - Continued

No-Cost Device Coding

When a hospital furnishes a device for which it incurs no cost, (these cases include, but are not limited to, devices replaced under warranty, due to recall, or due to defect in a previous device; devices provided in a clinical trial; or devices provided as a sample) the hospital charge for a device furnished to the hospital at no cost should equal $0.00. However, some hospital's billing systems require that a charge be reported for separately billable codes in order for the claim to be submitted for payment, even items for which the hospital incurs no cost.

REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

Hospitals paid under the OPPS that implant a device furnished at no cost to the hospital shall report a charge of zero for the device, or, if the hospital's billing system requires that a charge be entered, the hospital shall submit a token charge (e.g. $1.00) on the line with the device code.

CMS recognizes that showing a charge for a device that has been furnished without cost is not optimal, but showing a token charge in this circumstance will allow claims for reasonable and necessary services to be adjudicated.

61.3.6 - Medicare Payment Adjustment Beginning January 1, 2014

(Rev. 2903, Issued: 03-11-14, Effective: 04-01-14, Implementation: 04-07-14)

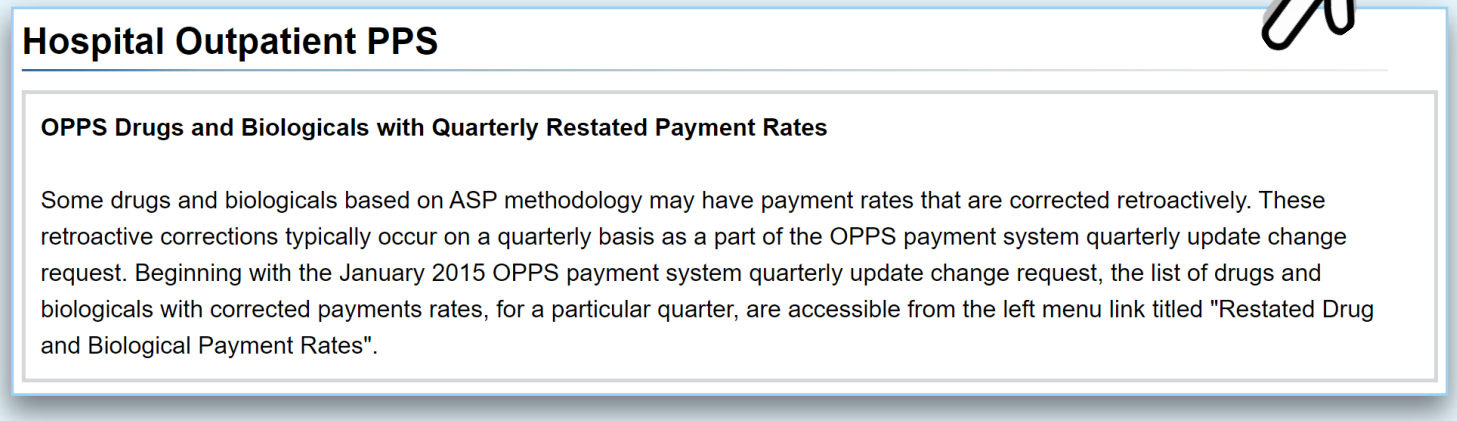
Effective January 1, 2014, Medicare payment is reduced by the amount of the device credit for specified procedure codes reported with value code "FD." The payment deduction is limited to the full device offset when the FD value code appears on a claim. Payment is only reduced for procedure codes that map to the Ambulatory Payment Classification groups (APCs) on the list of APCs subject to the adjustment that are reported with value code "FD" and that are present on claims with specified device HCPCS codes.

The OPPS Pricer deducts the lesser of the device credit or the full unadjusted device offset amount from the Medicare payment for a procedure code in an APC subject to the adjustment when billed with value code "FD" on the claim. This deduction is made from the Medicare payment after the multiple procedure discounting and terminated procedure discounting factors are applied, units of service are accounted for, and after the APC payment has been wage adjusted.

When two or more procedures assigned to APCs subject to the adjustment are reported with value code "FD" the OPPS Pricer will apportion the device credit to the applicable line on the claim for each procedure assigned to an APC subject to the adjustment. When value code "FD" is reported on a claim where multiple APCs would be subject to the adjustment, the OPPS Pricer apportions the device credit to each of those lines.

The percentage of the device credit apportioned to each applicable line is based on the percentage that the unadjusted payment of each applicable line represents, relative to the total unadjusted payment for all applicable lines.NOTE: The tables of APCs and devices to which the offset reductions apply, and the full and partial offset amounts, are available on the CMS Website at:

www.cms.hhs.gov/HospitalOutpatientPPS/.



REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

2021 MS-DRG List For Required Reporting Of Replaced Devices Offered Without Cost Or With A Credit

MDC	MS-DRG	MS-DRG Title
Pre-MDC	001	Heart Transplant or Implant of Heart Assist System with MCC
Pre-MDC	002	Heart Transplant or Implant of Heart Assist System without MCC
01	023	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator
01	024	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis without MCC
01	025	Craniotomy and Endovascular Intracranial Procedures with MCC
01	026	Craniotomy and Endovascular Intracranial Procedures with CC
01	027	Craniotomy and Endovascular Intracranial Procedures without CC/MCC
01	040	Peripheral, Cranial Nerve and Other Nervous System Procedures with MCC
01	041	Peripheral, Cranial Nerve and Other Nervous System Procedures with CC or Peripheral Neurostimulator
01	042	Peripheral, Cranial Nerve and Other Nervous System Procedures without CC/MCC
03	140	Major Head and Neck Procedures with MCC
03	141	Major Head and Neck Procedures with CC
03	142	Major Head and Neck Procedures without CC/MCC
05	215	Other Heart Assist System Implant
05	216	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC
05	217	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC
05	218	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization without CC/MCC
05	219	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC
05	220	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with CC
05	221	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization without CC/MCC
05	222	Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/Heart Failure/Shock with MCC
05	223	Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/Heart Failure/Shock without MCC
05	224	Cardiac Defibrillator Implant with Cardiac Catheterization without AMI/Heart Failure/Shock with MCC
05	225	Cardiac Defibrillator Implant with Cardiac Catheterization without AMI/Heart Failure/Shock without MCC

REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

MDC	MS-DRG	MS-DRG Title
05	226	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC
05	227	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
05	242	Permanent Cardiac Pacemaker Implant with MCC
05	243	Permanent Cardiac Pacemaker Implant with CC
05	244	Permanent Cardiac Pacemaker Implant without CC/MCC
05	245	AICD Generator Procedures
05	258	Cardiac Pacemaker Device Replacement with MCC
05	259	Cardiac Pacemaker Device Replacement without MCC
05	260	Cardiac Pacemaker Revision Except Device Replacement with MCC
05	261	Cardiac Pacemaker Revision Except Device Replacement with CC
05	262	Cardiac Pacemaker Revision Except Device Replacement without CC/MCC
05	265	AICD Lead Procedures
05	266	Endovascular Cardiac Valve Replacement And Supplement Procedures with MCC
05	267	Endovascular Cardiac Valve Replacement And Supplement Procedures without MCC
05	268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
05	269	Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC
05	270	Other Major Cardiovascular Procedures with MCC
05	271	Other Major Cardiovascular Procedures with CC
05	272	Other Major Cardiovascular Procedures without CC/MCC
05	319	Other Endovascular Cardiac Valve Procedures with MCC
05	320	Other Endovascular Cardiac Valve Procedures without MCC
08	461	Bilateral or Multiple Major Joint Procedures Of Lower Extremity with MCC
08	462	Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC
08	466	Revision of Hip or Knee Replacement with MCC
08	467	Revision of Hip or Knee Replacement with CC
08	468	Revision of Hip or Knee Replacement without CC/MCC
08	469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement
08	470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC
08	521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC
08	522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC

NEW UPDATE

IMPLANTABLE DEFIBRILLATOR ICD-10 CODING

Providers which offer automatic cardiac defibrillator (C1882) procedures should ensure the HIM department is aware of a new MLN article released on January 9, 2021 regarding ICD-10 coding which supports medical necessity requirements.

The new article stresses the importance of recording ICD-10 codes for heart failure to meet the requirements of medical necessity, even if the symptoms of heart failure have been managed successfully.A link and excerpts are provided below:

https://www.cms.gov/files/document/se20006.pdf

NCD 20.4 Implantable Cardiac Defibrillators (ICDs)

MLN Matters Number: SE20006	Related Change Request (CR) Number: 10865
Article Release Date: March 3, 2020	Effective Date: N/A
Related CR Transmittal Number: N/A	Implementation Date: N/A

> "The current requirements for reporting heart failure codes (ICD-10 diagnosis codes I50.21, I50.22, I50.23, I50.41, I50.42, and I50.43) for patients with ischemic or non-ischemic cardiomyopathy are based on NCD language, which specifically adds this requirement. ...
>
> "CMS believes that perhaps some have misinterpreted correct coding principles with respect to the use of these codes. CMS agrees that patients do not have to have "active heart failure" to qualify for an Automatic Implantable Cardioverter Defibrillator (AICD) but they also do not have to have "active heart failure" in order to append one of these codes...."

This clarification is particularly important in light of the nationwide Recovery Audit Contractor issue, approved on October 6, 2020, which authorized RACs to examine whether medical necessity requirements were met for inpatient implantable defibrillator claims.Defibrillator claims are usually fairly high cost, due to the expense of the implantable device; failure to meet medical necessity on these cases can represent a large sum that includes out-of-pocket costs to the provider for the device itself.

RAC auditors will focus on inpatient defibrillator cases performed after National Coverage Determination 20.4 became effective on February 15, 2018.In addition to requirements related to patient condition as represented on the claim by ICD-10 codes, the NCD requires a formal "shared decision making visit" between the patient and the physician prior to the procedure.If that visit was not conducted, reimbursement will be recouped in full.Since inpatient ICD cases are typically reimbursed at between $30,000 and $90,000, the threat is significant.

NEW UPDATE

IMPLANTABLE DEFIBRILLATOR ICD-10 CODING

A link and an excerpt from the approved issue announcement on the CMS website:

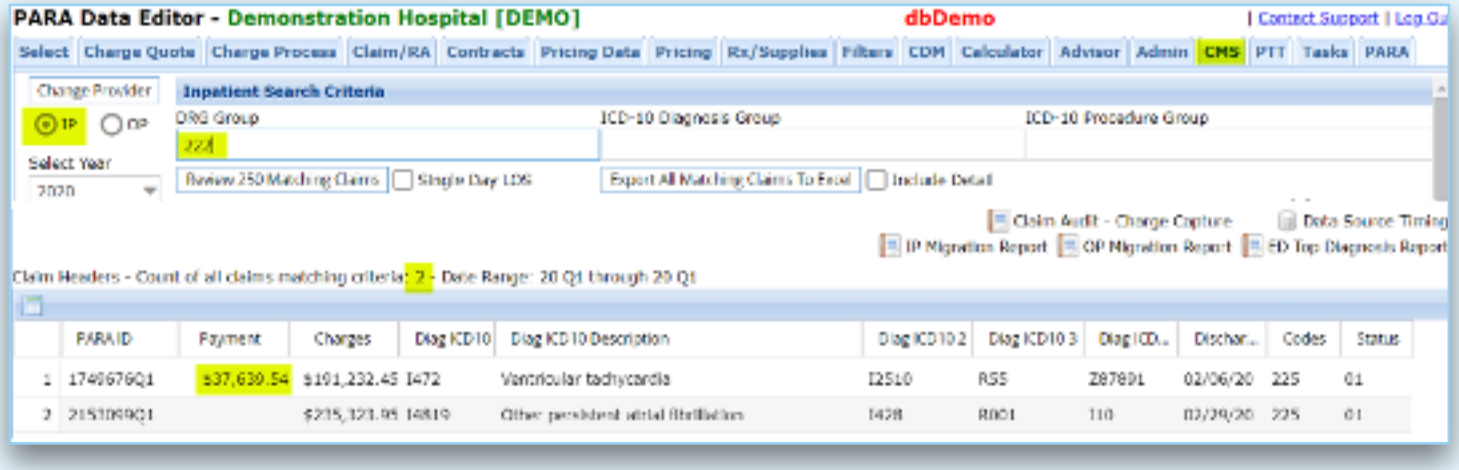
https://www.cms.gov/node/1439781

Issue Name: 0195-Implantable Automatic Defibrillator- Inpatient Procedure: Medical Necessity and Documentation Requirements

MAC Jurisdiction: All A/B MACs

Description: The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.

PARA clients can identify the number of inpatient cases at risk of audit by using the CMS Claims Database on the **PARA Data Editor**. Search inpatient claims for DRGs 222, 223, 224, 225, 226, and 227:



The National Coverage Determination for Implantable Automatic Defibrillators (NCD 20.4) became effective February 15, 2019.The NCD is available on the CMS Coverage Database at the link below:

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=110&ncdver=4&DocID=20.4&bc=gAAAAAIAAAAA&

National Coverage Determination (NCD) for Implantable Automatic Defibrillators (20.4)

The NCD requires that most patients receiving an initial ICD placement must first attend a "formal shared decision making visit" with their doctor prior to the ICD placement procedure.If the ICD is placed without the required prerequisite visit, Medicare will not cover the procedure.Since payment is not predicated upon submitting the visit documentation in advance, many hospitals have been billing ICD cases and receiving substantial payments while unaware that the cases did not meet medical necessity.

