March 25, 2020

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

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FAST LINKS

ABORTED MECHANICAL THROMBECTOMY

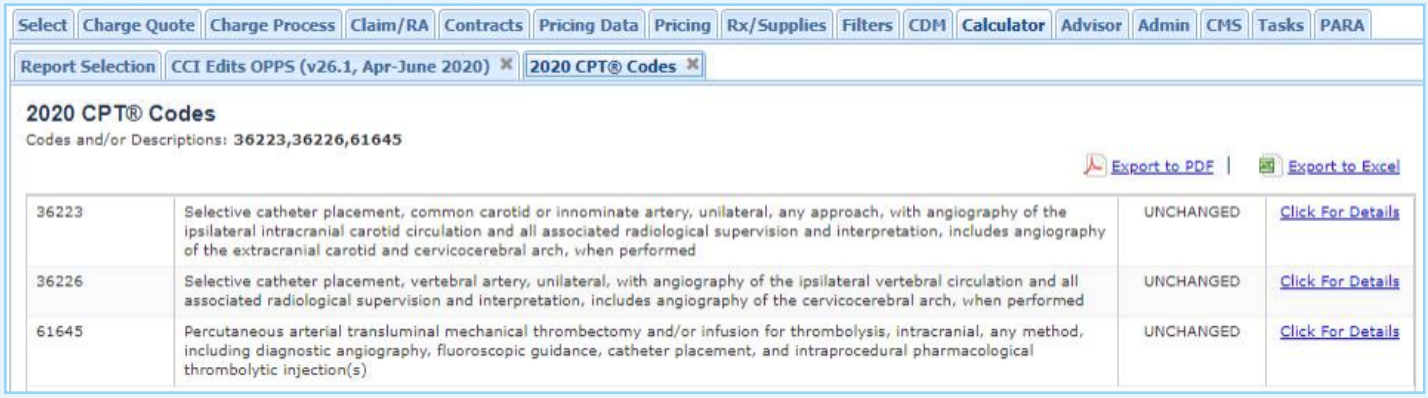
Q. What is the appropriate code for the aborted mechanical thrombectomy based on the operative note. We are considering 36226 w/ modifier XS and 61645.

A. **Answer:** Report CPT® code 36223 reported for the catheter selection into the left common carotid. The left femoral artery was the access point. They struggled getting a catheter to advance but the documentation does show a catheter accessed the left common carotid.

This code includes the angiography. CPT® code 36226 is not appropriate for this documentation as there was no catheter selection with the catheter INTO the vertebral artery. This is noted in procedure title state vertebral artery, however the body of the report indicates common carotid. Coders must code from the body of the report.

The body of the report will provide details of the actual procedure performed. The documentation does not support that a thrombectomy was performed. Therefore, CPT® code 61645 should not be reported.

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



PARA
HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

COVID-19

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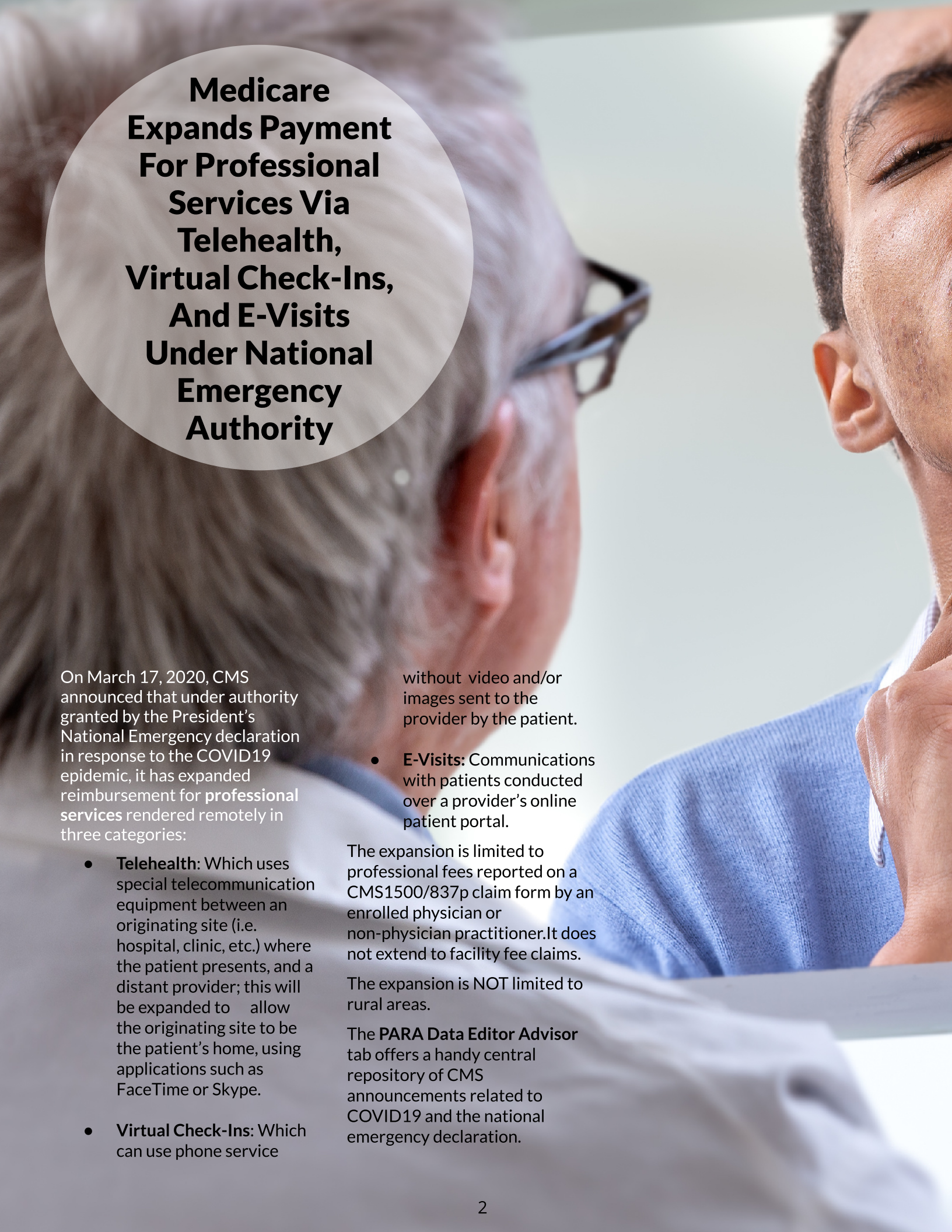
Special publication

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

In this Special Publication from PARA HealthCare Analytics and Healthcare Financial Resources (HFRI), the experts answer coding and financial questions.

The responses to Coronavirus are rapidly changing. That's why we've brought together a compilation of informative articles to simplify and clarify issues.

Medicare Expands Payment For Professional Services Via Telehealth, Virtual Check-Ins, And E-Visits Under National Emergency Authority



On March 17, 2020, CMS announced that under authority granted by the President's National Emergency declaration in response to the COVID19 epidemic, it has expanded reimbursement for **professional services** rendered remotely in three categories:

- **Telehealth**: Which uses special telecommunication equipment between an originating site (i.e. hospital, clinic, etc.) where the patient presents, and a distant provider; this will be expanded to allow the originating site to be the patient's home, using applications such as FaceTime or Skype.

- **Virtual Check-Ins**: Which can use phone service without video and/or images sent to the provider by the patient.

- **E-Visits:** Communications with patients conducted over a provider's online patient portal.

The expansion is limited to professional fees reported on a CMS1500/837p claim form by an enrolled physician or non-physician practitioner.It does not extend to facility fee claims.

The expansion is NOT limited to rural areas.

The **PARA Data Editor Advisor** tab offers a handy central repository of CMS announcements related to COVID19 and the national emergency declaration.

CMS issued a separate press release which explains that, under the emergency expansion, "…Medicare beneficiaries will be able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves or others at risk. …"

CMS addresses HIPAA concerns both within the Fact Sheet (link here https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet) which specifically mentions the use of telecommunications that will serve the patient in the home, such as FaceTime or Skype:

> *HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.*

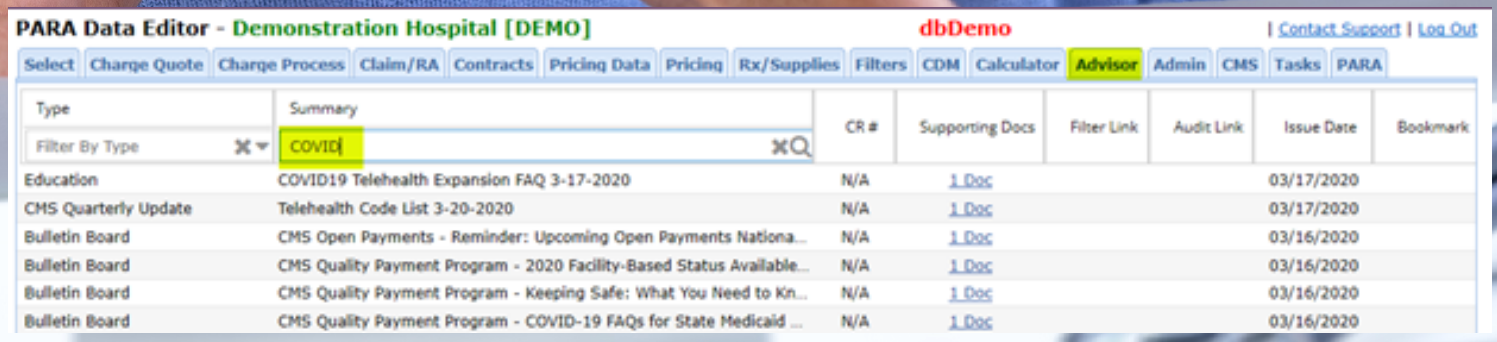
For more information:
https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Links to additional CMS and HHS announcements relating to providers and the national emergency declaration are provided below:

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

https://apps.para-hcfs.com/para/Documents/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

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



Con't.

Medicare Expands Payment For Professional Services Via Telehealth, Virtual Check-Ins, And E-Visits Under National Emergency Authority

Medicare Telehealth Frequently Asked Questions (FAQs)
March 17, 2020

1. **Q: How will recently enacted legislation allow CMS to utilize Medicare telehealth to address the declared Coronavirus (COVID-19) public health emergency?**

   A: The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home.

COVID-19 Emergency Declaration
Health Care Providers Fact Sheet

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers combat and contain the spread of 2019 Novel Coronavirus Disease (COVID-19). In response to COVID-19, CMS is empowered to take proactive steps through 1135 waivers and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are available:

Coverage and Payment Related to COVID-19
Medicare

Original Medicare

Diagnostic Tests

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

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Notification of Enforcement Discretion for telehealth remote communications during the COVID-19 nationwide public health emergency

We are empowering medical providers to serve patients wherever they are during this national public health emergency. We are especially concerned about reaching those most at risk, including older persons and persons with disabilities. – Roger Severino, OCR Director.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

CMS

COVID-19 FAQs

Is the HIPAA Privacy Rule suspended during a national or public health emergency?

Answer:

No; however, the Secretary of HHS may waive certain provisions of the Rule under the Project Bioshield Act of 2004 (PL 108-276) and section 1135(b)(7) of the Social Security Act.

What provisions may be waived

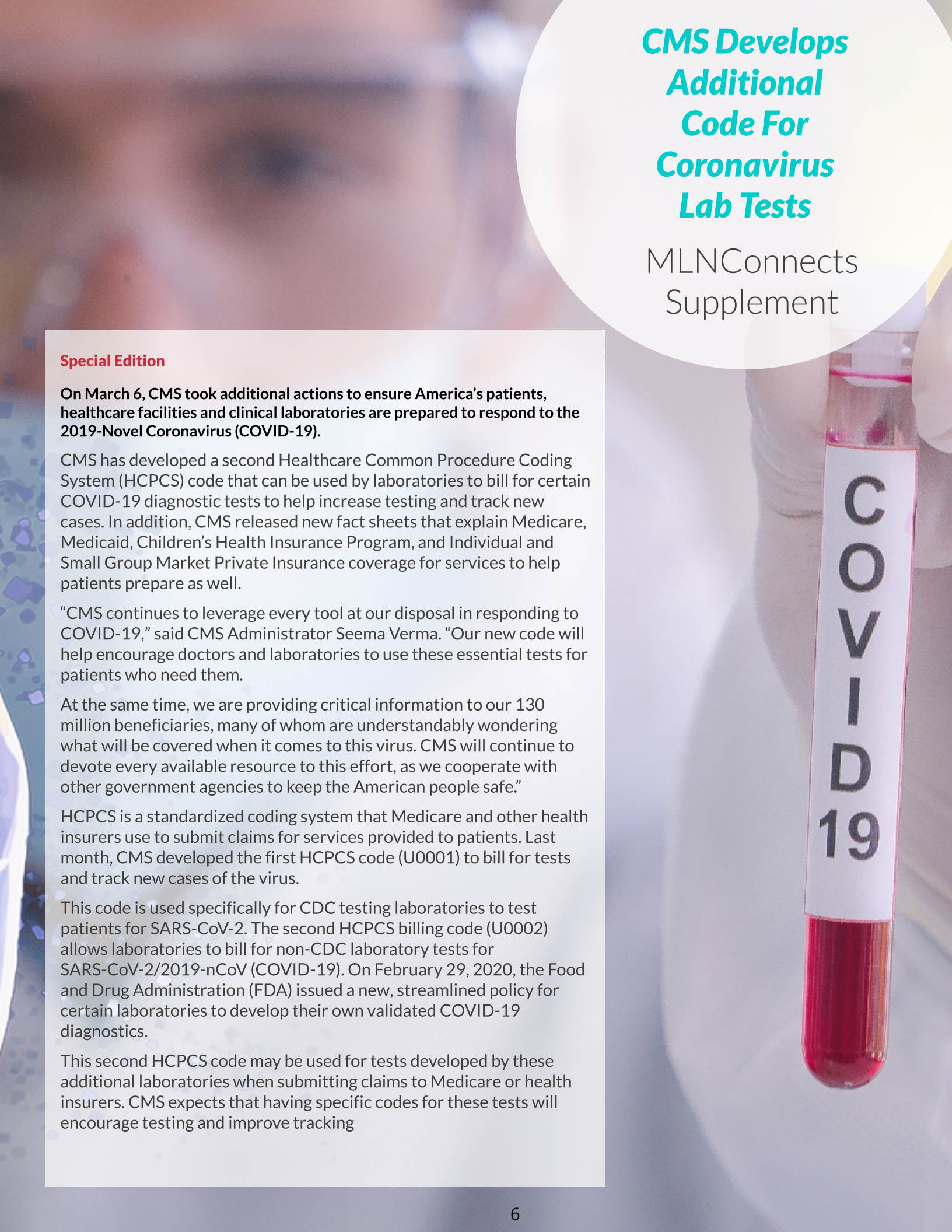
If the President declares an emergency or disaster *and* the Secretary declares a public health emergency, the Secretary may waive sanctions and penalties against a covered hospital that does not comply with certain provisions of the HIPAA Privacy Rule:

1. the requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care (45 CFR 164.510(b))
2. the requirement to honor a request to opt out of the facility directory (45 CFR 164.510(a))
3. the requirement to distribute a notice of privacy practices (45 CFR 164.520)
4. the patient's right to request privacy restrictions (45 CFR 164.522(a))
5. the patient's right to request confidential communications (45 CFR 164.522(b))

https://www.hhs.gov/hipaa/for-professionals/faq/1068/is-hipaa-suspended-during-a-national-or-public-health-emergency/index.html

CMS Develops Additional Code For Coronavirus Lab Tests

MLNConnects Supplement



Special Edition

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

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

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

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

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

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

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

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020.

Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates.

Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them.

As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

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

Other Important Links:

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

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights(PDF): Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states.

States are required to provide both inpatient and outpatient hospital services to beneficiaries.

All states provide coverage of hospital care for children and pregnant women enrolled in CHIP.

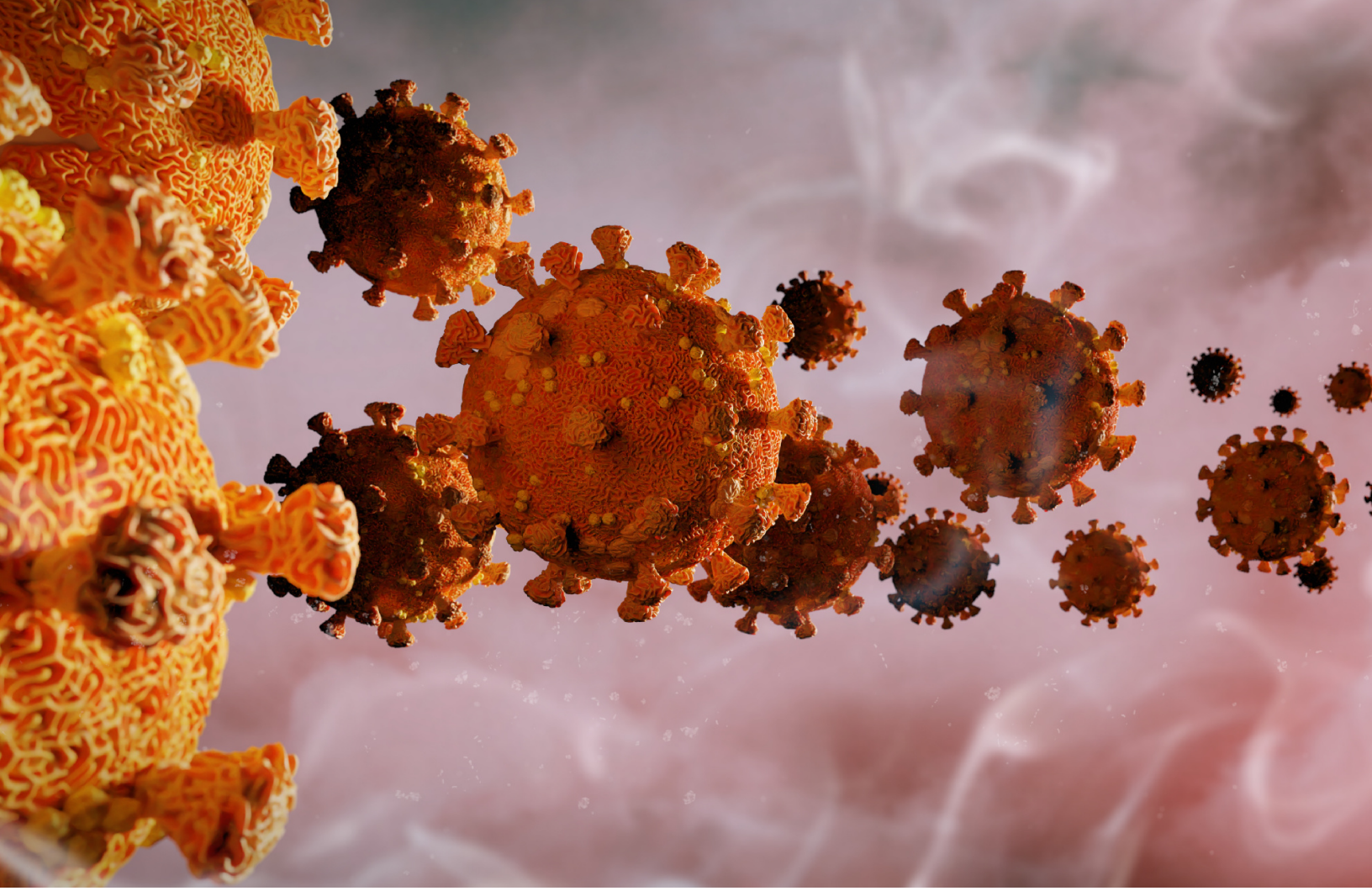
Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage(PDF):

CMS Announces Actions to Address Spread of Coronavirus.

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

View this edition as PDF (PDF)



Coding changes are evolving rapidly in response to the national COVID-19 emergency.

New codes have been released for the COVID-19 testing and are listed here:

Question: When should CPT® code 87635 be used versus the HCPCS codes established by CMS?

Answer: Code selection is based on the payer.

For Medicare patients, report the HCPCS Level II codes (U0002).

The CPT® and HCPCS level II codes should not be reported on the same claim.

Contact your local third-party payer directly to determine their specific reporting guidelines.

Medicare will accept claims billed with HCPCS code U0002 beginning on April 1, 2020 for dates of service starting February 4, 2020.