In addition to other coverage requirements, the shared decision-making visit applies to the following categories of patients who may be considering an implantable ICD procedure:

- Patients with a prior MI and a measured Left Ventricular Ejection Fraction (LVEF) ≤ 0.30

NEW UPDATE

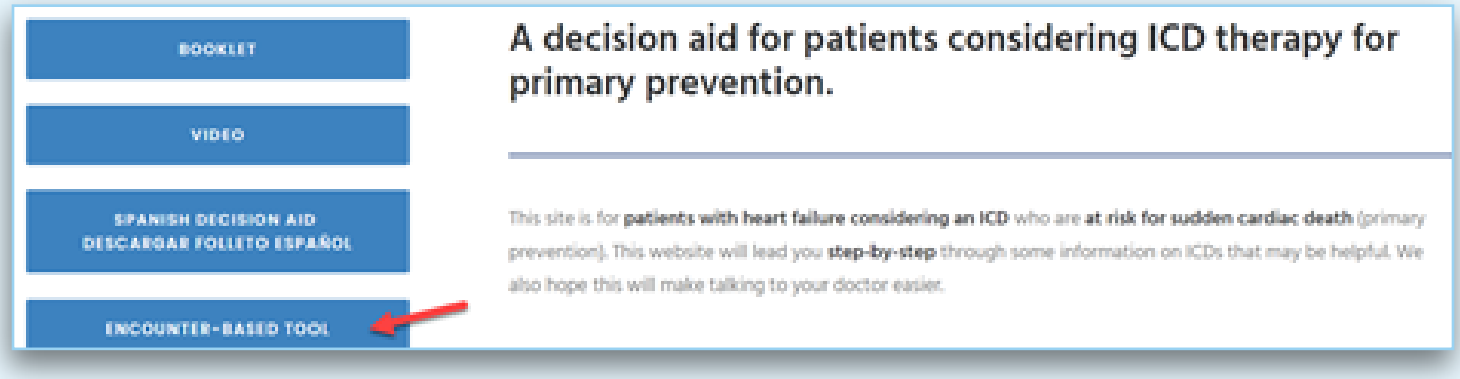
IMPLANTABLE DEFIBRILLATOR ICD-10 CODING

- Patients who have severe, ischemic, dilated cardiomyopathy but no personal history of sustained VT or cardiac arrest due to VF, and have NYHA Class II or III heart failure, LVEF ≤ 35%
- Patients who have severe, non-ischemic, dilated cardiomyopathy but no personal history of cardiac arrest or sustained VT, NYHA Class II or III heart failure, LVEF ≤ 35%, been on optimal medical therapy for at least three months
- Patients with documented, familial or genetic disorders with a high risk of life-threatening tachyarrhythmias (sustained VT or VF, to include, but not limited to, long QT syndrome or hypertrophic cardiomyopathy

However, the shared decision-making visit is not required to patients with a personal history of sustained Ventricular Tachyarrhythmia (VT) or cardiac arrest due to Ventricular Fibrillation (VF), or patients that have had an ICD previously and require an ICD replacement procedure.

The formal shared decision-making encounter must occur between the patient and a physician or qualified non-physician practitioner using an evidence-based decision tool on ICDs prior to initial ICD implantation. The Colorado Program for Patient Centered Decisions offer such a tool at the following website:

https://patientdecisionaid.org/icd/



Hospitals would be well served to ensure that ICD-10 coding is appropriate and evidence of the shared decision-making visit is on file prior to performing an implantable defibrillator procedure for a Medicare beneficiary for both inpatient and outpatient cases.

The procedure is costly due to the expensive purchased implants – lost revenue for these procedures is more than benign because the significant cost of the implanted defibrillator device itself is at risk.

PRICE TRANSPARENCY: CLARIFYING THE UNKNOWN

Let us clarify the facts, the questions and uncertainties about Price Transparency.

Click on the video clip below and watch how **PARA HealthCare Analytics** and **HFRI** can ease the anxieties of hospital compliance executives.

SPECIAL

BILLING AND CODING FOR COVID-19 VACCINES

On Friday, December 18, 2020 the FDA approved the Moderna COVID-19 vaccine for use under an Emergency Use Authorization (EUA).This vaccine joins the Pfizer product which was provided EUA on December 11, 2020.

Under the CARES Act, Medicare will provide beneficiaries COVID-19 vaccine administration with no cost-sharing to beneficiaries under Part B coverage.

Initially, providers will not incur a cost for the drug product as they will be distributed through government agencies.Providers should not bill for the drug when they receive it at no cost.CMS states it will establish COVID-19 drug product allowances, which will be based on reasonable costs (or, for physician offices, 95% of Average Wholesale Prices), later. Effective immediately after the FDA approves vaccinations for EUA, providers may report the COVID-19 administration code based on the type of vaccine and the which dose is provided.

Vaccine Code	CPT Long Descriptor	Mfr Vaccine / Procedure Name	Medicare Payment Allowance	Effective Dates
91300*	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use *(**PARA** note: Report administration code 0001A or 0002A)*	**Pfizer**-Biontech Covid-19 - **Vaccine**	$0.01	12/11/2020
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative-free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	**Pfizer**-Biontech Covid-19 Vaccine Administration – **First Dose**	$ 16.94.39	12/11/2020
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative-free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	**Pfizer**-Biontech Covid-19 Vaccine Administration – **Second Dose**	$ 28.39	12/11/2020

SPECIAL

BILLING AND CODING FOR COVID-19 VACCINES

Vaccine Code	CPT Long Descriptor	Mfr Vaccine / Procedure Name	Medicare Payment Allowance	Effective Dates
91301*	**Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL do sage, for intramuscular use** *(**PARA** note: Report administration code 0011A or 0012A)*	**Moderna** Covid-19 - **Vaccine**	$0.01	12/18/2020
0011A	Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative-free, 100 mcg/0.5mL dosage; first dose	**Moderna** Covid-19 Vaccine Administration – **First Dose**	$ 16.94	12/18/2020
0012A	Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative-free, 100 mcg/0.5mL dosage; second dose	**Moderna** Covid-19 Vaccine Administration – **Second Dose**	$ 28.39	12/18/2020

*Per the The Medicare Claims Processing Manual Chapter 32 - Billing Requirements for Special Services section 67.2 providers should not bill for drugs when they receive it at no cost.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf#

67.2 – Institutional Billing for No Cost Items
(Rev. 4013, Issued: 03-30-18, Effective: 01-01-09, Implementation: 06-29-18)

In anticipation of the EUA approval of the COVID-19 vaccine that is currently in development by AstraZeneca and the University of Oxford, the AMA CPT® code set for the vaccine product and administration.Like both the Pfizer and Moderna vaccines, administration code will be reported based whether it is the first or the second dose.