AMA Current Procedural Terminology (CPT®) Editorial Panel approved a new, specific CPT code to describe laboratory testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).	
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Medicare Claims: HCPCS codes established by the Centers for Medicare & Medicaid Services (CMS) for Coronavirus testing	
U0001	Specifically, for CDC testing laboratories to test patients for SARS-CoV-2 and to track new cases of the virus
U0002	Intended for laboratories to report non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

Coronavirus Update

As Of March 23, 2020

What is the Coronavirus?

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

The 2019 Novel Coronavirus is a new form of coronavirus first identified in Wuhan, Hubei Province, China.

This virus is officially named "SARS-CoV2" which is a betacoronavirus.The disease it causes is now referred to as COVID-19 (previously referred to as 2019-nCoV).

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

Symptoms of the COVID-19 can include fever, cough and shortness of breath.

However, some patients with confirmed COVID-19 have developed little to no symptoms depending on the incubation period.

The CDC reported, "Symptoms may appear in as few as 2 days or as long as 14 after exposure ".

The CDC has developed a real-time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens.

ICD-10 CM: Coding COVID-19

As new clinical information becomes available, detail in coding selection may be revised.

The ICD-10-CM codes provided in this reference are intended to provide information on the coding of encounters related to coronavirus.

All coding selections should be supported by documentation.

Respiratory conditions such as Pneumonia, Bronchitis, Respiratory Infection and Acute Respiratory Distress Syndrome (ARDS) have been identified in patients with confirmed COVID-19 diagnosis.

Con't. Coronavirus Upda

Confirmed Cases:

New code available 4-1-20: For confirmed cases of COVID-10, report ICD-10 CM code U07.1,2019-nCoV acute respiratory disease.

On Wednesday, March 18, 2020, the Centers for Disease Control (CDC) announced that the ICD-10-CM diagnosis code, previously slated to be effective October 1, 2020, will now be effective April 1, 2020.

This code should only be reported for confirmed COVID-19 cases.

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

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

PARA - Healthcare Financial Services
ICD10 Codes

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

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

PARA - Healthcare Financial Services
ICD10 Codes

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

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

PARA - Healthcare Financial Services
ICD10 Codes

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

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

PARA - Healthcare Financial Services
ICD10 Codes

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

ate

As Of March 23, 2020

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

PARA - Healthcare Financial Services
ICD10 Codes

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

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

PARA - Healthcare Financial Services
ICD10 Codes

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

Concern for or Exposure to COVID-19

In some cases, the patient may be evaluated for exposure or possible exposure to the COVID-19; however, after the evaluation the condition may be ruled out.In those cases, it would not be appropriate to report a code for the actual virus.

Please refer to the **PARA Data Editor** code descriptions for exposure without symptoms.

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

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

PARA - Healthcare Financial Services
ICD10 Codes

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

When documenting signs and symptoms, the coder should report that symptom rather than a code for exposure or possible exposure. Please refer to the **PARA Data Editor** for symptom code descriptions.

PARA - Healthcare Financial Services
ICD10 Codes

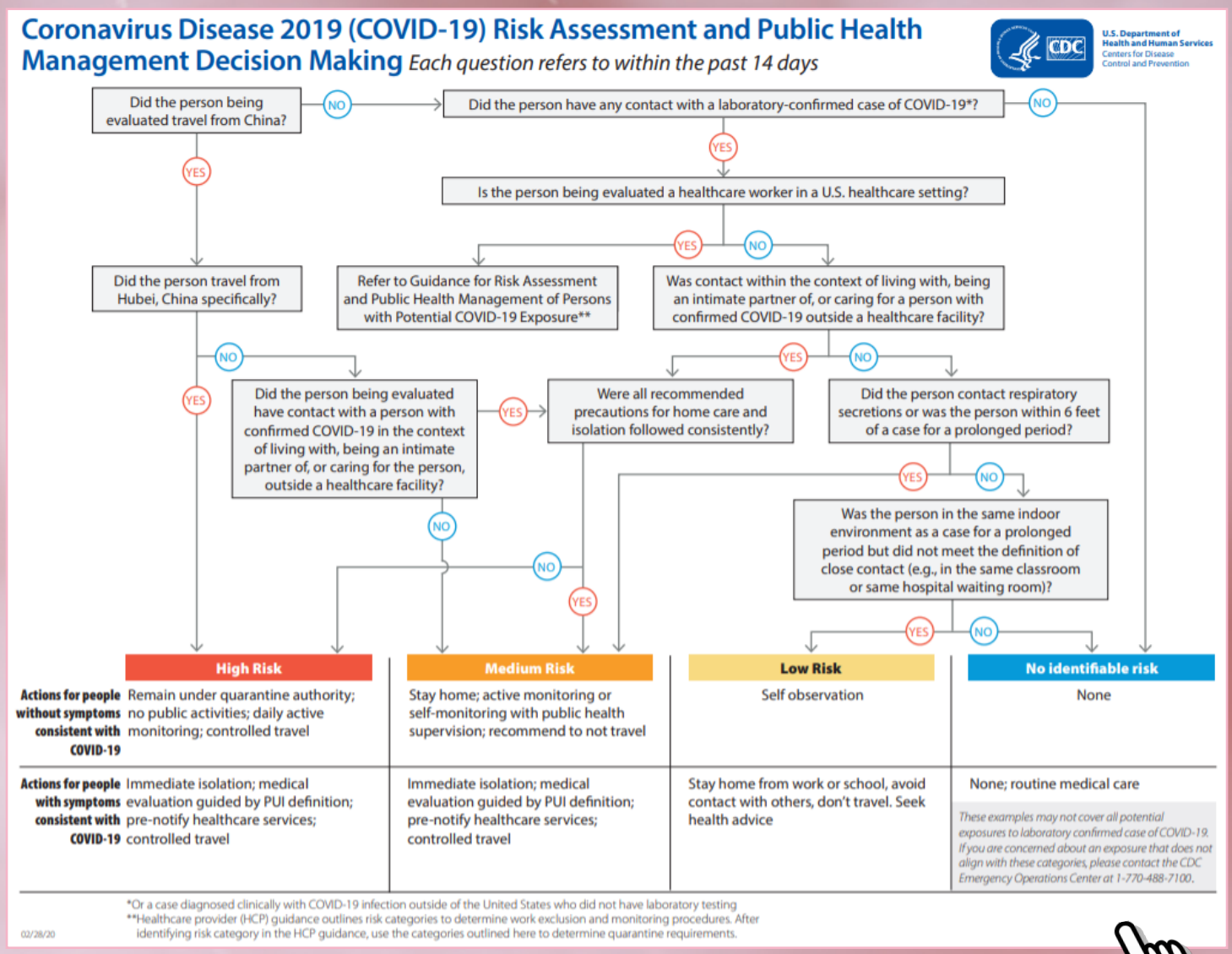
ICD10 Code	Description
R05	Cough
R0602	Shortness of breath
R509	Fever, unspecified

Con't. Coronavirus Update

Risk Assessment

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

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



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

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

PARA
HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

An Open Letter To HealthCare Providers

With all of the recent restrictions for the crisis, we are reaching out to all of our clients and prospects that we have had conversations with to assist them if their internal insurance follow up teams are unable to work or will be experiencing shortages.

PARA HealthCare Analytics and **Healthcare Financial Resources (HFRI)**, is now operating remotely 100% and have the capacity to help out with any hospital system that are experiencing any pain.

If any of this is of interest to you please let us know. We are here to help.

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EXTREMITY ANGIOPLASTY

Q. What codes should be reported for right upper extremity angioplasty w/ left lower extremity angiogram based on the documentation? We are considering 76937, 36246 w/ modifier XS, 75710 w/ modifier XS, 37246. Please advise.

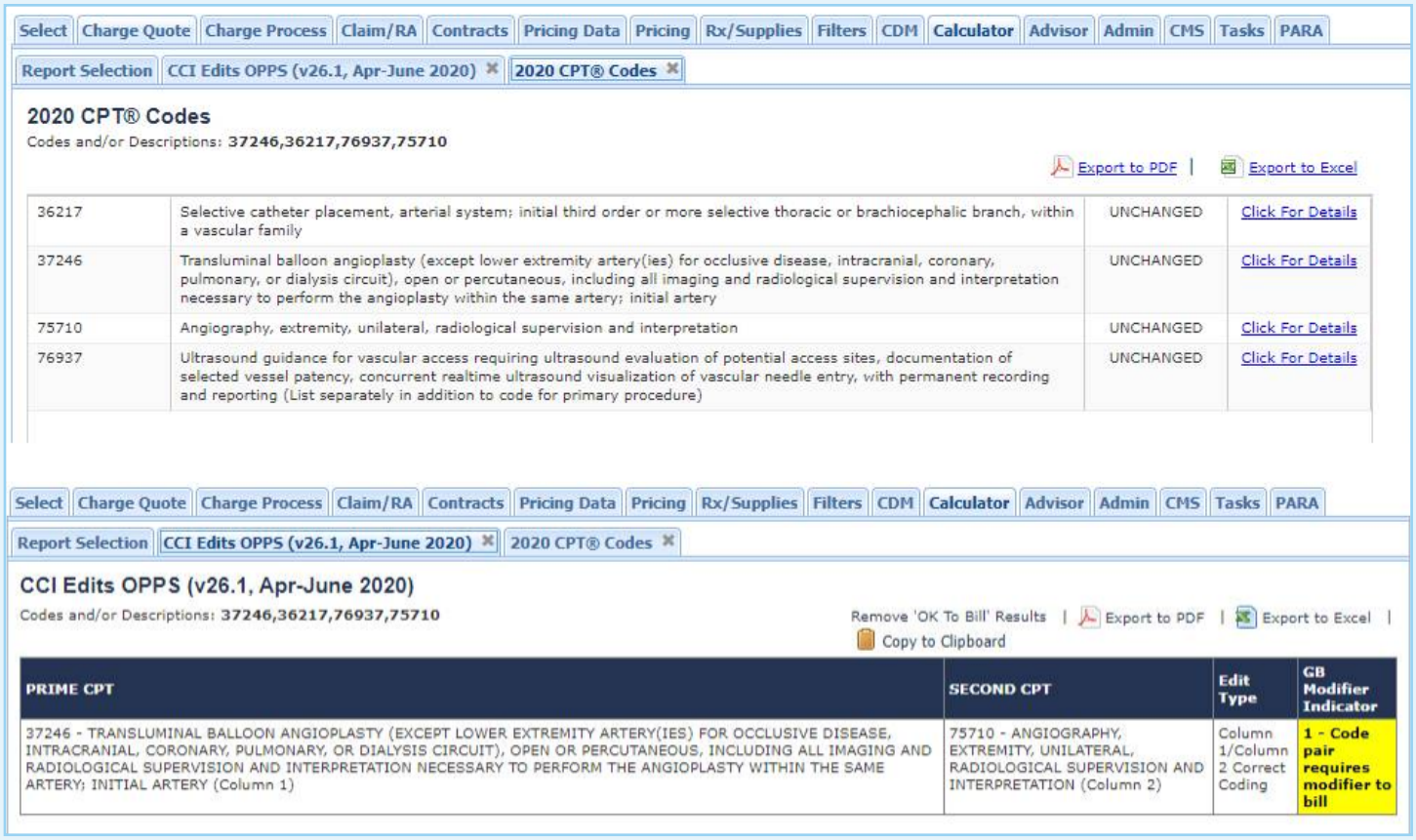
A. **Answer:** Report CPT® codes 37246, 36217, 76937 and 75710-59 for the upper extremity, and CPT codes 36246 and 75710-XS for the lower extremity. There are no edits that would require a modifier on the second code 36246.

CPT® code 75710 is reported twice to reflect that there are distinct unilateral extremities imaged. In the right upper extremity, apply modifier -59 to bypass the NCCI edit with code 37246. The modifier is applied to indicate it is diagnostic in nature, and the basis for intervention, prior to the intervention being performed.

The 2020 CPT® manual instructional guideline states "If diagnostic angiography is necessary, is performed at the same session as the interventional procedure and meets the above criteria, modifier 59 must be appended to the diagnostic radiological supervision and interpretation code(s) to denote that diagnostic work has been done following these guidelines."

For the left lower extremity, append modifier -XS to bypass the NCCI edit with code 37246 to indicate that the lower extremity angiography is a distinct site from the upper extremity angioplasty. AHA Coding Clinic for HCPCS - Second Quarter 2014 Page: 3-7 discusses it is appropriate to use modifiers to bypass edits when the procedures are performed on "different anatomic regions".

Please refer to the **PARA Data Editor** code description and CCI edits.



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

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

2020 CPT® Codes

Codes and/or Descriptions: **37246,36217,76937,75710**

Export to PDF | Export to Excel

36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	UNCHANGED	Click For Details
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	UNCHANGED	Click For Details
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	UNCHANGED	Click For Details
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	UNCHANGED	Click For Details

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

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

CCI Edits OPPS (v26.1, Apr-June 2020)

Codes and/or Descriptions: **37246,36217,76937,75710**

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

PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
37246 - TRANSLUMINAL BALLOON ANGIOPLASTY (EXCEPT LOWER EXTREMITY ARTERY(IES) FOR OCCLUSIVE DISEASE, INTRACRANIAL, CORONARY, PULMONARY, OR DIALYSIS CIRCUIT), OPEN OR PERCUTANEOUS, INCLUDING ALL IMAGING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION NECESSARY TO PERFORM THE ANGIOPLASTY WITHIN THE SAME ARTERY; INITIAL ARTERY (Column 1)	75710 - ANGIOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 2)	Column 1/Column 2 Correct Coding	**1 - Code pair requires modifier to bill**

REHAB AND G2061-2063

Q. Received an email from our Rehab department wanting to bill G2061-G2063. Does the telemed waiver 1135 from CMS expand coverage to these codes to billed by an institution rather then as a prof fee? Information attached from APTA indicating that this is ok to bill.

A. **Answer:** An enrolled therapist can be paid by Medicare for the codes G2061-G2063 on a professional fee claim only – hospitals cannot be paid for these codes, they are OPPS status M – not paid.

2020 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **G206** for selected Provider:
Results returned(below): 9
AWI: **1**, DME: **WY**, Clinical Lab Fee Schedule: **WY**, Physician Fee Schedule:**WYOMING**

Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule	Initial APC	Payment
G2061 - qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes **M - Not paid under OPPS.** **Berenson-Eggers Type of Service:** M5D - SPECIALIST - OTHER	GB (Physician Facility): $12.22 GB (Physician Non-Facility): $12.22		
G2062 - qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes **M - Not paid under OPPS.** **Berenson-Eggers Type of Service:** M5D - SPECIALIST - OTHER	GB (Physician Facility): $21.55 GB (Physician Non-Facility): $21.55		
G2063 - qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes **M - Not paid under OPPS.** **Berenson-Eggers Type of Service:** M5D - SPECIALIST - OTHER	GB (Physician Facility): $33.41 GB (Physician Non-Facility): $33.77		

The G2061-G0263 codes may be reported on a professional fee claim when rendered by clinicians who may not independently bill (i.e. Physical therapists etc.). However, the individual has to have been enrolled with Medicare so that their NPI, when reported on the "rendering" line, will be accepted. If the "rendering" NPI on a professional fee claim is not an enrolled provider, they will reject the claim. You might find out if your therapists are already enrolled as individuals (for instance, if they work at other clinics besides the hospital.)

Medicare has announced an expedited enrollment process to help meet the need for additional healthcare providers during the national emergency. Therefore, it may be possible to have your therapists enrolled in short order. To read more about this process, visit: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

The hospital could enroll the therapists under the existing medical group, and then the therapist could work out of one of the clinics to bill the G2061-G2063 codes on a professional fee claim.

Attached is the CMS 855i enrollment form for individuals, such as doctors and non-physician practitioners. There is also a means of enrolling online via PECOS, but we believe there are some signature pages that must be submitted on paper when enrolling a provider for the first time. Your Medicare Administrative Contractor can guide you through the process.

The last time we checked, a provider would be eligible for reimbursement from the day the successful application was submitted. You'd have to hold claims until the application was approved. If the application is rejected for any reason (a technicality, usually) then the clock starts when the new application is submitted again.

REHAB AND G2061-2063

Here's a screen shot from the Medicare enrollment application (855i) for non-physicians.

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

H. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

If you are an eligible professional, check the appropriate box below to indicate your specialty.

All individuals must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

Check only one of the following: If you have multiple non-physician specialty types, you must complete and submit a separate CMS-855I application for each non-physician specialty type.

- ☐ Anesthesiology Assistant
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Certified Clinical Nurse Specialist (CNS) (See section 2L)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller (See section 2L)
- ☐ Nurse Practitioner (See section 2L)
- ☐ Occupational Therapist In Private Practice (See section 2K)
- ☐ Physical Therapist In Private Practice (See section 2K)
- ☐ Physician Assistant (See section 2I)
- ☐ Psychologist, Clinical (See section 2J)
- ☐ Psychologist Billing Independently (See section 2J2)
- ☐ Qualified Audiologist
- ☐ Qualified Speech Language Pathologist
- ☐ Registered Dietitian or Nutrition Professional
- ☐ Undefined Non-Physician Practitioner Specialty

(Specify): _____

The 855i is just the first bit of paperwork that needs to be processed. There are several other forms that require completion before a provider is fully enrolled.

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf

CMS

2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)

1. **How is CMS using its authority under Section 1135 of the Social Security Act to offer flexibilities with Medicare provider enrollment to support the 2019-Novel Coronavirus (COVID-19) national emergency?**

CMS is exercising its 1135 waiver authority in the following ways:

Physicians and Non-Physician Practitioners

- Establish toll-free hotlines to enroll and receive temporary Medicare billing privileges
- Waive the following screening requirements:
  - Criminal background checks associated with fingerprint-based criminal background checks (FCBC) - 42 C.F.R 424.518 (to the extent applicable)
  - Site visits - 42 C.F.R 424.517
  - Postpone all revalidation actions

All Other Providers and Suppliers (including DMEPOS)

- Expedite any pending or new applications
  - All clean web applications will be processed within 7 business days and all clean paper applications in 14 business days
- Waive the following screening requirements for all enrollment applications received on or after March 1, 2020:
  - Application Fee – 42 C.F.R. 424.514
  - Criminal background checks associated with the FCBC – 42 C.F.R. 424.518 (to the extent applicable)
  - Site-visits – 42 C.F.R. 424.517
  - Postpone all revalidation actions

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO: HTTPS://PECOS.CMS.HHS.GOV

CMS

CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN

In a transmittal announcing the April 1 2020 update of the OPPS released on March 6, 2020, CMS implemented new coverage and payment rates for acupuncture and dry needling for low back pain.

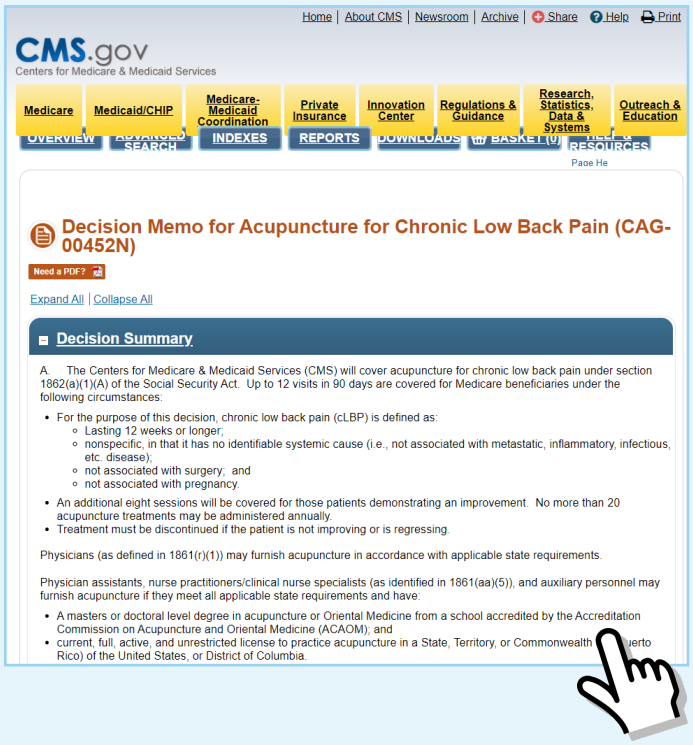
The following HCPCS will be changed from "excluded" status E1 to status S –separately

CPT®	Long Description	OPPS Status Indicator	OPPS APC
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	S	5731
20561	Needle insertion(s) without injection(s); 3 or more muscles	S	5731
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	S	5731
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)	N	N/A
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	S	5731
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)	N	N/A

CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN

Excerpts from the Decision Memo appear here:

https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=295



Decision Memo for Acupuncture for Chronic Low Back Pain (CAG-00452N)

A. The Centers for Medicare & Medicaid Services (CMS) will cover acupuncture for chronic low back pain under section 1862(a)(1)(A) of the Social Security Act.Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

- For the purpose of this decision, chronic low back pain (cLBP) is defined as:
  - -Lasting 12 weeks or longer;
  - -nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
  - -not associated with surgery;and
  - -not associated with pregnancy
- An additional eight sessions will be covered for those patients demonstrating an improvement.No more than 20 acupuncture treatments may be administered annually
- Treatment must be discontinued if the patient is not improving or is regressing

Physicians (as defined in 1861(r)(1)) may furnish acupuncture in accordance with applicable state requirements.

Physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

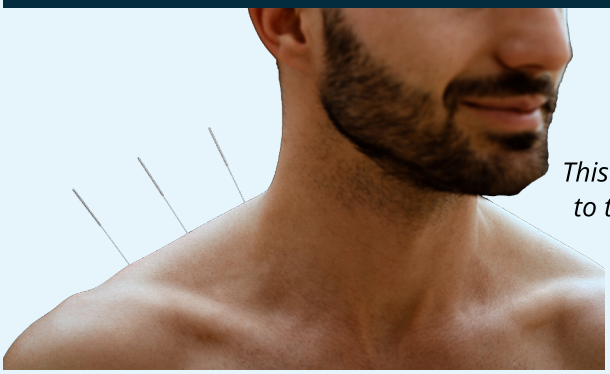
Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist required by our regulations at 42 CFR §§ 410.26 and 410.27.

...

The decision memo is lengthy, and includes an appendix which provides language in red text which will be added to the National Coverage Determination manual for these services.

That appendix appears on the next page.

CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN



APPENDIX B
Medicare National Coverage Determinations Manual

This draft NCD is subject to formal revisions and formatting changes prior to the release of the final NCD contractor instructions and publication in the Medicare National Coverage Determinations Manual.

Table of Contents
(Rev.)

30.3.3 - ACUPUNCTURE

The Centers for Medicare & Medicaid Services (CMS) is finalizing changes to its acupuncture National Coverage Determination (NCD) policy that will expand Medicare coverage. The scope of this review is limited to acupuncture for chronic low back pain (cLBP) and will be manualized under NCD 30.3.3, Acupuncture for cLBP. However, any corresponding policy changes that appear in the final decision memorandum will also be manualized in changes to NCD 30.3, Acupuncture. In addition, clarifying changes would be necessary in NCD 30.3.1, Acupuncture for Fibromyalgia and NCD 30.3.2, Acupuncture for Osteoarthritis.

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications

Effective for services performed on or after January 21, 2020 CMS will cover acupuncture for Medicare patients

with chronic low back pain. Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

- *For the purpose of this decision, chronic low back pain (cLBP) is defined as:*
  - *Lasting 12 weeks or longer;*
  - *nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);*
  - *not associated with surgery; and*
  - *not associated with pregnancy*

- *An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.*

- *Treatment must be discontinued if the patient is not improving or is regressing.*

  Physicians (as defined in 1861(r)(1)) may furnish acupuncture in accordance with applicable state requirements.

  Physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- *A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,*

- *Current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.*

Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist required by our regulations at 42 CFR §§ 410.26 and 410.27. ***C. Nationally Non-Covered Indications***

All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare.

D. Other *N/A*

CMS COVERS ACUPUNCTURE, DRY NEEDLING FOR LOW BACK PAIN

30.3 - ACUPUNCTURE

A. General

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications

Effective for claims with dates of service on and after January 21, 2020, acupuncture is only covered for chronic low back pain under section 1862(a)(1)(A) of the Social Security Act (the Act). See National Coverage Determination section 30.3.3 for specific coverage criteria.

C. Nationally Non-Covered Indications

Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic or for other therapeuticpurposes, may not be made unless the specific indication is excepted. Accordingly, acupuncture is not considered reasonable and necessary within the meaning of §1862(a)(1)(A) of the Act. All indications for acupuncture outsided of NCD section 30.3.3 remain non-covered.

D. Other *N/A*

30.3.1 – ACUPUNCTURE FOR FIBROMYALGIA

A. General

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications *N/A for acupuncture for fibromyalgia.*

C. Nationally Non-Covered Indications

Effective for claims with dates of service on and after April 16, 2004, after careful reconsideration of its initial non-coverage determination for acupuncture, the Centers for Medicare & Medicaid Services (CMS) concludes that there is no convincing evidence for the use of acupuncture for pain relief in patients with fibromyalgia. Study design flaws presently prohibit assessing acupuncture's utility for improving health outcomes. Accordingly, CMS determines that acupuncture is not considered reasonable and necessary for the treatment of fibromyalgia within the meaning of §1862(a)(1) of the Social Security Act, and the national non-coverage determination for acupuncture for fibromyalgia continues.

D. Other *N/A (This NCD last reviewed April 2004.)*

30.3.2 – ACUPUNCTURE FOR OSTEOARTHRITIS

A. General

Acupuncture is the selection and manipulation of specific acupuncture points by penetrating the skin with fine needles.

B. Nationally Covered Indications

N/A for acupuncture for osteoarthritis.

C. Nationally Non-Covered Indications

Effective for claims with dates of service on and after April 16, 2004, after careful reconsideration of its initial non-coverage determination for acupuncture, the Centers for Medicare & Medicaid Services (CMS) concludes that there is no convincing evidence for the use of acupuncture for pain relief in patients with osteoarthritis. Study design flaws presently prohibit assessing acupuncture's utility for improving health outcomes. Accordingly, CMS determines that acupuncture is not considered reasonable and necessary for the treatment of osteoarthritis within the meaning of §1862(a)(1) of the Social Security Act, and the national non-coverage determination for acupuncture for osteoarthritis continues.

D. Other *N/A (This NCD last reviewed April 2004.)*

REVISED MOON FORM REQUIRED APRIL 1, 2020

On January 20, 2017, CMS released Transmittal 3695, which finalizes language in the Medicare Claims Processing Manual relating to the requirements of the "**Medicare Outpatient Observation Notice**" (MOON).

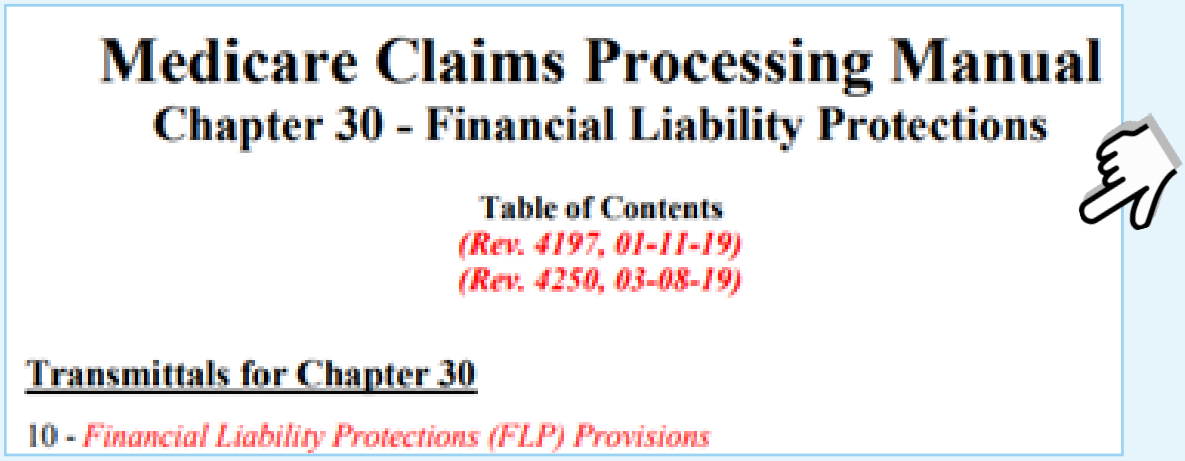
Beginning April 1, 2020, hospitals and CAHs are required to use the new MOON form that extends the expiration date to December 31, 2022.

Hospitals may either use the old or the current form through March 31, 2020.A download for English and Spanish versions of the new MOON form are available from the link below:

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

Chapter 30 of the Medicare Claims Processing Manual Section 400 provides information and instructions on the requirements of the MOON:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf



Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

Table of Contents

(Rev. 4197, 01-11-19)

(Rev. 4250, 03-08-19)

Transmittals for Chapter 30

10 - *Financial Liability Protections (FLP) Provisions*

The language changes operationalize the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), which became law in August 2015.Under this law, all hospitals and critical access hospitals (CAHs) are required to provide written notification and an oral explanation of such information to individuals receiving observation services as outpatients for greater than 24 hours.

The NOTICE Act, 2017 IPPS rule, and a CMS Frequently Asked Questions update are available on the **PARA Data Editor Advisor** tab.

Use the search term MOON:

REVISED MOON FORM REQUIRED APRIL 1, 2020

PARA Data Editor - Demonstration Hospital [DEMO] dbDemo | Contact Sup

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

Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date
Filter By Type	MOON					
Bulletin Board	Cahaba GBA -Moon Outpatient Observation Notice (MOON)	N/A	1 Doc			07/24/2017
Links	CMS FAQ MOON Notice Update	N/A	1 Doc			03/08/2017
Bulletin Board	CMS Medicare Outpatient Observation Notice (MOON)	N/A	1 Doc			02/12/2017
CMS Quarterly Update	Standard MOON Notice Now Required	N/A	1 Doc			01/27/2017
Transmittals	R3698CP - Medicare Outpatient Observation Notice (MOON) Instructi...	N/A	1 Doc			01/27/2017
Med Learn	MM9935 - Medicare Outpatient Observation Notice (MOON) Instructi...	N/A	1 Doc			01/24/2017
Transmittals	R3695CP - Medicare Outpatient Observation Notice (MOON) Instructi...	N/A	1 Doc			01/20/2017
Transmittals	MOON Notice - Final	N/A	1 Doc			12/08/2016
Bulletin Board	CMS Updated: MOON draft available for comment / MOON implemen...	N/A	1 Doc			08/18/2016
Links	NOTICE Act of 2015	N/A	1 Doc			05/03/2016
CMS Quarterly Update	2016 IPPS Final Rule	N/A	1 Doc			04/27/2016

Congress passed the NOTICE Act in August 2015 to prevent Medicare beneficiaries from being blind-sided by patient liability, which is calculated very differently for patients in inpatient status versus observation status, particularly as it pertains to subsequent Skilled Nursing Facility stays. Medicare provides coverage for a medically necessary SNF stay provided it follows a three-day inpatient stay. Beneficiaries discharged to SNF care following three days of observation care, however, have discovered that Medicare will not cover the SNF care.