The effective date for these codes will follow the EUA approval.The codes are provided on the following page.

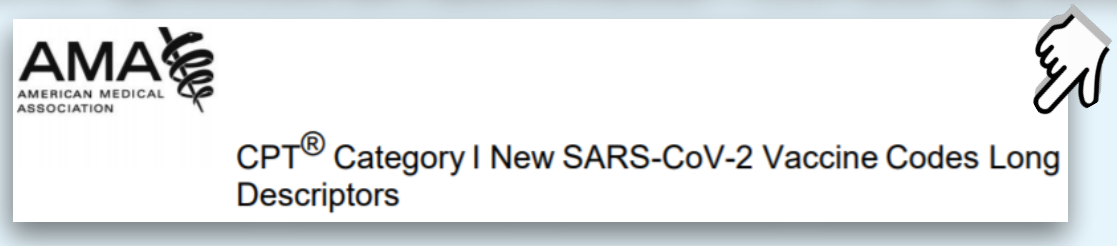
SPECIAL

BILLING AND CODING FOR COVID-19 VACCINES

Vaccine Code	CPT Long Descriptor	Mfr Vaccine / Procedure Name	Payment Allowance	Effective Dates
91302*	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage, for intramuscular use *(**PARA** note: Report administration code 0021A or 0022A)*	**AstraZeneca** Oxford Covid-19 - **Vaccine**	$0.01*	TBD
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose	**AstraZeneca** Oxford Covid-19 Vaccine Administration – **First Dose**	$ 16.94	TBD
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; second dose	**AstraZeneca** Oxford Covid-19 Vaccine Administration – **Second Dose**	$ 28.39	TBD

*Per the The Medicare Claims Processing Manual Chapter 32 - Billing Requirements for Special Services section 67.2 providers should not bill for drugs when they receive it at no cost.

The AMA provides instructions for coding the administration of the COVID-19 vaccines through the following document: https://www.ama-assn.org/system/files/2020-11/covid-vaccine-long-descriptors.pdf



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 11, 2021

News

- PEPPERs for Short-term Acute Care Hospitals
- Colorectal Cancer: Medicare Covers Screening

Compliance

- Ambulance Services & SNF Consolidated Billing Requirements: Avoid Improper Payments

Claims, Pricers, & Codes

- Average Sales Price Files: April 2021

Events

- Medicare Part A Cost Report Appeals Listening Session — March 16
- Long-Term Care: Dementia-related Psychosis Call — March 23
- Open Payments & You Call — March 25

MLN Matters® Articles

- April 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.1
- April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes — Revised

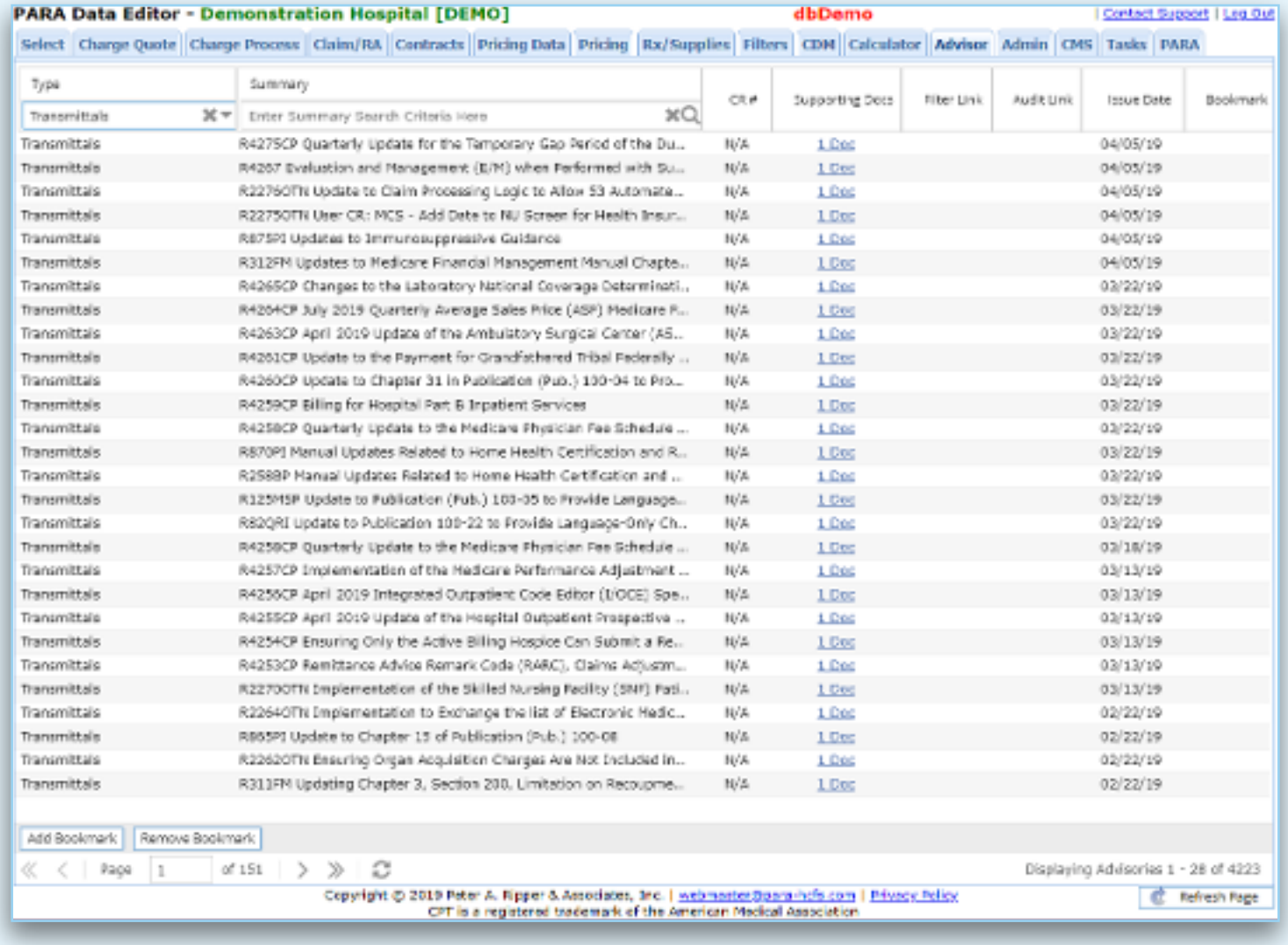
View this edition as PDF (PDF)

There were 12 new or revised
MedLearns released this week.

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

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

12



The link to this MedLearn MM12185

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Update to Rural Health Clinic (RHC) Payment Limits

MLN Matters Number: MM12185 | Related Change Request (CR) Number: 12185

Related CR Release Date: March 16, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10679OTN | Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Rural Health Clinics (RHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare patients.

PROVIDER ACTION NEEDED

This article tells you about the payment limit for RHCs effective April 1, 2021. Please be sure your billing staffs are aware of these updates.

BACKGROUND

As Section 1833(f) of the Social Security Act (the Act) authorizes, Medicare makes Part B payment to independent RHCs at 80% of the All-Inclusive Rate (AIR). This is subject to a payment limit for medically necessary medical, mental, and qualified preventive face-to-face visits with an RHC practitioner and a Medicare patient for RHC services. CMS increases the payment limits for subsequent years using the rate of increase in the Medicare Economic Index (MEI).

Also, under Section 1833(f) of the Act, an RHC that is Provider-Based (PB) to a hospital with fewer than 50 beds is exempt from the national payment limit per visit. That is, a PB RHC's payment per visit is based on their average allowable costs determined at cost report settlement. In the interim final rule with comment, published in the May 8, 2020, Federal Register (90 FR 27550-27529), we implemented a policy that excludes temporarily added surge capacity beds due to the Public Health Emergency (PHE) for the COVID-19 pandemic (defined at Section 400.200) from a hospital's bed count (discussed at Section 412.105(b)) for the purposes of determining whether an RHC that's provider-based to that hospital is exempt from the national payment limit per visit.

Effective January 1, 2021, the RHC payment limit per visit for Calendar Year (CY) 2021 is $87.52. We implemented this payment limit in CR 12035.

The Consolidated Appropriations Act of 2021, signed December 27, 2020, updated Section

CMS Medicare Learning Network

The link to this MedLearn MM12108

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Updated Billing Requirements for Home Infusion Therapy (HIT) Services on or After January 1, 2021

MLN Matters Number: MM12108 | Related Change Request (CR) Number: 12108

Related CR Release Date: March 15, 2021 | Effective Date: January 1, 2021

Related CR Transmittal Number: R10621CP | Implementation Date: July 6, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Home Infusion Therapy (HIT) services provided to Medicare patients.

PROVIDER ACTION NEEDED

This article informs you of new changes to Medicare claims processing for HIT services on or after January 1, 2021. Make sure your billing staffs are aware of this change.

BACKGROUND

Section 5012(d) of the 21st Century Cures Act (Pub. L. 144-255) amended Sections 1861(s)(2) and 1861(iii) of the Social Security Act (the Act), requiring the Secretary of HHS to establish a new Medicare HIT services benefit. The Medicare HIT services benefit covers the professional services, including nursing services, furnished in accordance with the plan of care, including:

- Patient training and education (not otherwise covered under the Durable Medical Equipment (DME) benefit)
- Remote monitoring
- Monitoring services for the provision of HIT services
- Home infusion drugs rendered by a qualified HIT supplier

Section 1861(iii)(3)(C) of the Act defines "home infusion drug," as a parenteral drug or biological administered intravenously, or subcutaneously, for an administration period of 15 minutes or more, in an individual's home through a pump that is a DME item (as defined in Section 1861(n) of the Act). Such term does not include insulin pump systems or self-administered drugs or biologicals on a self-administered drug exclusion list.

CMS Medicare Learning Network

The link to this MedLearn MM12193

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KNOWLEDGE • RESOURCES • TRAINING

April Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM12193 | Related Change Request (CR) Number: 12193

Related CR Release Date: March 12, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10681CP | Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for DMEPOS items or services Medicare pays for using the DMEPOS fee schedule for Medicare patients.

PROVIDER ACTION NEEDED

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

BACKGROUND

CMS updates the DMEPOS fee schedule as required by statute and regulations. Medicare must pay for certain DMEPOS and surgical dressings under Sections 1834(a), (h), and (i) of the Social Security Act (the Act) on a fee schedule basis. Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician's office. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to fee schedule adjustments using information on the payment determined for these items under the DMEPOS Competitive Bidding Program (CBP), as well as codes that aren't subject to the CBP or fee schedule adjustments.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for DME items included in the CBP for payment of the items in areas that are not Competitive Bidding Areas (CBAs). Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR Section 414.210(g).

CMS Medicare Learning Network®

The link to this MedLearn MM12102

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM12102 | Related Change Request (CR) Number: 12102

Related CR Release Date: March 11, 2021 | Effective Date: July 1, 2021

Related CR Transmittal Number: R10650CP | Implementation Date: July 6, 2021

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

This article tells you of updates to the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare's Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Make sure billing staffs are aware of these updates. If you use the MREP or PC Print software, be sure to get the updated software.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to be able to conduct standard electronic transactions that HHS adopted under HIPAA using valid standard codes. Medicare policy states that MACs must use CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, in the remittance advice and coordination of benefits transactions.

CMS instructs your MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

We provide this information as a code update notification indicating when updates to CARC and RARC lists are made available on the official Accredited Standards Committee (ASC) X12 website. The SSMs are responsible for implementing code deactivation, making sure MACs don't use any deactivated code in original business messages and allowing the deactivated code in derivative messages. The SSMs must make sure that Medicare does not report any

CMS Medicare Learning Network

The link to this MedLearn MM12131

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM12131 Revised | Related Change Request (CR) Number: 12131

Related CR Release Date: March 8, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10613CP | Implementation Date: April 5, 2021

Note: We revised this article to reflect a revised CR 12131. The CR revision changed the date that we added HCPCS code 87428. The correct date is November 10, 2020. (See bullet 13 on page 7.) We revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® is for laboratories, physicians, hospitals, and other providers billing Medicare Administrative Contractors (MACs) for laboratory services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article tells you about the new HCPCS codes for 2021 that are subject to and excluded from Clinical Laboratory Improvement Amendments (CLIA) edits. Make sure your billing staffs are aware of these updates.

BACKGROUND

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

KEY POINTS

The HCPCS codes that are laboratory tests under CLIA change each year. CMS tells the MACs about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

The following HCPCS code was discontinued on March 31, 2020:

CMS | Medicare Learning Network

The link to this MedLearn MM12155

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KNOWLEDGE • RESOURCES • TRAINING

Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2021 Update

MLN Matters Number: MM12155 | Related Change Request (CR) Number: 12155

Related CR Release Date: March 10, 2021 | Effective Date: January 1, 2021

Related CR Transmittal Number: R10631CP | Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

This MLN Matters article is for physicians, hospitals and other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients that Medicare pays using the Medicare Physician Fee Schedule (MPFS).

PROVIDER ACTION NEEDED

CR 12155 informs you of the issuance of April 2021 updates of the 2021 MPFS. Make sure your billing staffs are aware of these updates.