According to the Medicare Claims Processing Manual:

400.3.3 - Hospital Delivery of the MOON
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals and CAHs must deliver the MOON to beneficiaries in accordance with section 400.2 above. Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification.

Since the NOTICE Act has been in effect since August 2015, many hospitals have created an improvised notice that resembles the CMS form. Some hospitals have been providing the beneficiary publication from Medicare at the following link:

https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf

Revised August 2018

Are You a Hospital Inpatient or Outpatient?

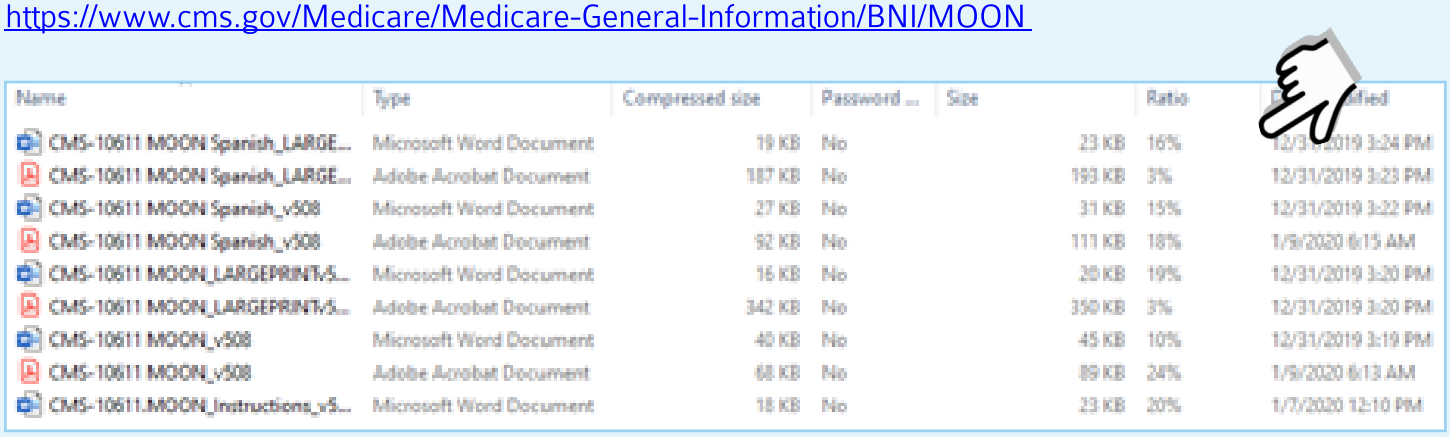
If You Have Medicare – Ask!

Did you know that even if you stay in a hospital overnight, you might still be considered an "outpatient?" Your **hospital status** (whether the hospital considers you an "inpatient" or "outpatient") affects how much **you pay** for hospital services (like X-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility (SNF) following your hospital stay.

REVISED MOON FORM REQUIRED APRIL 1, 2020

The link to the newly required form and its instructions is listed below.A copy of the MOON notice appears on the following pages.

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



Name	Type	Compressed size	Password ...	Size	Ratio	Modified
CMS-10611 MOON Spanish_LARGE...	Microsoft Word Document	19 KB	No	23 KB	16%	12/31/2019 3:24 PM
CMS-10611 MOON Spanish_LARGE...	Adobe Acrobat Document	187 KB	No	193 KB	3%	12/31/2019 3:23 PM
CMS-10611 MOON Spanish_v508	Microsoft Word Document	27 KB	No	31 KB	15%	12/31/2019 3:22 PM
CMS-10611 MOON Spanish_v508	Adobe Acrobat Document	92 KB	No	111 KB	18%	1/9/2020 6:15 AM
CMS-10611 MOON_LARGEPRINTv5...	Microsoft Word Document	16 KB	No	20 KB	19%	12/31/2019 3:20 PM
CMS-10611 MOON_LARGEPRINTv5...	Adobe Acrobat Document	342 KB	No	350 KB	3%	12/31/2019 3:20 PM
CMS-10611 MOON_v508	Microsoft Word Document	40 KB	No	45 KB	10%	12/31/2019 3:19 PM
CMS-10611 MOON_v508	Adobe Acrobat Document	68 KB	No	89 KB	24%	1/9/2020 6:13 AM
CMS-10611.MOON_Instructions_v5...	Microsoft Word Document	18 KB	No	23 KB	20%	1/7/2020 12:10 PM

Page 1 of 2:

(Hospitals may include contact information or logo here)

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Form CMS 10611-MOON Expiration 12/31/2022 OMB approval 0938-1308

REVISED MOON FORM REQUIRED APRIL 1, 2020

Page 2 of 2:

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

_____ Signature of Patient or Representative

_____ Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS 10611-MOON

Expiration 12/31/2022 OMB approval 0938-1308

REVISED MOON FORM REQUIRED APRIL 1, 2020

MOON Notice Instructions:

Notice Instructions: Medicare Outpatient Observation Notice

Page 1 of the Medicare Outpatient Observation Notice (MOON)

The following blanks must be completed by the hospital. Information inserted may be typed or legibly hand-written in 12-point font or the equivalent.

Patient Name:

Fill in the patient's full name or attach patient label.

Patient ID number:

Fill in an ID number that identifies this patient, such as a medical record number or the patient's birthdate or attach a patient label. This number should not be the patient's social security number.

"You're a hospital outpatient receiving observation services. You are not an inpatient because:"

Fill in the specific reason the patient is in an outpatient, rather than an inpatient stay.

Page 2 of the MOON

Additional Information:

This may include, but is not limited to, Accountable Care Organization (ACO) information, notation that a beneficiary refused to sign the notice, hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs, Part A cost sharing responsibilities if the beneficiary is subsequently admitted as an inpatient, physician name, specific information for contacting hospital staff, or additional information that may be required under applicable state law.

Hospitals may attach additional pages to this notice if more space is needed for this section.

Oral Explanation:

When delivering the MOON, hospitals and CAHs are required to explain the notice and its content, document that an oral explanation was provided and answer all beneficiary questions to the best of their ability.

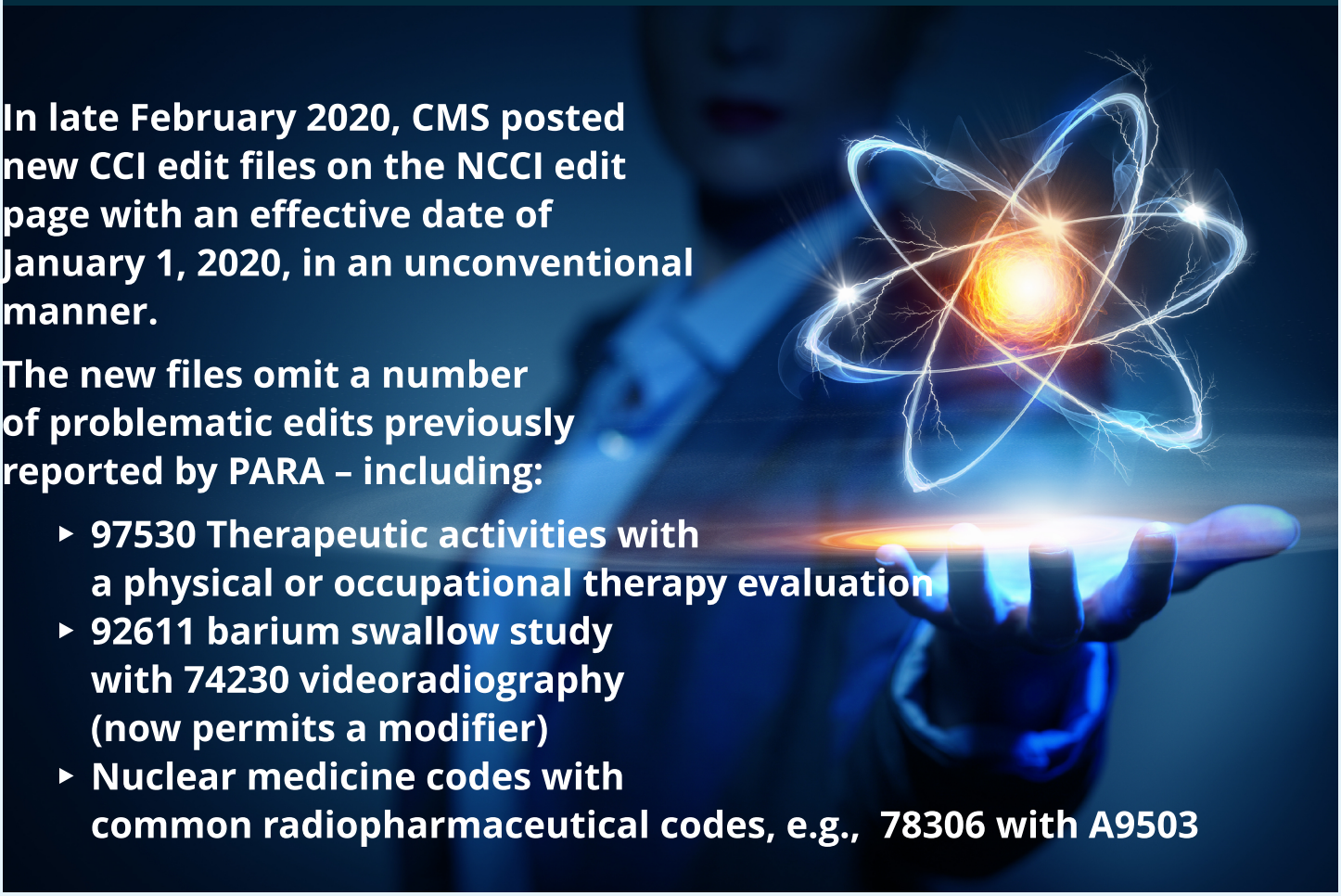
Instructions CMS-10611 OMB expiration: 12-31-2022

Signature of Patient or Representative:

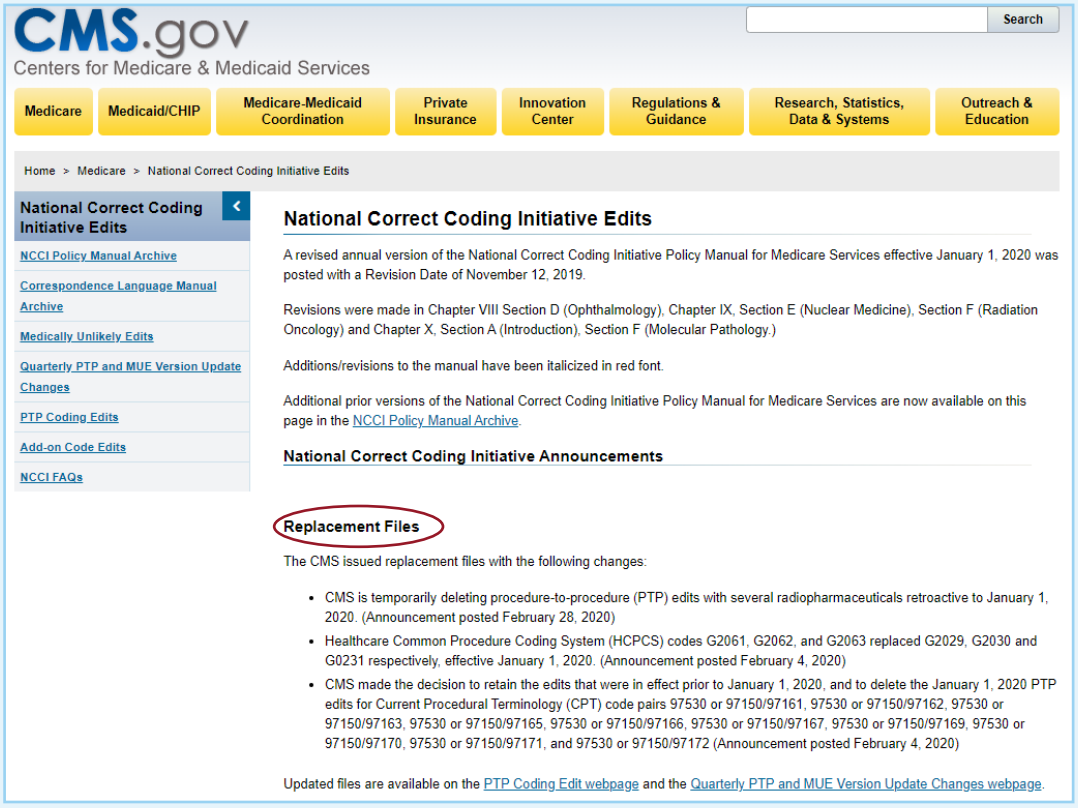
Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents. If a representative's signature is not legible, print the representative's name by the signature.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

REVISED CCI EDIT FILES POSTED



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



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Home > Medicare > National Correct Coding Initiative Edits

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

National Correct Coding Initiative Edits

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

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

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

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

National Correct Coding Initiative Announcements

Replacement Files

The CMS issued replacement files with the following changes:

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

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

REVISED CCI EDIT FILES POSTED

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

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

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

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

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

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

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

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

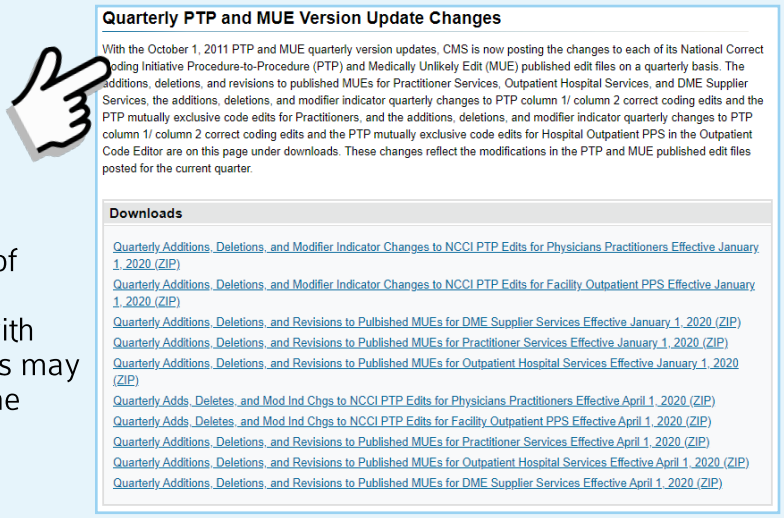
REVISED CCI EDIT FILES POSTED

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

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

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

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



"Medicaid:

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

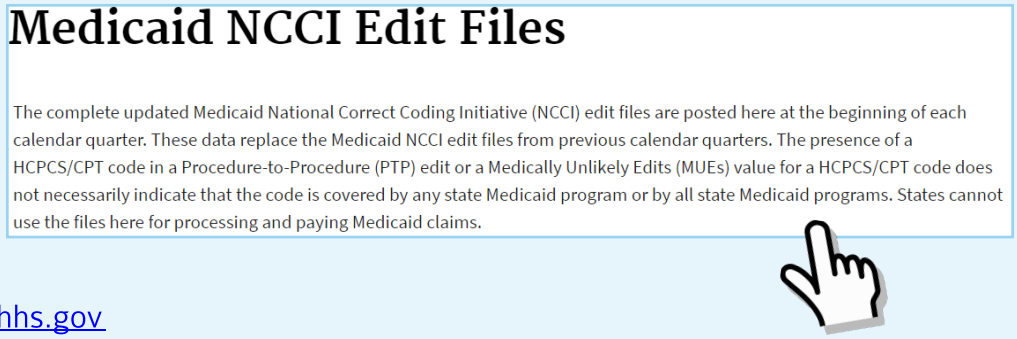
"Providers may choose to delay submission of claims for deleted edits until after the implementation of the replacement edit file with retroactive date of January 1, 2020. Providers may also choose to appeal claims denied due to the PTP edits to the appropriate MAC including supporting documentation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

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

"Sincerely,

Capitol Bridge, LLC

National Correct Coding Initiative Contractor



Email:NCCIPTPMUE@cms.hhs.gov

P.O. Box 368

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

HOSPICE CARE FACT SHEET

Download This Informative Fact Sheet

Timeliness Compliance Threshold for HIS Submissions: Fact Sheet

Updated: February 2020

This fact sheet outlines the timeliness compliance threshold for HIS submissions, finalized by CMS in the FY 2016 Final Rule as well as presenting a preliminary algorithm for the timeliness compliance threshold calculation.

Summary of Timeliness Compliance Threshold for HIS Submission

In Sections E.6.d and E.6.e of the FY 2016 Final Rule, CMS finalized a timeliness compliance threshold for HIS submissions. These policies went into effect for the FY 2018 reporting year, which began January 1, 2016.

- Section E.6.d of the Final Rule states that hospices are required to submit all HIS records (HIS-Admission and HIS-Discharge records) by the submission deadline. The submission deadline for HIS records is 30 days from the event date (the patient's admission to or discharge from the hospice).
- Section E.6.e of the Final Rule states that beginning with the FY 2018 reporting year, in order to avoid the 2 percentage point reduction in their Annual Payment Update (APU), hospices will be required to submit a minimum percentage of their HIS records by the 30 day submission deadline. CMS incrementally increased this compliance threshold over a 3 year period. For the FY 2018 APU determination, at least 70% of all required HIS records must have been submitted within the 30 day submission deadline to avoid the 2 percentage point reduction in the FY 2018 APU. For the FY 2019 APU determination, providers must have submitted 80% of all required HIS records by the 30 day deadline. Finally, for the FY 2020 APU determination and **ALL** subsequent years, providers must submit 90% of all required HIS records according to the 30 day deadline.
- Please note that this compliance threshold is related to the submission deadline for HIS records only; completion deadlines will not be considered in the timeliness compliance threshold calculations.

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 19, 2020

News

·Quality Payment Program: 2020 Facility-Based Status

·Lower Extremity Joint Replacement: Comparative Billing Report in March

·IRF Provider Preview Reports: Review Your Data by April 13

·LTCH Provider Preview Reports: Review Your Data by April 13

·Hospice Provider Preview Reports: Review Your Data by April 13

·IRF Compare Refresh

·LTCH Compare Refresh

·LTCH CARE Data Submission Specifications

·Hospital Quality Reporting: Updated 2020 QRDA I Schematron and Sample File

·Influenza Activity Continues: Are Your Patients Protected?