BACKGROUND

CMS issued Calendar Year (CY) 2021 MPFS payment files to the MACs based upon the CY 2021 MPFS Final Rule published in the Federal Register on December 28, 2020.Those files are effective for services furnished between January 1, 2021, and December 31, 2021.

Below is a summary of the changes for the April update to the 2021 MPFS. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2021.

The following new code is effective for dates of service January 1, 2021, and after. This code was implemented under CR 11907 for the January 2021 HCPCS update.

- G2211 - Procedure Status = B; there are no Relative Value Units (RVUs), payment policy indicators don't apply.

The following code has changes to the Multiple Procedure (Multi Proc) Payment Reduction (MPPR) indicator. These changes are effective for dates of service January 1, 2021, and after.

Code	Modifier	Action
0508T		Mult Proc = 0
0508T	TC	Mult Proc = 0
0508T	26	Mult Proc = 0

CMS Medicare Learning Network

The link to this MedLearn MM12178

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM12178 | Related Change Request (CR) Number: 12178

Related CR Release Date: March 9, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10656CP | Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for clinical diagnostic laboratories that submit claims to Medicare Administrative Contractors (MACs) for laboratory services they provide to Medicare patients.

PROVIDER ACTION NEEDED

This article gives you details of the quarterly update to the Clinical Laboratory Fee Schedule (CLFS). Please be sure your billing staff is aware of these updates.

BACKGROUND

Here is a summary of the revisions for the April update:

Advanced Diagnostic Laboratory Tests (ADLTs)
Please refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html#ADLT_tests for additional information regarding these tests:

Next CLFS Data Reporting Period for Clinical Diagnostic Laboratory Tests — DELAYED
The next CLFS data reporting period for Clinical Diagnostic Laboratory Tests (CDLTs) is delayed. Section 1834A of the Social Security (the Act), as established by Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for CDLTs under the CLFS. CMS published the CLFS final rule, Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule (CMS-1621-F), in the Federal Register on June 23, 2016.

The CLFS final rule implemented Section 1834A of the Act. Under the CLFS final rule, reporting entities must report to CMS certain private payor rate information (applicable information) for their component applicable laboratories. The data collection period (the period where applicable information for an applicable laboratory is obtained from claims for which the laboratory received final payment during the period) was from January 1, 2019, through June 30, 2019.

CMS | Medicare Learning Network

The link to this MedLearn MM12140

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Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

MLN Matters Number: MM12140	Related Change Request (CR) Number: 12140
Related CR Release Date: March 9, 2021	Effective Date: January 1, 2021
Related CR Transmittal Number: R10615CP	Implementation Date: No later than March 19, 2021

PROVIDER TYPE AFFECTED

This MLN Matters Article is for laboratories and providers billing Medicare Administrative Contractors (MACs) for specimen collection services provided to Medicare patients.

PROVIDER ACTION NEEDED

This article informs you about the Calendar Year (CY) 2021 changes to travel allowances when billed:

- On a per mileage basis using HCPCS code P9603
- On a flat rate basis using HCPCS code P9604

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 Act. Payment for these services is made based on the Clinical Laboratory Fee Schedule (CLFS).

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

BACKGROUND

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 covers the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MAC discretion allows the 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.

CMS Medicare Learning Network

The link to this MedLearn MM12062

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April 2021 Update to the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS)

MLN Matters Number: MM12062 | Related Change Request (CR) Number: 12062

Related CR Release Date: March 9, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10669CP | Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Rural Referral Centers (RRCs), Medicare Dependent Hospitals (MDHs), MDH RRCs, Sole Community Hospital (SCH) RRCs, or Essential Access Community Hospital (EACH) RRCs submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you of changes that CMS is making for the April 2021 update of the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS). Note that the MACs will be reprocessing certain claims as we explain in this article. Make sure your staff are aware of these changes.

BACKGROUND

Section 533(b) of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) amended Section 1886(d)(5) of the Social Security Act (the Act) to add subparagraphs (K) and (L) and establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare.

In the September 7, 2001, final rule (66 FR 46902), CMS established that cases using approved new technology would be appropriate candidates for an additional payment when:

- The technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries
- The payment for such cases can be demonstrated to be inadequately paid otherwise under the Diagnosis-Related Group (DRG) system

CMS Medicare Learning Network

The link to this MedLearn MM12187

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April 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.1

MLN Matters Number: MM12187 | Related Change Request (CR) Number: 12187

Related CR Release Date: March 8, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10667CP | Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article informs you of changes to the April 2021 version of the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the I/OCE that Medicare uses:

- Under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers
- For limited services when provided in a HH agency not under the HH PPS
- For a hospice patient for treating a non-terminal illness

Please make sure your billing staffs are aware of these changes.

BACKGROUND

CR 12187 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that an I/OCE update will occur on April 1, 2021. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

We summarize the modifications of the I/OCE for the April 2021, V22.1 release, in the table below. You should also read through the entire specifications document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the

CMS Medicare Learning Network

The link to this MedLearn MM12175

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April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM12175	Related Change Request (CR) Number: 12175
Related CR Release Date: March 8, 2021	Effective Date: April 1, 2021
Related CR Transmittal Number: R10666CP	Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

This MLN Matters article is for hospitals billing Medicare Administrative Contractors (MACs) for hospital outpatient services they provide to Medicare patients.

PROVIDER ACTION NEEDED

Related CR12175 describes changes to and billing instructions for various payment policies implemented in the April 2021 Outpatient Prospective Payment System (OPPS) update. The April 2021 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 12175. Please make sure your billing staffs are aware of these updates.

BACKGROUND

1. Revised APC Assignments for Pfizer-BioNTech and Moderna COVID-19 CPT Administration Codes

CMS listed the CPT codes associated with the Pfizer and Moderna COVID-19 vaccines and their administration in Section I.B.4. (New COVID-19 CPT Vaccines and Administration Codes) of the January 2021 OPPS Update of the Hospital OPPS (Transmittal 10541, CR 12120, dated December 31, 2020). Because it was too late for us to establish new APCs for the January 2021 I/OCE update, we assigned COVID-19 vaccine administration CPT codes 0001A and 0011A to APC 1492 (New Technology – Level 1B ($11-$20)) with a payment rate of $15.50 and CPT codes 0002A and 0012A to APC 1493 (New Technology – Level 1C ($21-$30)) with a payment rate of $25.50.

To pay appropriately for the COVID-19 vaccine administration codes, for the April 2021 I/OCE update, we are updating the APC assignments for the administration codes. We are reassigning CPT codes 0001A and 0011A from APC 1492 to APC 9397 and codes 0002A and 0012A from APC 1493 to APC 9398.

CMS Medicare Learning Network

The link to this MedLearn MM12131

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

MLN Matters Number: MM12131 Revised | Related Change Request (CR) Number: 12131

Related CR Release Date: March 8, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10613CP | Implementation Date: April 5, 2021

Note: We revised this article to reflect a revised CR 12131. The CR revision changed the date that we added HCPCS code 87428. The correct date is November 10, 2020. (See bullet 13 on page 7.) We revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® is for laboratories, physicians, hospitals, and other providers billing Medicare Administrative Contractors (MACs) for laboratory services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article tells you about the new HCPCS codes for 2021 that are subject to and excluded from Clinical Laboratory Improvement Amendments (CLIA) edits. Make sure your billing staffs are aware of these updates.

BACKGROUND

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

KEY POINTS

The HCPCS codes that are laboratory tests under CLIA change each year. CMS tells the MACs about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

The following HCPCS code was discontinued on March 31, 2020:

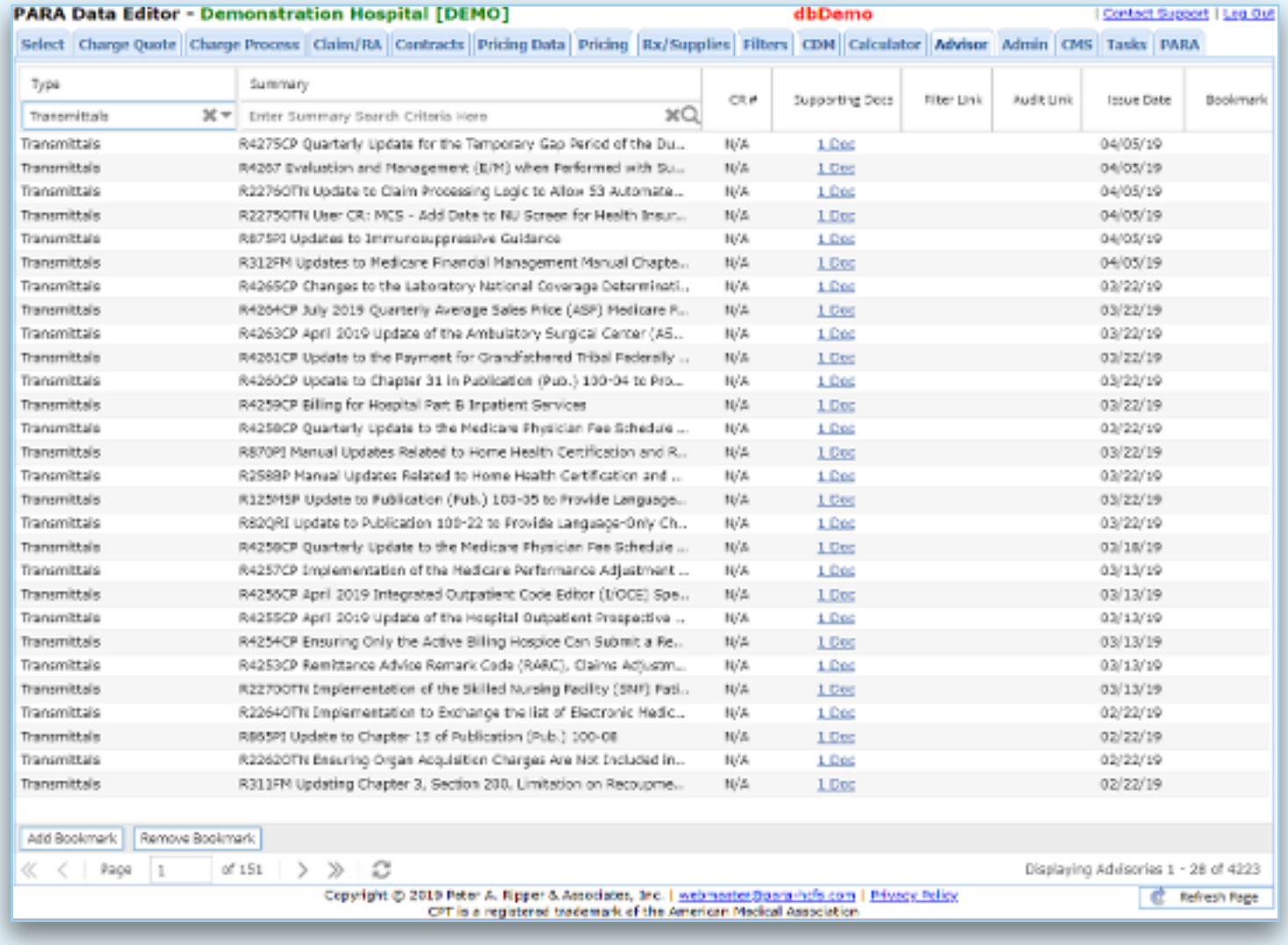
CMS Medicare Learning Network®

There were 36 new or revised
Transmittals released this week. We are listing 12 of them here.

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**

12



The link to this Transmittal R10596OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10596	**Date: March 16, 2021**
	Change Request 12085

SUBJECT: Correction to Period Sequence Edits on Home Health Claims

I. SUMMARY OF CHANGES: This Change Request revises Common Working File home health period sequence edits to no longer exclude low utilization payment adjustment claims.

EFFECTIVE DATE: January 1, 2020 - Claim "From" dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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	

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:
One Time Notification

The link to this Transmittal R10634OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10634	**Date: March 16, 2021**
	Change Request 12043

SUBJECT: User CR: ViPS Medicare System (VMS) - Update Interactive Correspondence Online Reporting (ICOR) Mail Date Calculation

I. SUMMARY OF CHANGES: This Change Request (CR) requires VMS to ensure the calculation of the Interactive Correspondence Online Reporting (ICOR) Mail Date field on the ICOR Header screen is updated to use the Date of Determination (DOD) rather than the System Date. This change will bring the calculation in line with the description of the field as documented in the VMS manuals. Currently, this inconsistency is causing erroneous values to display on the 323 - Appeals Activity Report used by the DME MACS to provide timeliness reporting.

EFFECTIVE DATE: July 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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N/A	N/A

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10655OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10655	**Date: March 16, 2021**
	Change Request 11723

SUBJECT: Mobile Personal Identity Verification (PIV) Station Installation

I. SUMMARY OF CHANGES: This change request (CR) is for Palmetto Government Benefit Administrators (PGBA) to install a CMS supplied mobile PIV station computer system at the PGBA office located in Columbia, SC.