Compliance

·Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

·SNF Claims Incorrectly Cancelled

Events

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

·Interoperability and Patient Access Final Rule Call — April 7

MLN Matters® Articles

·Ensure Required Patient Assessment Information for Home Health Claims

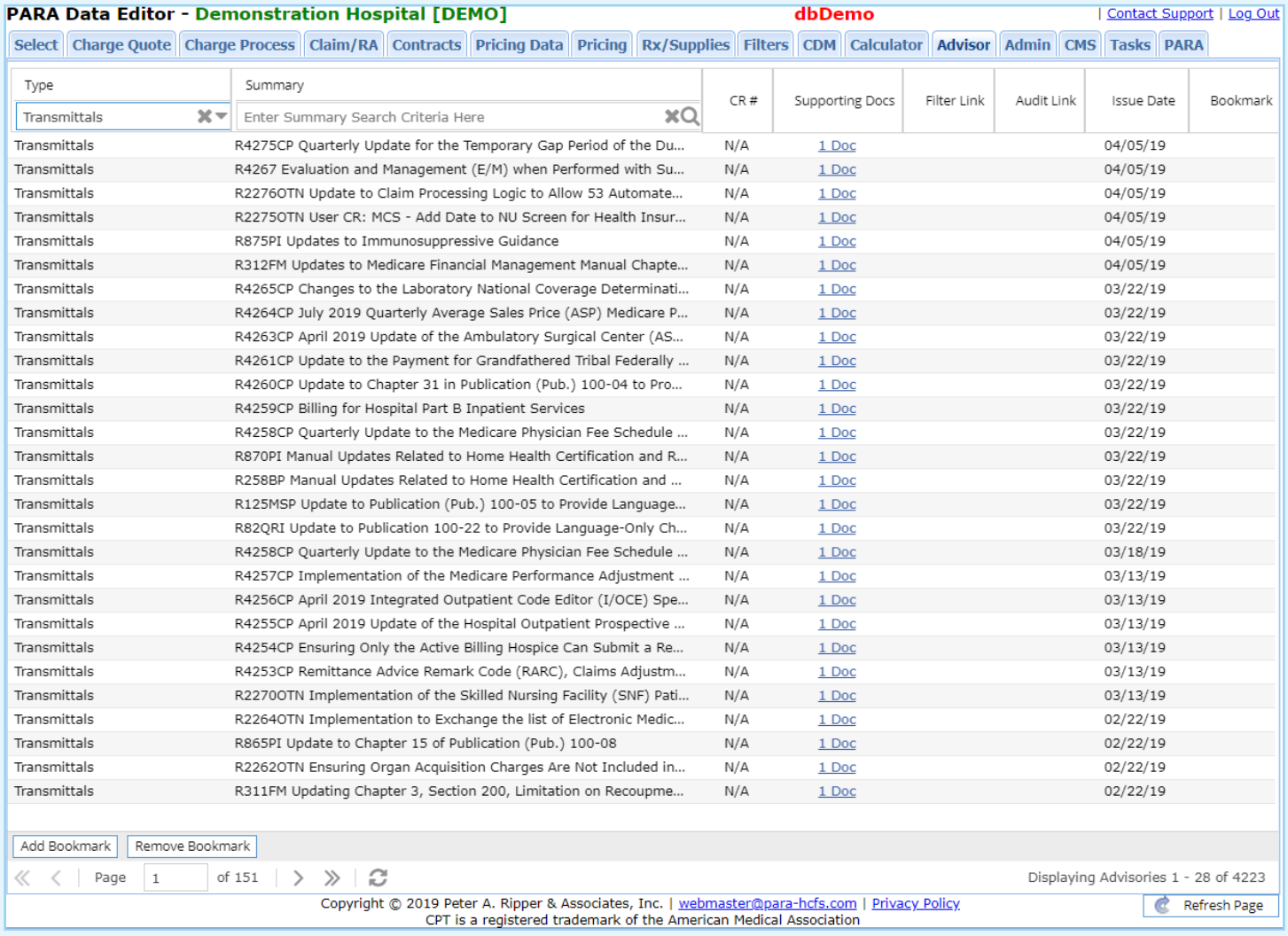
·Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

·Medicare FFS Response to the Public Health Emergency on the Coronavirus (COVID-19) — Revised

There were TWO new or revised MedLearns released this week.

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

FIND ALL THESE TRANSMITTALS IN THE **ADVISOR** TAB OF THE **PDE** 2



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

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The link to this MedLearn MM11701

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KNOWLEDGE • RESOURCES • TRAINING

April 2020 Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM11701
Related Change Request (CR) Number: 11701
Related CR Release Date: March 20, 2020
Effective Date: April 1, 2020
Related CR Transmittal Number: R10003CP
Implementation Date: April 6, 2020

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 11701 informs MACs about new and revised Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) supplies MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are available in Chapter 4, Section 50 of the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

BACKGROUND

The ASP methodology is based on quarterly data manufacturers submit to CMS. CR 11701 instructs MACs to download and implement the April 2020 and, if released, the revised January 2020, October 2019, July 2019, and April 2019 ASP drug pricing files for Medicare Part B drugs

CR 11701 addresses the following pricing files:

- File: April 2020 ASP and ASP NOC -- Effective Dates of Service: April 1, 2020, through June 30, 2020
- File: January 2020 ASP and ASP NOC -- Effective Dates of Service: January 1, 2020, through March 31, 2020
- File: October 2019 ASP and ASP NOC -- Effective Dates of Service: October 1, 2019, through December 31, 2019
- File: July 2019 ASP and ASP NOC -- Effective Dates of Service: July 1, 2019, through

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM11702

Related Change Request (CR) Number: 11702

Related CR Release Date: March 20, 2020

Effective Date: April 1, 2020

Related CR Transmittal Number: R10004CP

Implementation Date: April 6, 2020

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 11702 informs DME MACs about the changes to the DMEPOS fee schedule that Medicare updates on a quarterly basis when necessary to implement fee schedule amounts for new codes. In addition, the update corrects any fee schedule amounts for existing codes and updates to the DMEPOS Rural ZIP code file. The update process for the DMEPOS fee schedule is available in the Medicare Claims Processing Manual, Chapter 23, Section 60 at: https://www.cms.gov/files/document/chapter-23-fee-schedule-administration-and-coding-requirements.pdf. Make sure your billing staff is aware of this update.

BACKGROUND

CR 11702 provides instructions for the April 2020 DMEPOS Rural ZIP code file containing the Quarter 2, 2020 Rural ZIP code changes. Also included in the update is the former Competitive Bidding Area (CBA) ZIP code file containing the Quarter 2, 2020 Round 1 2017 and Round 2 Re-compete CBA ZIP codes. An April update to the 2020 DMEPOS and PEN fee schedule files is not required.

The following DMEPOS fee schedule and ZIP code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html:

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There were FIVE new or revised Transmittals released this week.

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

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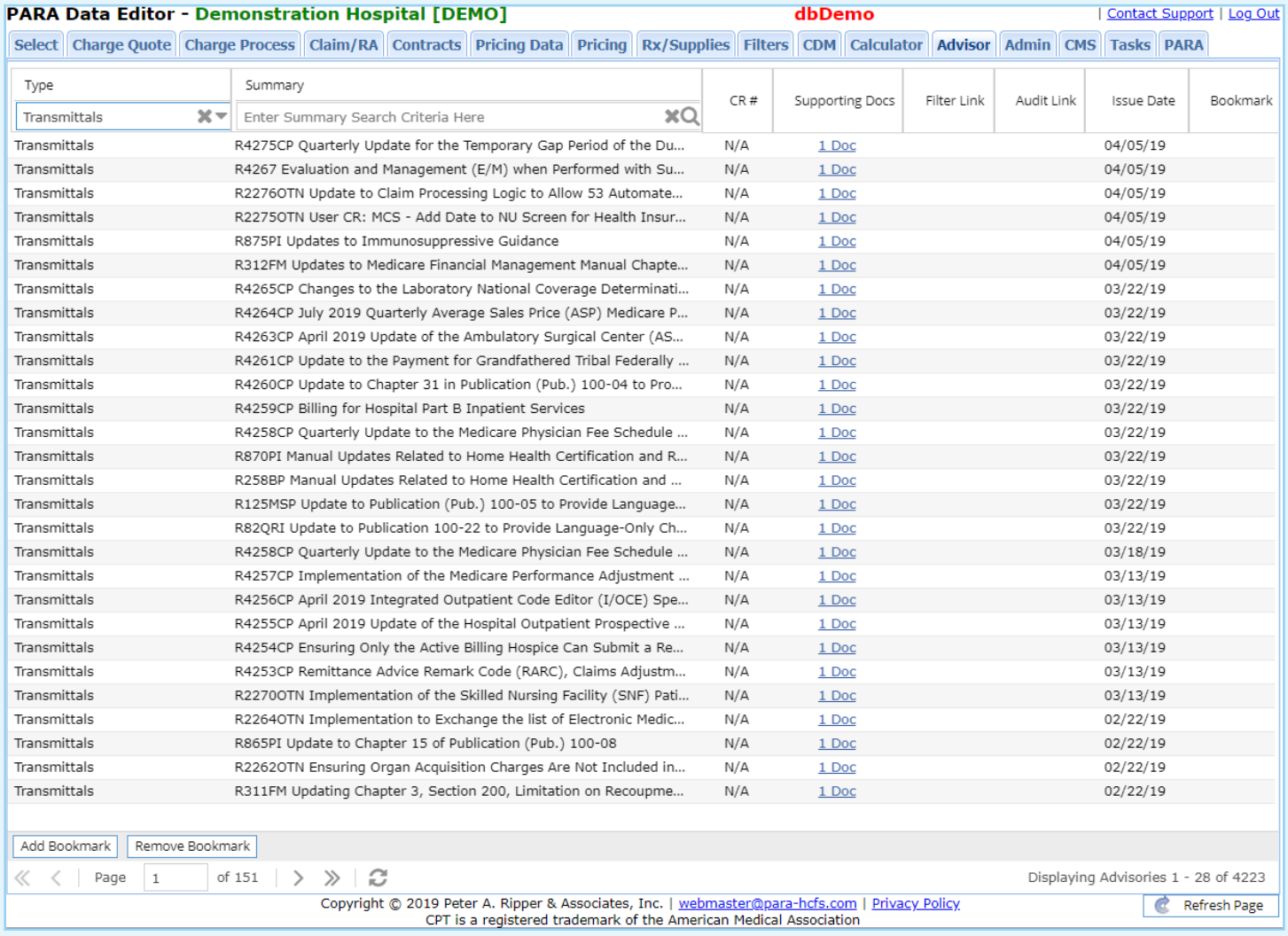

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Transmittals	R4259CP Billing for Hospital Part B Inpatient Services	N/A	1 Doc			03/22/19	
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The link to this Transmittal R10006CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10006	**Date: March 20, 2020**
	Change Request 11718

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

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

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

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

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

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

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

IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10003CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10003	**Date: March 20, 2020**
	Change Request 11701

SUBJECT: April 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

I. SUMMARY OF CHANGES: The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply the contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in chapter 4, section 50 of the Internet Only Manual.

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

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

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

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10009CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10009	**Date: March 20, 2020**
	Change Request 11640

Transmittal 4542, dated March 6, 2020, is being rescinded and replaced by Transmittal 10009, dated, March 20, 2020 to revise the background section removing the first instance of code 0091U. All other information remains the same.

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

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

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

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

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10004CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10004	**Date: March 20, 2020**
	Change Request 11702

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

I. SUMMARY OF CHANGES: The DMEPOS fee schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes, correct any fee schedule amounts for existing codes, and update the DMEPOS Rural ZIP code file. The quarterly update process for the DMEPOS fee schedule is located at publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

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

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10002CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10002	**Date: March 20, 2020**
	Change Request 11687

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 90.4.2

I. SUMMARY OF CHANGES: This Change request makes updates to chapter 3 of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: April 20, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 20, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/90/90.4.2 - Billing for Liver Transplant and Acquisition Services

III. FUNDING:

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

Business Requirements
Manual Instruction

Contact Our Team

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pripper@para-hcfs.com

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Randi Brantner
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Introducing, our new partner.

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