EFFECTIVE DATE: April 15, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 15, 2021

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

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10671BP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10671	**Date: March 16, 2021**
	Change Request 12188

SUBJECT: Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021

I. SUMMARY OF CHANGES: This Change Request (CR) implements the CY 2021 rate updates and policies for the ESRD PPS and implements the payment for renal dialysis services furnished to beneficiaries with AKI in ESRD facilities. This Recurring Update Notification applies to Publication 100-02, Medicare Benefit Policy Manual, chapter 11, section 50.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10665BP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10665	**Date: March 16, 2021**
	Change Request 12161

SUBJECT: Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Opioid Treatment Programs (Manual Updates Only)

I. SUMMARY OF CHANGES: This Change Request (CR) revises the Medicare Benefit Policy Manual, chapter 17, and the Medicare Claims Processing Manual, chapter 39, to reflect changes made in the Calendar Year (CY) 2021 Physician Fee Schedule Final Rule.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 15, 2021

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	17/20/Definitions relating to OTPs
R	17/40/40.1.1/Aspects of the bundle

III. FUNDING:
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IV. ATTACHMENTS:

Business Requirements
Manual Instruction

The link to this Transmittal R10665CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10665	**Date: March 16, 2021**
	Change Request 12161

SUBJECT: Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Opioid Treatment Programs (Manual Updates Only)

I. SUMMARY OF CHANGES: This CR revises the Medicare Benefit Policy Manual, chapter 17, and the Medicare Claims Processing Manual, chapter 39, to reflect changes made in the Calendar Year (CY) 2021 Physician Fee Schedule Final Rule.

EFFECTIVE DATE: January 1, 2021
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IMPLEMENTATION DATE: April 15, 2021

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	39/Table of Contents
R	39/30/30.5/Site of service (telecommunications)
R	39/30/30.6/Coding
R	39/30/30.6.1/Adjustments to Bundled Payment Rate
R	39/30/30.7/Cost Sharing
R	39/30/30.8/Locality Adjustments
R	39/40/Claims submission

III. FUNDING:
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IV. ATTACHMENTS:
Business Requirements
Manual Instruction

The link to this Transmittal R10651CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10651	**Date: March 16, 2021**
	Change Request 12142

SUBJECT: July 2021 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder

I. SUMMARY OF CHANGES: The complete HCPCS file is updated and released quarterly to the Medicare contractors. The file contains existing, new, revised and discontinued HCPCS codes for the July 2021 quarter. Contractors must download the file via the CMS mainframe in June 2021. The recurring update notification applies to chapter 23, section 20 of the Medicare Claims Processing Manual.

EFFECTIVE DATE: July 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10679OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10679	**Date: March 16, 2021**
	Change Request 12185

SUBJECT: Update to Rural Health Clinic (RHC) Payment Limits

I. SUMMARY OF CHANGES: This Change Request updates the payment limit for Rural Health Clinics (RHCs) in Chapter 9, Section 20.2 - "Payment Limit under the AIR" of the Claims Processing Manual effective April 1, 2021.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10678CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10678	**Date: March 16, 2021**
	Change Request 12212

SUBJECT: April 2021 Quarterly Update to HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

I. SUMMARY OF CHANGES: This notification provides updates to the lists of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS).

Changes to Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes and Medicare Physician Fee Schedule designations will be used to revise CWF edits to allow MACs to make appropriate payments in accordance with policy for SNF consolidated billing in chapter 6, section 20.6.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10663OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10663	**Date: March 16, 2021**
	Change Request 12144

SUBJECT: Revisions to Medicare Administrative Contractor (MAC) Standardized Monthly Status Report (MSR) Narrative Template

I. SUMMARY OF CHANGES: The Centers for Medicare & Medicaid Services' (CMS) Medicare Contractor Management Group (MCMG) is updating the Part A and B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Monthly Status Report (MSR) narrative to ensure that these reports continue to capture meaningful and useful information about the MACs' activities and performance across business functions. MCMG is combining the MSRW template for A/B and DME MACs.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 20, 2021

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N/A	N/A

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

IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10574CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10574	**Date: March 16, 2021**
	Change Request 12132

SUBJECT: Shared System Support Hours for Application Programming Interfaces (APIs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide hours for the Fiscal Intermediary Shared System (FISS) and Multi-Carrier System (MCS) Maintainers to support maintenance, enhancements, and MAC onboarding of the existing APIs in the FISS and MCS using Agile development practices.

EFFECTIVE DATE: July 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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:

Recurring Update Notification

The link to this Transmittal R10621CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10621	**Date: March 15, 2021**
	Change Request 12108

SUBJECT: Updated Billing Requirements for Home Infusion Therapy (HIT) Services on or After January 1, 2021

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide contractor guidance and claims processing systems instructions necessary to implement new changes for HIT services on or after January 1, 2021.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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	32/411/4//Billing and Payment Requirement
R	32/411/5 /Return as Un-Processable, Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages
R	32/411/6 CWF and MCS Editing Requirements

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

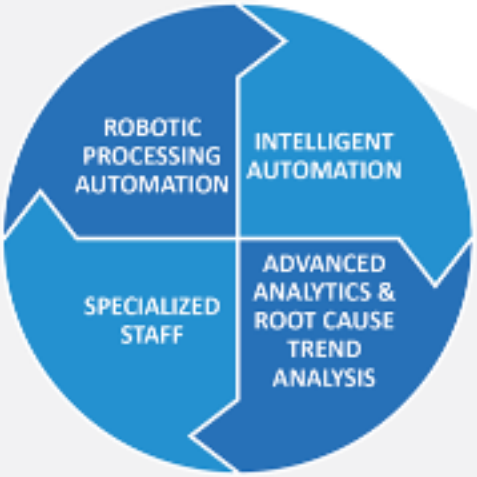
Creating results through our experience and automated processes.

30%+
INCREASE IN COLLECTIONS
IN SOME CASES UP TO 100% OR MORE

25%+
REDUCTION IN AN ACCOUNT'S LIFE CYCLE
LOWERING YOUR AR DAYS

20%+
DECREASE IN FUTURE DENIALS
INCREASING CASHFLOW & LOWERING WRITE-OFFS

Our Approach Uses:



HFRI Automation Process

- CATEGORIZE WORK INTO SIMILAR ISSUES
- IDENTIFY HIDDEN CAUSES OF DELAYED PAYMENTS
- TRAIN BOTS TO DO TEDIOUS FOLLOW-UP ACTIVITIES
- RESULT IN INCREASED PRODUCTION & COLLECTIONS

Additional Benefits Include:

AR FEES ARE CONTINGENCY BASED
PAY ONLY WHEN WE DELIVER CASH TO YOU

OUR SERVICE SITS ON THE BACKEND
AND DOESN'T DISRUPT ANY OTHER VENDOR OR INTERNAL EFFORTS ON AR

CANCEL AT ANY TIME FOR ANY REASON
WHETHER YOU WANT SHORT-TERM ASSISTANCE OR ARE EVER UNSATISFIED

PARA HealthCare Analytics | HEALTHCARE FINANCIAL RESOURCES

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